JAN
Informing Practice and Policy Worldwide through Research and Scholarship

ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

Prevention of involuntary admission through Family Group Conferencing: a qualitative case study in community mental health nursing

Gideon de Jong, Gert Schout & Tineke Abma

Accepted for publication 12 April 2014

Correspondence to G. de Jong:
e-mails: gideon.de.jong@gmail.com;
g.jong1@vumc.nl

Gideon de Jong MSc RN
PhD candidate
Department of Medical Humanities,
EMGO+, VU University Medical Center,
Amsterdam, the Netherlands

Gert Schout PhD RN
Senior Researcher
Department of Medical Humanities,
EMGO+, VU University Medical Center,
Amsterdam, the Netherlands

Tineke Abma PhD
Professor
Department of Medical Humanities,
EMGO+, VU University Medical Center,
Amsterdam, the Netherlands

DE JONG G., SCHOUT G. & ABMA T. (2014) Prevention of involuntary admission through Family Group Conferencing: a qualitative case study in community mental health nursing. *Journal of Advanced Nursing* 70(11), 2651–2662. **doi: 10.1111/jan.12445**

Abstract

Aim. To understand whether and how Family Group Conferencing might contribute to the social embedding of clients with mental illness.

Background. Ensuring the social integration of psychiatric clients is a key aspect of community mental health nursing. Family Group Conferencing has potency to create conditions for clients' social embedding and subsequently can prevent coercive measures.

Design. A naturalistic qualitative case study on the process of one conference that was part of 41 conferences that had been organized and studied from January 2011–September 2013 in a public mental health care setting in the north of the Netherlands.

Methods. Semi-structured interviews ($N = 20$) were conducted with four stakeholder groups ($N = 13$) involved in a conference on liveability problems in a local neighbourhood wherein a man with schizophrenia resides.

Findings. To prevent an involuntary admission to a psychiatric ward of a man with schizophrenia, neighbourhood residents requested a family group conference between themselves, the sister of the man and the mental health organization. As a possible conference aggravated psychotic problems, it was decided to organize it without the client. Nine months after the conference, liveability problems in the neighbourhood had been reduced and coercive measures adverted. The conference strengthened the community and resulted in a plan countering liveability problems.

Conclusion. The case indicates that social embedding of clients with severe psychiatric problems can be strengthened by Family Group Conferencing and that hence coercive measures can be prevented. A shift is required from working with the individual client to a community driven approach.

Keywords: assertive community treatment, care avoidance, coercion, community mental health nursing, Family Group Conferencing, nursing, public mental health care, qualitative case study, social embedding

© 2014 John Wiley & Sons Ltd

Why is this research or review needed?

- Ensuring the social integration of psychiatric clients and mobilising help from their network is a key aspect of community mental health nursing.
- On the basis of social network theory, Family Group Conferencing has potency to create conditions for clients' social embedding and subsequently can prevent coercive measures.
- There is limited experience with Family Group Conferencing in mental health care. This article is an attempt to understand the process of Family Group Conferencing in assertive community treatment.

What are the key findings?

- Family Group Conferencing can also succeed without clients being present. When a conference evokes fear or aggravates psychotic problems they can be represented by a spokesperson.
- Involuntary admission to a psychiatric ward can be averted when informal support through a family group conference is sufficiently mobilized.
- Family Group Conferencing has the potency to bridge the informal world of the community with the formal world of the agencies so the resources of both worlds become available.

How should the findings be used to influence policy/practice/research/education?

- Family Group Conferencing can complement the repertoire of social network strategies whereon nurses in assertive community treatment and public mental health care can draw.
- A reorientation is required from the well-being of the client to the needs of the community, an approach wherein results are not achieved in but through the community.

Introduction

As already been articulated by Hildegard Peplau in 1952 (Peplau 1952, 1997) and recently emphasized by nursing scientists (Hewitt & Coffey 2005, Norman 2009), promoting autonomy and establishing a therapeutic relationship form the core of nursing in mental health care. In addition, there is growing attention to outpatient treatment wherein the family (Jubb & Shanley 2002, Sherman *et al.* 2005, Ewertzon *et al.* 2008, Lakeman 2008, Macleod *et al.* 2011) and broader community (Norman 2009, O'Brien *et al.* 2009, Coffey & Hannigan 2013) are involved to take care of clients with psychiatric problems. A form of such case management is assertive community treatment (ACT). A substantial proportion of professionals working in ACT teams is formed by nurses (McAdam & Wright 2005, Macleod *et al.* 2011). The core of ACT is establishing contact and gaining trust from clients who have lost faith in mental health agencies and its representatives. Outreach care is flexible to maintain a therapeutic relationship with clients. Clients who are helped in ACT teams are mostly diagnosed with schizophrenia or schizoaffective disorder (Marshall & Lockwood 2010).

