

Understanding the longer-term effects of family group conferences

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Abstract

Few studies estimate the longer-term effects of family group conferences (FGCs), as previous research has been mainly qualitative or has focused only on the shorter-term effects of FGCs. This study analyses, using a randomized controlled design, the longer-term effects of adult FGCs in terms of social support, mental health, and re-employment. A total of 149 Norwegian longer-term social assistance recipients were randomly assigned to intervention and control groups. Participants were followed up 12 months after baseline. To gain in-depth knowledge of the FGC process, 15 participants were interviewed. Despite high shares of participant satisfaction and significant shorter-term effects, the one-year follow-up identified neutral effects of the intervention. Qualitative interviews demonstrated that lack of reciprocity in social relationships and lack of follow-up were the main reasons for the stagnation of an initially positive FGC process.

Keywords: Randomized controlled study; Family Group Conference; Reciprocity; Social assistance recipients; Mental health; Social support; Re-employment

Introduction

A family group conference (FGC) is a meeting in which the individual and his or her social network establish a plan that addresses problems the individual wants to discuss. The FGC is a structured intervention including an introductory phase, a meeting between the participant and the network, and a concluding phase. The process is handled by a neutral coordinator (Lupton, 1998). Although FGCs are increasingly being used in various areas of social work, little is known of their longer-term effects, and existing findings are highly inconsistent (Crampton, 2007; Holland & Rivett, 2008; Weigensberg *et al.*, 2009). Much of the literature focuses on describing practices through case studies, qualitative interviews or through evaluations conducted soon after the FGC process, and few studies have focused on FGCs in adult contexts (Mutter *et al.*, 2008; Sheets *et al.*, 2009; Malmberg-Heimonen, 2011; Johansen, 2012).

This study examines FGCs for longer-term social assistance recipients at the social service offices in two Norwegian cities, Oslo and Bergen. Social assistance recipients are people who do not qualify for other social security benefits, or whose received benefits are insufficient. Of the adult population in Norway, 2.4% received social assistance in 2009, and although social assistance is meant to be short-term and occasional, statistics indicate that 42% of recipients receive the benefit for six months or longer and are, as such, longer-term recipients (Statistics Norway, 2008; Statistics Norway, 2010). It has been demonstrated that longer-term social assistance recipients have fewer social resources, especially when it comes to the less dense types (van der Wel *et al.*, 2006).

The main reason for implementing FGCs in social services was to increase social support in order to generate positive processes. Based on a randomized experimental design and qualitative interviews, this study analyses the longer-term effects of FGCs on social assistance recipients' life satisfaction, mental health, and employment. The main

questions are whether longer-term effects can be identified and how the findings can be understood in light of qualitative data.

Social support and reciprocity

The importance of social support for health and wellbeing is the foundation of a variety of network interventions (Fyrand, 2003; Seikkula *et al.*, 2003; Soyez *et al.*, 2006). Social support is defined as ‘information leading the subject to believe that he is cared for and loved, esteemed and valued, and belongs to a network of communication and mutual obligation’ (Cobb, 1976) or as ‘the resources that persons perceive to be available or that are actually provided to them by non-professionals in the context of both formal support groups and informal helping relationships’ (Cohen *et al.*, 2000, p. 4).

Network interventions aim to mobilize the social support resources of the subject in order to solve practical, emotional, and/or social problems (Fyrand, 2003; Fyrand, 2005). Social support is effective if it meets needs of the recipient. However, this condition is violated if, for example, perceptions differ between the supporters and recipient as to what helps, or if the recipient is dissatisfied with the support (Williams, 1995). Reciprocity is necessary for an efficient and lasting support process, as it is considered fundamental for maintaining stability and longevity in social relationships (Derlega *et al.*, 1993; Williams, 1995; Fyrand, 2010).

Reciprocity is understood as the *balance* in people’s social interaction, such as giving, receiving, and repaying social support (Williams, 1995; Fyrand, 2010). A vital aspect of the social support exchange is the recipients wish and need to reciprocate, i.e. to ‘repay those who have helped’ (Williams, 1995, p. 401). Williams (1995) argues that the social relationship can be strained if the recipient feels unable to repay. Equity theory can explain why an imbalance in reciprocity may be detrimental to the support process:

people who receive more than they give feel indebtedness, guilt, and shame, while people who give more than they receive feel unfairness and burden (Bowling *et al.*, 2005). Recent empirical studies support this hypothesis, receiving more support than one gives is associated with depressive symptoms and lowered self-efficacy beliefs (Väänänen *et al.*, 2008; Jaeckel *et al.*, 2012). As such, the psychological burden of reciprocal imbalance can be a barrier to establish and maintain social support processes (Cutrona & Cole, 2000; Williams, 1995). To understand the success and/or failure of a social support intervention, one must take into account the extent to which both the recipient's and provider's needs have been met in a relationship (Coyne *et al.*, 1990).

It is further assumed that close relations (e.g. family and close friends) will have a longer-term perspective on the reciprocity balance, while more incidental contacts will expect 'repayment' within a shorter time (e.g., Antonucci & Jackson, 1990; Fyrand, 2010). This is in accordance with the rationale underlying network interventions, such as the FGC, which assumes that a participant's social network will display a longer-term commitment to offer support than the public services can offer (Cutrona & Cole, 2000). One would therefore expect that the FGC model, from a longer-term perspective, meet the terms of reciprocity in the social support exchange.