A main goal of ACT is preventing involuntary admission to psychiatric wards. As multidisciplinary teams of psychiatrists, nurses and social workers provide (if necessary) unsolicited assistance, are available seven days a week and 24 hours a day and share clients in their caseload, it is the assumption that latent crises are easier to be detected and consequently coercive measures can be averted (McAdam & Wright 2005, Sytema *et al.* 2007, Mancini *et al.* 2009, Marshall & Lockwood 2010). Averting coercion with this target group is a major benefit, as consequently the accumulation of negative experiences with professional care will be halted (Forchuk & Reynolds 2001, O'Brien & Golding 2003, Bertram & Stickley 2005, Frueh *et al.* 2005, Robins *et al.* 2005, Katsakou *et al.* 2010, Landeweer *et al.* 2011, Voskes *et al.* 2013). However, as caseloads are extensive and negatively impacted by administrative pressures, professionals can spend little time per client (Salyers & Bond 2001, Macleod *et al.* 2011), resulting in what Simpson (2005, p. 695) calls 'limited nursing'. It is therefore not always possible to prevent deterioration of clients' conditions and as a result, coercive measures are still deployed. The assumption is that when clients' social networks are intensively involved, a gradual deterioration can be prevented as relatives and neighbours in an early stage can help indicating an aggravation of psychotic symptoms. In other words, strengthening social support decreases clients' vulnerability (Poortinga 2006, Chen 2008, Langeland & Wahl 2009, Thoits 2011, Chen & Ogden 2012). There are, however, doubts whether mobilizing informal support of clients with severe mental health problems and their social integration is possible at all (Lub & Uyterlinde 2012). More specifically, questions have been raised concerning the willingness of the social network to contribute and support people who have difficulties in maintaining reciprocal relationships.

The purpose of this article is to explore whether and how Family Group Conferencing (FGC) can strengthen the social embedding of clients with severe mental illness and avert coercive measures. There is limited experience with FGC in mental health care. On the bases of findings from the social network theory that strengthening informal support has a positive impact on the quality of life of psychiatric clients

© 2014 John Wiley & Sons Ltd

(see among others Becker *et al.* 1998, Strine *et al.* 2008, Panayiotou & Karekla 2013, Sündermann *et al.* 2013), it is plausible that FGC has potency to create conditions for the social embedding of clients with severe mental health problems. In this article we describe a case on the struggles of residents of a local neighbourhood living together with an ACT-client with schizophrenia. We selected this case out of 41 cases, because this case is suitable to understand the pattern of strengthening social embedding. It is a 'case of' (Luck *et al.* 2006, p. 105) a living situation wherein the willingness of residents in a neighbourhood to provide shelter to a man diagnosed with schizophrenia is described and all the struggles that comes along with it.

Background – Family Group Conferencing

In an earlier article we questioned if Family Group Conferencing (FGC) could contribute to the social integration of clients with limited informal resources (De Jong & Schout 2011). FGC is based on traditions of the Maoris, an indigenous tribe from New Zealand. Its main principle is shared decision-making during meetings wherein extended family members and representatives of the community participate (Burford & Hudson 2000).

FGC consists of four phases: (1) a client or family is referred to a conference by a professional; (2) an independent coordinator will prepare the conference. Together with the client, the resources from the informal network are being indicated who should be invited for the conference; (3) the conference itself starts with sharing information on the problem situation. Professionals are asked to share their ideas for possible solutions. Crucial during the conference is the private family time: free from supervision of professionals, clients and their network are stimulated to come up with a plan on their own. At the end of the conference, it is being decided who will ensure the implementation of the plan. This can be the client himself, a member from the social network or a professional; (4) one month after the conference, the coordinator will contact all actors involved to figure out if the plan is being implemented as where all actors have agreed on. If necessary, a new conference is being planned that should result in a better plan.

In a family group conference professionals help clients and their network coming up with a plan on their own. They provide information during the first part of the conference and will indicate if the plan ensures safety if prior to the conference there were risks and a conference was deployed to avert a coercive measure. After the conference they will help, where necessary, to implement the plan.

The study

For 2 years, we have studied the course and impact of 41 family group conferences in a public mental health care (PMHC) setting in the north of the Netherlands. PMHC serves as a safety net for those who are in need for help, but who avoid the care they actually need or do not find their way to the services (Schout *et al.* 2011). When clients in ACT are reluctant towards help, PMHC professionals could be counselled how to restore contact.

We conducted this research project between January 2011–September 2013. In total, we have interviewed 312 participants of the conferences. Each of these respondents was asked to take part in a group member check that followed the individual interviews to validate interim findings (Guba & Lincoln 1989). A total of 144 respondents participated in the 41 member checks. Respondents who could not, or would not be able to participate were subsequently asked to reflect on interim findings by telephone. Overall, in the 41 meetings, participants acknowledged that our description on the process of the conference and all its twists and turns was correct. Both the individual interviews and member checks gave us insight in how the conferences proceeded and whether they could be indicated as successful or as a failure. Finally, of each conference, a case study report had been written. Specifically to the in this article highlighted case, the two member checks also had the positive side-effect that participants could evaluate the past period and make new future plans.

Aim

The aim of this qualitative case study was to understand the process of a family group conference that was organized to ensure the social embedding of a man diagnosed with schizophrenia in a neighbourhood and the specific approach of community mental health nurses that should come along with it.

Research design

The qualitative case study in a social constructivist paradigm is increasingly seen as a fully fledged research method in nursing sciences (Zucker 2001, Gangeness & Yurkovich 2006, Luck *et al.* 2006, Anaf *et al.* 2007) 'to evaluate phenomena or professional interest appropriateness for many nursing contexts' (Anthony & Jack 2009, p. 1177). In our research we have used Stake's (1995) case study approach. Herein, explicit attention is paid to the involvement of

© 2014 John Wiley & Sons Ltd

Table 1 Respondents case study.

Respondent and/or participant of the conference	Participating in the conference	M/F	Age	Being interviewed and when	Length of the interview
ACT client, also indicated as Arie (pseudonym) in this article	No	M	49	Not being interviewed, see 'ethical considerations'	
Sister of Arie	Yes	F	47	1st interview: 28/09/2012 11·00 2nd interview: 27/03/2013 14·00	80 minutes 50 minutes
Resident 1	Yes	M	54	1st interview: 14/09/2012 14·00 2nd interview: 22/03/2013 13·00	60 minutes 50 minutes
Resident 2	Yes	M	50	1st interview: 19/09/2012 11·00 2nd interview: 14/03/2013 10·00	90 minutes 100 minutes
Resident 3	Yes	F	65	1st interview: 24/09/2012 10·00 2nd interview: 18/03/2013 15·00	90 minutes 85 minutes
Resident 4	Yes	F	50	1st interview: 01/10/2012 11·00 2nd interview: not being interviewed, was out of reach	135 minutes
Resident 5	No	F	51	1st interview: not being interviewed, was out of reach 2nd interview: 19/03/2013 20·00	55 minutes
Resident 6	Yes	M	50	Not being interviewed, was out of reach	
FGC coordinator, has been a volunteer coordinator for more than 5 years and works full time as a secondary school teacher	Yes	F	60	1st interview: 07/09/2012 09·30 2nd interview: not having knowledge on the long-term impact after the conference, so therefore not being interviewed a second time	90 minutes
ACT case manager 1, originally psychiatric nurse	Yes	F	40	1st interview: 27/09/2012 10·00 2nd interview: did not want to be interviewed a second time	65 minutes
ACT case manager 2, originally psychiatric nurse, also indicated as Petra	Yes	F	45	1st interview: 27/09/2012 13·15 2nd interview: did not want to be interviewed a second time	75 minutes
ACT case manager 3, originally psychiatric nurse, also indicated as Guido	No	M	51	1st interview: became involved after the conference so could not reflect on the situation beforehand 2nd interview: 18/03/2013 12·00	40 minutes
PMHC professional, originally psychiatric nurse, also indicated as Harm	Yes	M	53	1st interview: 03/09/2012 13·00 2nd interview: was too busy when the follow-up interviews were deployed	60 minutes
Consultant housing association	Yes	F	51	1st interview: 10/09/2012 16·00 2nd interview: 21/03/2013 11·00	35 minutes 30 minutes
Concierges of the local education institute	No	2× M	60 and 57	1st interview: 12/09/2012 14·30 2nd interview: 20/03/2013 10·00	35 minutes 20 minutes
Local police officer	No	M	32	1st interview: 04/10/2012 11·00 2nd interview: not being interviewed, was out of reach	40 minutes

What we consider under 'local neighbourhood' should be understood as eight houses around a courtyard. Five of these houses belong to a housing association that on the basis of social housing policies rent these houses to people who have a below average income. The other three houses are owner-occupied. The social bonds between the residents are strong; when there are problems in their courtyard, then they are willing to solve them and help each other out. Before the client was given shelter in one of the houses, it were the residents who deliberately wanted him to live there, as they did not longer want him languishing on the streets.

various stakeholder groups, including silenced voices (Abma 2005, Anthony & Jack 2009), with an aim to gain a holistic understanding of the case (Abma & Stake 2014). In that sense, there are 'case[s] within a case' (Bergen & While 2000, p. 929). In our study, the PMHC target group with multiple problems and members from their social network have often been expropriated by professionals from taking decisions themselves and they are rarely involved as partici-

 © 2014 John Wiley & Sons Ltd

pants in studies (for some exceptions, see Jones & Scannell 2002, Kirsh & Tate 2006, Schout *et al*. 2010).

Participants

We aimed to interview everyone (potentially 17 participants) who was involved in the conference or could reflect on its impact (Table 1). In the period between 1–3 months after the conference, 13 respondents were interviewed retrospectively (one dual interview) on the problem situation prior to the conference, the course of the conference itself and the implementation of the plan. In the follow-up study that took place even up to 9 months after the conference, 9 respondents (one dual interview) reflected on the long-term course. Ensuring diversity of perceptions is crucial in case study research (Abma & Stake 2014) and an indication of its rigour (Anthony & Jack 2009). We therefore ensured a sufficient involvement of respondents from four stakeholder groups: (1) those involved in the problem situation (neighbourhood residents); (2) members from the social network of the client (his sister and the two concierges); (3) professionals (three ACT case managers, a PMHC professional, a police officer and a consultant of the housing association); (4) the FGC coordinator.

Data collection

The first study was done 3 months after the conference, the follow-up after 9 months to reconstruct the problem situation prior to the conference, the course of the conference itself and its impact over the long run. Interviews were conducted at sites being designated by respondents (at their home, their work or in a neutral environment) and at moments convenient to them (during daytime and evenings, weekdays and in weekends).

The interviews were recorded and transcribed verbatim. During the interviews respondents retrospectively looked back on the course of the conference. Interviews were structured along a topic list. Issues were based on the FGC model as described in the background and therefore included the outline of the problem, referral to the conference and its preparation, the conference itself, the implementation and evaluation of the plan and all the twists and turns that happened over the long run.

Ethical considerations

Public mental health care is a network organization operating in an ethical laden context. The contributing organizations, like mental health care, addiction care, social work and the municipality, have their own ethical committees. For this study, executives of these organizations formed an advisory board to assess the legal and ethical implications that come along with it and approved the procedures under the condition that names of individuals, families, streets, cities and organizations were coded or fictitious and only traceable for the researchers and all audio data would be stored until 2015 and then deleted (Silverman 2013).

All interviewees – e.g. the participants of the conference – agreed prior to the conference to be interviewed for research purposes and were aware that findings could be used for publication under the aforementioned conditions. After several attempts to stimulate the client for participation in the conference and evaluation study, it became clear to us that cognitive problems disabled him from participating, such as a lack of concentration and being unable to conform to norms when others are given attention. He was not able to structure impressions in a coherent manner and therefore risked that psychotic symptoms would aggravate. We finally decided not to continue stimulating the client for participation and therefore asked the mental health organization and his sister to share information on him. In consultation with his sister, the client agreed that the conference should go ahead, even without him being present and subsequently its course and outcomes being evaluated, sharing information on him. He was informed where and when the conference was held and that he was welcome to join, but that neighbours would want to make a plan on how to deal with his behaviour so liveability problems in their neighbourhood would be reduced and consequently an involuntarily admission be averted.

Such a case study as ours is ethically laden. Restrictions for anonymity and privacy are easily violated and there is the risk of disempowerment when researchers share discrete information (e.g. Abma & Stake 2014). In this case, however, it is not our aim to predominately foreground the client and his problems, but rather the difficulties the neighbours have with his behaviour and how they can address the consequences of his illness.

Data analysis

The data analysis was an iterative process starting during the data gathering. We added new topics when fresh insights emerged during the interviews (Silverman 2013). The analysis therefore took place in a cyclical process of constant comparison (Boeije 2002). A content analysis was performed using ATLAS.ti. Codes were assigned to meaningful fragments (open coding). These codes were combined

© 2014 John Wiley & Sons Ltd

and grouped into categories (axial coding). Eventually, data were linked (selective coding), so it became possible to describe the course prior, during and after the conference.

Rigour of the study

Findings from the interviews were validated during two group member checks (Guba & Lincoln 1989) moderated by the first author. Respondents, who could not be present, were subsequently asked to reflect on interim findings by telephone. To ensure reliability of the data, the researchers acted as 'social anthropologists' so that they would be sensitive to insights and unexpected twists during interviews (cf. Anderson *et al.* 2005, Silverman 2013). The case report is the result of an ongoing dialogue between the researchers and the participants of the conference.

Findings

Four themes characterize the process of FGC in this particular case: (1) a history of compulsory treatment and care avoidance; (2) participation of the client during the conference not mandatory; (3) involuntary admission to psychiatric ward being averted after the conference; (4) abrasive contact between the neighbourhood and ACT case managers being solved.

A history of compulsory admission and care avoidance

The case revolved around issues in a local neighbourhood of a medium sized city in the Netherlands wherein a man (from now on referred to as Arie), who is 49 years and diagnosed with schizophrenia is living. Seven people, including one couple, reside in the neighbourhood. A few years ago Arie was deliberately given shelter by the residents when a house in the neighbourhood became available. He had been living on the streets for years and languishing for a long time. His sister tells that Arie had been involuntarily referred to a psychiatric hospital after a suicide attempt around his 18th birthday:

> There he received medication. That was still Haldol and he always says that this has damaged a lot inside of him. [Sister]

Arie developed an aversion towards medication. Since then, he was admitted to a psychiatric hospital against his will several times. After his last admission, about twenty years ago, he ended up on the streets without care. His sister lost sight of him, but traced him back. About fifteen years ago Arie roamed around an education institute where he slept under the stairs of the main entrance. He had contact with two concierges working at the institute. During an unbearably cold winter, the concierges organized a warm place to sleep:

> I had asked for permission from the facility manager, but at first Arie did not want it. However, when that second night was so cold again, he came to me and asked if he could have shelter in the tool house. [Concierge 1]

During this period, he got in touch with residents living close to the institute. As the place where Arie slept would be demolished, two residents contacted the housing association and ensured that Arie could come to live in a house in their neighbourhood. Arie was reluctant, but after being urged by the concierges he agreed.

Arie's sister has since then been the regular contact between Arie and the residents. Arie was also been approached by an ACT team. He had avoided professional care for a long time and is still suspicious towards unknown case managers and never wants more than one worker visiting him. The nature and frequency of contact with Arie is unstable:

> During a period of 6 months we had not seen him. Then we went there every day, announced and unannounced, but he did not open the door or he was not at home. [Case manager 1]

Participation of the client during the conference not mandatory

Residents also noticed the gradual deterioration of Arie's mental conditions. During the first years not many problems occurred. Despite his psychotic problems, Arie refused medication and it became increasingly difficult for the residents to handle (un)certain behaviour:

> They were so concerned, they thought that everything is acceptable which is, of course, not the case. Where do you draw a line? They needed that to know. There were feelings of fear and insecurity among the residents. 'Suppose I would correct Arie, would that not have a negative impact on him? Would he not become angry? What would he do?' [Case manager 3]

At some point, the residents became divided on when and how they should limit Arie:

> That was one discussion issue we had among each other. At one point I even thought: 'Wait a minute, are you not hospitalizing him right now? Is it his demand for care, or your concern to take care of him?' [Resident 2]

This discord was the reason for the neighbourhood to contact Arie's case manager of the ACT team. The case manager just met Arie and in consultation with the former

 © 2014 John Wiley & Sons Ltd

case manager they decided that involuntary admission to a psychiatric ward was necessary to prevent further escalation:

At one certain moment it was not going well with him, even in such an extension that the neighbours indicated it was getting a bit out of hand. [...] Some situations wherein Arie acted aggressive had occurred, so we needed to do something. [Case manager 2]

This was not what the residents intended: they only wanted advice on how to deal with Arie:

We told his case manager that he had crossed a line and that something needed to be done. But not that he would be send to a psychiatric ward! [Resident 1]

A PMHC professional was consulted. He recommended deploying a family group conference to restore contact between Arie, his case managers and the residents.

The FGC coordinator had difficulties to establish contact with Arie and gain his trust:

I constantly tried to get in touch with Arie, because the conference was organised around him. But at one point, it appeared from all sides that it was just not possible he would participate. [FGC coordinator]

After several attempts, the residents and his sister tried to motivate Arie, but without any result. They reasoned the conference evoked too much fear that fuelled his psychotic behaviour. As Arie kept aloof, it was decided to change the focus of the conference from strengthening his well-being to supporting the community. Ultimately it was decided to organize a conference without Arie.

Ten persons participated in the conference: five residents, Arie's sister, both case managers, a consultant of the housing association and the PMHC professional. Everyone recognized the need for a plan to stabilize the situation. It was decided to cancel the involuntary admission. The PMHC professional helped the residents on how to handle unacceptable behaviour without risking escalation by providing psycho education and coaching.

Involuntary admission being adverted

Limiting Arie's behaviour made the situation after the conference initially worse, but in the longer term it appeared to have a positive effect on Arie as well on the residents:

He has now realised that the residents want him to stay, but that they do not accept all of his behaviour. I think that he now feels safer and comfortable with these new boundaries [...] He is able to make contact with people in a proper way and can ask them for help. That is really an indication that he has been empowered. [Sister]

Nine months after the conference had been organized, it appears that Arie is still living in the neighbourhood without coercive measures being executed. This positive outcome is articulated as follows:

It is relatively quiet, no big fuss, no serious incidents, no fear. [Resident 5]

Abrasive contact between the residents and ACT case managers being solved

After the escalation of unacceptable behaviour that preceded the conference, the residents wanted immediately an appointment with Arie's case manager. This was difficult to establish. When the residents spoke with her for the first time, they got to know that an involuntary admission to a psychiatric ward was requested. This had a negative impact on the contact between the residents and the case manager:

They [the mental health organisation] had let us down. We had requested for an appointment. It was difficult to make an appointment, it lasted a few months! When it finally came to it, they told us that they had applied for an involuntary admission. The reason was that incident [referring to Arie's aggressive behaviour towards a neighbour], which in the meantime had happened months ago! [Resident 5]

As the residents made clear that they had severe difficulties in dealing with Arie but considered an involuntary admission undesirable, it was being decided that it would be temporarily postponed. However, it was not possible to restore the damaged relationship between the residents and the mental health organization. In the meantime, Arie behaved unacceptable and finally the PMHC professional became involved. He requested the family group conference. Shortly after the conference, the contact with the two case managers remained problematic, so on request of the PMHC professional the mental health organization decided to add a new case manager who concentrated on the residents.

Since the third case manager became involved mutual trust between the residents and the mental health organization had been restored:

I think that confidence in the mental health care has returned. We have reconnected with the residents in many ways. [Case manager 3]

Also a local police officer and a consultant of the housing association got involved. In case of difficulties in the

© 2014 John Wiley & Sons Ltd

neighbourhood they will not execute drastic measures too quickly:

If there is a problem I can contact the police officer and then Arie will not instantly be locked away. [Resident 2]

Also the contact between the residents and the housing association improved after the conference:

Before I did not know how they were living there and how they perceived their living circumstances. I think they did not know what I had to offer. There is more mutual trust right now. [Consultant housing association]

Discussion

Principal findings

The case presented illustrates how a formal and rather bureaucratic system world dominating the mental health organization was not willing to embrace the perspective of the informal life world of the residents and the client's sister. Instead of strengthening their capabilities to deal with the client, case managers proposed an involuntary admission. This solution had been the path of the least resistance for a long time in community mental health care when professionals were faced with complex problems, but negative consequences for clients were not always taken fully into account. The highlighted case shows that halting negative experiences with mental health care and its representatives and learning to have trust in them was of significant importance to the client and his neighbours. Engaging clients in care is crucial in ACT. The family group conference provided safe grounds wherein residents could express their grievances and were heard. All parties felt they needed each other to come up with a sustainable solution. A plan was established whereon everyone agreed – it bridged the informal life world with the formal system world. However, the relationship between the residents and the case managers remained tense after the conference, so a new case manager was added who focused on the community. As the residents felt they were backed up by this case manager and the PMHC professional, it became possible to achieve results through the community. Both professionals strengthened the residents' capabilities to deal with unacceptable behaviour without risking an escalation and subsequently an involuntary admission. The residents held each other accountable and acted as a unified entity. They corrected the clients' behaviour and simultaneously gave him the feeling that they also wanted him to be part of the neighbourhood as an equal citizen. Nine months after the conference the client was still living in his house without being sent to a psychiatric ward. The sister indicated he felt more respected, trusted and valued and consequently behaved more accountable towards the community.

Findings in relation to other studies

The case indicates that the family group conference, requested by residents, restored the liveability for everyone. The conference yielded a convincing plan and hence the mental health organization decided to withdraw the application for an involuntary admission. If FGC has the potency to prevent involuntary admissions, it is plausible it would also have the potency to prevent lesser forms of coercion in community mental health care, such as unsolicited help, assertive outreach or conditional assistance. That FGC potentially can avert coercion in mental health care resonates with the literature on FGC for children and multi problem families which already indicated that this decision-making model can prevent outplacements of children (Weigensberg *et al.* 2009, Pennell *et al.* 2010, Wang *et al.* 2012) and relapse into juvenile delinquency (Jeong *et al.* 2012).

The question is whether this case is representative for the Dutch situation. Society sometimes acts offensive when psychiatric clients are stimulated to integrate herein (Verplanke & Duyvendak 2010). Contrary to Lub and Uyterlinde (2012) who argue that only clients with mild forms of psychiatric disorders can expect support from the community during their social integration, our case study indicates that the social embedding of clients with severe problems is sometimes within reach. In the presented case, the successful conduct after the conference is influenced by three factors. First, the commitment of the residents and the client's sister finding a way to avert the involuntary admission and guarantee everyone's quality of life in the neighbourhood. Second, the case manager's ability to create a fruitful collaboration with the residents, consequently, solving the abrasive relationship with the mental health organization. Finally, the switch of the ACT team from a one-sided focus on caring for the individual client to a broad approach wherein there is also attention to the needs of the social context wherein the client is living.

The mental health nursing profession is, however, increasingly encapsulated by the biomedical model, which focuses on 'quick-fix' solutions for individuals (Hewitt & Coffey 2005, Simpson 2005, Coffey & Hannigan 2013). As these quick-fix solutions are usually not at hand in assertive outreach or even do not work, achieving progress with clients is difficult (e.g. Pescosolido *et al.* 1998). Engaging clients to professional care and subsequently halting their

 © 2014 John Wiley & Sons Ltd

deterioration and languishing is actually a major achievement in this field of care. Coffey and Hannigan (2013) recently urged that nurses in the UK should instead of working in a biomedical model embrace the values of social psychiatry. Similar critics were also raised by mental health professionals in the Netherlands lately (Lohuis & Beuker 2013). However, Coffey and Hannigan (2013) question if medically qualified nurses are willing to incorporate a holistic approach: 'at the very least, realizing a 'social perspective' is likely to be far more complex than might be first imagined and, for nurses, is not an insignificant undertaking' (p. 1427). It is not the biomedical itself we reject, as it can actually lead to efficiency and transparency. It is rather its colonization of the practice of community mental health nursing we consider problematic as consequently its core values of attentiveness, responsibility, responsiveness and trust are underestimated. Further on, as Benner *et al.* (2009) propose, the utilitarian individualism that underlies the biomedical model violates seeing the person as member and participant in a human community. It is the communal capability that according those nursing scientists gives a more adequate account of caring for the vulnerable. Being mental health nurses ourselves, we therefore recommend that nursing schools should equip their future professionals with tools that are necessary in the complex practice of assertive outreach – skills to build not only a relationship of trust with clients but also with the resources from their social network who precisely can prevent clients from further deterioration.

Study limitations

In this study, we were interested in the unique case wherein specific twists occurred that are exemplary for the struggles of a neighbourhood wherein an ACT client resides. The findings from this case study are context-bound. In line with Abma and Stake (2014), our aim was to extract lessons from one particular case that can be of exemplary value to other situations wherein FGC can offer a solution for liveability problems and subsequently can avert coercive measures.

Our study holds two major limitations. First, the researchers did not participate in the conference, because within FGC professionals withdraw from the conference to encourage the client and social network to establish their own plan. As a consequence, we could only reconstruct the decision-making process retrospectively. This non-interventionist stance limited the influence of the researchers on the outcome of the plan. Second and equally or even more important, a case study research such as ours on a personal story encounters several ethical tensions (Abma & Stake 2014). Researchers should especially be careful not to solidify the case in a way that it hurts those involved, both in the short as the long run. Our case is ethically laden and could lead to exposure. We tried to capture this by reflecting ourselves whether personal disclosures could harm, embarrass or disempower those involved and especially, the client. In addition, his sister shared our reports with him and asked him if he would agree with disclosure in a scientific journal.

Conclusion

The imminent involuntary admission in the described case had an unintended positive consequence as it united the residents of the local neighbourhood to request a family group conference. Nine months after the conference the liveability had improved for all. The case study demonstrates that FGC can complement the repertoire of social network strategies whereon nurses in assertive outreach can draw. This requires a reorientation from the well-being of the individual client to the needs of the whole community. In such an approach, results are not achieved in but through the community.

Acknowledgements

We are grateful to all participants of the case study but especially to the sister of the client for her feedback on draft versions of our article. She emphasized that our research took place in a relatively stable period, up to 1 year after the conference. However, there have been ups and downs afterwards. Now, 2 years after the conference, the situation in the neighbourhood is tense – a situation where the support of mental health services is crucial for this small community to endure this difficult period.

We thank the following recently graduated students of the Hanze University of Applied Sciences in Groningen for their contribution in this case study: Valentine Aartsen, Neeltsje Bouma, Anique Bleumink and Dieuwke Smit.

Funding

The 41 Family Group Conferences were 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), Netherlands Foundation of Mental Health (Fonds Psychische Gezondheid) and Fonds NutsOhra.

© 2014 John Wiley & Sons Ltd

Conflict of interest

There are no conflicts of interests to be reported.

Author contributions

GdJ, GS and TA were responsible for the study conception and design, and revisions of the article; GdJ performed the data collection and analysis; GdJ, GS and TA were responsible for the drafting of the manuscript; GS and TA supervised the study. GS obtained funding and provided administrative, technical or material support.

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

References

Abma T.A. (2005) Responsive evaluation: its meaning and special contribution to health promotion. *Evaluation and Program Planning* **28**(3), 279–289.

Abma T. & Stake R. (2014) Science of the particular. *Qualitative Health Research*, in press.

Anaf S., Drummond C. & Sheppard L.A. (2007) Combining case study research and systems theory as a heuristic model. *Qualitative Health Research* **17**(10), 1309–1315.

Anderson R.A., Crabtree B.F., Steele D.J. & McDaniel R.R. (2005) Case study research: the view from complexity science. *Qualitative Health Research* **15**(5), 669–685.

Anthony S. & Jack S. (2009) Qualitative case study methodology in nursing research: an integrative review. *Journal of Advanced Nursing* **65**(6), 1171–1181.

Becker T., Leese M., Clarkson P., Taylor R.A., Turner D., Kleckham J. & Thornicroft G. (1998) Links between social networks and quality of life: an epidemiologically representative study of psychotic patients in South London. *Social Psychiatry and Psychiatric Epidemiology* **33**(7), 299–304.

Benner P., Tanner C. & Chesla C. (2009) *Expertise in Nursing Practice. Caring, Clinical Judgment and Ethics*, 2nd edn. Springer Publishing Company, New York.

Bergen A. & While A. (2000) A case for case studies: exploring the use of case study design in community nursing research. *Journal of Advanced Nursing* **31**(4), 926–934.

Bertram G. & Stickley T. (2005) Mental health nurses, promoters of inclusion or perpetrators of exclusion? *Journal of Psychiatric and Mental Health Nursing* **12**(4), 387–395.

Boeije H. (2002) A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality & Quantity* **36**(4), 391–409.

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

Chen F. (2008) A fine line to walk: case managers' perspectives on sharing information with families. *Qualitative Health Research* **18**(11), 1556–1565.

Chen F. & Ogden L. (2012) A working relationship model that reduces homelessness among people with mental illness. *Qualitative Health Research* **22**(3), 373–383.

Coffey M. & Hannigan B. (2013) New roles for nurses as approved mental health professionals in England and Wales. *International Journal of Nursing Studies* **50**(10), 1423–1430.

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

Ewertzon M., Lützen K., Svensson E. & 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), 439–449.

Forchuk C. & Reynolds W. (2001) Clients' reflections on relationships with nurses: comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing* **8**(1), 45–51.

Frueh C.B., Knapp R.G., Cusack K.J., Grubaugh A.L., Sauvageot J.A., Cousins V.C., Yim E., Robins C.S., Monnier J. & Hiers T.G. (2005) Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services* **56**(9), 1123–1133.

Gangeness J.E. & Yurkovich E. (2006) Revisiting case study as a nursing research design. *Nurse Researcher* **13**(4), 7–18.

Guba E.G. & Lincoln Y.S. (1989) *Fourth Generation Evaluation*. SAGE Publications, Newbury Park, CA.

Hewitt J. & Coffey M. (2005) Therapeutic working relationships with people with schizophrenia: literature review. *Journal of Advanced Nursing* **52**(5), 561–570.

Jeong S., McGarrell E.F. & Kroovand Hipple N. (2012) Long-term impact of family group conferences on re-offending: the Indianapolis restorative justice experiment. *Journal of Experimental Criminology* **8**(4), 369–385.

Jones A. & Scannell T. (2002) Research and organizational issues for the implementation of family work in community psychiatric services. *Journal of Advanced Nursing* **38**(2), 171–179.

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

Katsakou C., Bowers L., Amos T., Morriss R., Rose D., Wykes T. & Priebe S. (2010) Coercion and treatment satisfaction among involuntary patients. *Psychiatric Services* **61**(3), 286–292.

Kirsh B. & Tate E. (2006) Mental health developing a comprehensive understanding of the working alliance in community. *Qualitative Health Research* **16**(8), 1054–1074.

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), 44–56.

Landeweer E., Abma T.A. & Widdershoven G.A.M. (2011) Moral margins concerning the use of coercion in psychiatry. *Nursing Ethics* **18**(3), 304–316.

Langeland E. & Wahl A.K. (2009) The impact of social support on mental health service users' sense of coherence: a longitudinal

 © 2014 John Wiley & Sons Ltd

panel survey. *International Journal of Nursing Studies* **46**(6), 830–837.

Lohuis G. & Beuker A., (eds) (2013) *Zonder Sociaal Geen Psychiatrie [Without Social No Psychiatry]*. SWP, Amsterdam.

Lub V. & Uyterlinde M. (2012) Evaluating state-promoted civic engagement and participation of vulnerable groups: the paradoxical policies of the Social Support Act in the Netherlands. *Journal of Social Policy* **41**(2), 373–390.

Luck L., Jackson D. & Usher K. (2006) Case study: a bridge across the paradigms. *Nursing Inquiry* **13**(2), 103–109.

Macleod S.H., Elliott L. & Brown R. (2011) What support can community mental health nurses deliver to carers of people diagnosed with schizophrenia? Findings from a review of the literature. *International Journal of Nursing Studies* **48**(1), 100–120.

Mancini A.D., Moser L.L., Whitley R., McHugo G.J., Bond G.R., Finnerty M.T. & Burns B.J. (2009) Assertive Community Treatment: facilitators and barriers to implementation in routine mental health settings. *Psychiatric Services* **60**(2), 189–195.

Marshall M. & Lockwood A. (2010) Assertive community treatment for people with severe mental disorders (Review). *Cochrane Database of Systematic Reviews* (2), CD001089. DOI: 10.1002/14651858.CD001089.

McAdam M. & Wright N. (2005) A review of the literature considering the role of mental health nurses in assertive outreach. *Journal of Psychiatric and Mental Health Nursing* **12**(6), 648–660.

Norman I. (2009) The art and science of mental health nursing: reconciliation of two traditions in the cause of public health. *International Journal of Nursing Studies* **46**(12), 1537–1540.

O'Brien A.J. & Golding C.G. (2003) Coercion in mental healthcare: the principle of least coercive care. *Journal of Psychiatric and Mental Health Nursing* **10**(2), 167–173.

O'Brien A.J., McKenna B.G. & Kydd R.R. (2009) Compulsory community mental health treatment: literature review. *International Journal of Nursing Studies* **46**(9), 1245–1255.

Panayiotou G. & Karekla M. (2013) Perceived social support helps, but does not buffer the negative impact of anxiety disorders on quality of life and perceived stress. *Social Psychiatry & Psychiatric Epidemiology* **48**(2), 283–294.

Pennell J., Edwards M. & Burford G. (2010) Expedited family group engagement and child permanency. *Children and Youth Services Review* **32**(7), 1012–1019.

Peplau H.E. (1952) *Interpersonal Relations in Nursing*. Putnam's Sons, New York.

Peplau H.E. (1997) Peplau's theory of interpersonal relations. *Nursing Science Quarterly* **10**(4), 162–167.

Pescosolido B.A., Brooks Gardner C. & Lubell K.M. (1998) How people get into mental health services: stories of choice, coercion and 'muddling through' from 'first-timers'. *Social Science & Medicine* **46**(2), 275–286.

Poortinga W. (2006) Social relations or social capital? Individual and community health effects of bonding social capital. *Social Science & Medicine* **63**(1), 255–270.

Robins C.S., Sauvageot J.A., Cusack K.J., Suffoletta-Maierle S. & Frueh C.B. (2005) Consumers' perceptions of negative experiences and 'sanctuary harm' in psychiatric settings. *Psychiatric Services* **56**(9), 1134–1138.

Salyers M.P. & Bond G.R. (2001) An exploratory analysis of racial factors in staff burnout among assertive community treatment workers. *Community Mental Health Journal* **37**(5), 393–404.

Schout G., De Jong G. & Zeelen J. (2010) Establishing contact and gaining trust: an exploratory study of care avoidance. *Journal of Advanced Nursing* **66**(2), 324–333.

Schout G., De Jong G. & Zeelen J. (2011) Beyond care avoidance and care paralysis. *Sociology* **45**(4), 665–681.

Sherman M.D., Faruque H.D. & Foley D.D. (2005) Family participation in the treatment of persons with serious mental illness. *Psychiatric Services* **56**(12), 1624–1625.

Silverman D. (2013) *Doing Qualitative Research*, 4th edn. SAGE publications, London.

Simpson A. (2005) Community psychiatric nurses and the care co-ordinator role: squeezed to provide 'limited nursing'. *Journal of Advanced Nursing* **52**(6), 689–699.

Stake R.E. (1995) *The Art of Case Study Research*. SAGE Publications, London.

Strine T.W., Chapman D.P., Baluz L. & Mokdad A.H. (2008) Health-related quality of life and health behaviors by social and emotional support: their relevance to psychiatry and medicine. *Social Psychiatry and Psychiatric Epidemiology* **43**(2), 151–159.

Sündermann O., Onwumere J., Kane F., Morgan C. & Kuipers E. (2013) Social networks and support in first-episode psychosis: exploring the role of loneliness and anxiety. *Social Psychiatry and Psychiatric Epidemiology* **49**(3), 359–366.

Sytema S., Wunderink L., Bloemers W., Roorda L. & Wiersma D. (2007) Assertive community treatment in the Netherlands: a randomized controlled trial. *Acta Psychiatrica Scandinavica* **116** (2), 105–112.

Thoits P.A. (2011) Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior* **52**(2), 145–161.

Verplanke L. & Duyvendak J.W. (2010) *Onder de Mensen? Over het Zelfstandig Wonen van Psychiatrische Patiënten en Mensen met een Verstandelijke Beperking [Being Part of the Community? On the Indepedent Living of Psychiatric Patients and People with Intellectual Disabilities]*. Amsterdam University Press, Amsterdam.

Voskes Y., Kemper M., Landeweer E.G.M. & Widdershoven G.A.M. (2013) Preventing seclusion in psychiatry: a care ethics perspective on the first five minutes at admission. *Nursing Ethics* doi: 10.1177/0969733013493217

Wang E.W., Lambert M.C., Johnson L.E., Boudreau B., Breidenbach R. & Baumann D. (2012) Expediting permanent placement from foster care systems: the role of family group decision making. *Children and Youth Services Review* **34**(4), 845–850.

Weigensberg E., Barth R.P. & Guo S. (2009) Family Group Decision Making: a propensity score analysis to evaluate child and family services at baseline and after 36-months. *Children and Youth Services Review* **31**(3), 383–390.

Zucker D.M. (2001) Using case study methodology in nursing research. *The Qualitative Report* **6**(2). Retrieved from http://www.nova.edu/ssss/QR/QR6-2/zucker.html on 06 November 2013.

© 2014 John Wiley & Sons Ltd

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- **High-impact forum:** the world's most cited nursing journal, with an Impact Factor of 1·527 – ranked 14/101 in the 2012 ISI Journal Citation Reports © (Nursing (Social Science)).
- **Most read nursing journal in the world:** over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 3,500 in developing countries with free or low cost access).
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).

 © 2014 John Wiley & Sons Ltd