Previous studies of the longer-term effects of FGCs

FGCs were developed from Maori culture in New Zealand, where child welfare services adopted traditional models of decision making involving the extended family (Holland & O'Neill, 2006). The FGC process is thought to contribute to a shift in power relationships between the public and private spheres, promoting empowerment (Horverak, 2009). It has also been demonstrated that relational processes, such as re-establishing contact

with network members and receiving appraisal support from family and friends, are important outcomes (Johansen, 2012).

Nevertheless, few studies have used experimental or quasi-experimental designs to analyse the longer-term effects of FGCs, and existing findings are inconsistent. Some studies within child-welfare have shown neutral longer-term effects, while other studies have shown positive effects (Sundell & Vinnerljung, 2004; Cosner Berzin, 2006; Hayden, 2009; Weigensberg *et al.*, 2009). In the juvenile offender context, McGarrell and Hipple (2007) and Baffour (2006) demonstrated lower rates of reoffending in the FGC group at longer-term follow-up, while McGarrell and Hipple (2007) found more pronounced short- than long-term effects. In addition, the three-month follow-up of the randomized data analysed in the present study demonstrated significant positive shorter-term effects of FGCs on life satisfaction and mental health. The study also demonstrated that participants themselves evaluated the FGC process positively: they had good experiences with the FGC preparations and were highly satisfied with the work of the FGC coordinator (Malmberg-Heimonen, 2011).

The adult FGC process

When FGCs are implemented in adult contexts, the main principles and steps are the same as when FGCs are implemented in contexts involving children or young people. However, the fact that the participant is an adult and not a minor or a young person frames the FGC. For example, Malmberg-Heimonen (2011) found that a significant part of those invited to FGCs were friends and not immediate family members.

The FGC process begins with the participant formulating themes to be discussed at the FGC meeting. After the questions have been formulated and the independent FGC coordinator has accepted the task, the contract meeting is held. This is a meeting

between the participant, FGC coordinator, and social worker at which questions related to professional confidentiality are resolved. After the contract meeting, the participant and the FGC coordinator begin their work. This part of the process begins by analysing the participant's network.

The FGC coordinator contacts and meets all those to be invited to the meeting and prepares them for the conference. A chair and note-taker are chosen for the meeting. If professionals are invited as informants for the first part of the FGC, the coordinator prepares them as well. When the day of the FGC has been determined and all practical matters related to the meeting have been arranged, official invitations are sent to invitees.

The meeting is divided into three parts:

- a) *The introduction*: The FGC coordinator welcomes everyone and reviews the structure of the meeting and the themes raised by the participant. The chair and the note-taker are introduced. If informants are involved, they participate in this part of the meeting; for example, a doctor may inform the network about the medical condition of the participant, and how this condition affects his or her daily life.
- b) *The private deliberation*: In this part of the meeting, the extended network discusses the questions raised by the participant. This part of the meeting includes no professionals, not even the FGC coordinator. The aim is to formulate a concrete action plan that responds to the themes raised by the participant.
- c) *The conclusion*: The FGC coordinator returns to the meeting and reviews the action plan with the participant and his or her private network, to ensure that everyone understands the agreement and that it is clearly written down. The agreed-to action plan is signed by everyone attending this concluding part of the meeting, and a copy of the

plan will be sent to all attendees. A follow-up meeting is agreed on, to be held three to six months after the present meeting.

Data and methods

Mixed method designs produce data that generate complementary and elaborative insights into the phenomenon under investigation (Brannen, 2005). A mixed method design is valuable, as the qualitative data add meaning to the statistical results, and the statistics may add precision to the findings of the semi-structured interviews (Burke Johnson & Onwuegbuzie, 2004).

In the present study, a randomized controlled design was used to investigate the longer-term effects of FGCs, whereas semi-structured interviews explored the participants' experiences with the FGC in order to explain the found effects. The data were collected from 2007 to 2010. In this period, social workers and coordinators were trained in the study methodology and the intervention. The included municipalities were responsible for training and implementation, whereas researchers at the Oslo and Akershus University College were responsible for the evaluation. Detailed information about the study design, including recruitment, randomization procedures, attrition, and procedures for administering baseline and follow-up questionnaires, have previously been reported by Malmberg-Heimonen (2011), who also reported the short-term **effects** of the study. A briefer description of the methodology used in the study is provided here, focusing on details relating to the longer-term follow-up.

The quantitative data

The eligibility criterion for study participation was long-term receipt of social assistance, i.e. continuous receipt for six months or longer. Social workers invited eligible recipients

face-to-face to participate in this randomized study: invitees received the baseline questionnaire (T1), consent form, and written information describing the study. Of the 395 invitees, 149 (38%) returned the T1 questionnaire and the consent form to the researchers. Comparing study participants with those who declined to participate indicates that the groups were similar in terms of gender, age, and immigration status. However, those who did not want to participate had been unemployed longer (registered in months) over the previous five years ($M = 44.3$, $SD = 19.87$) than had the study participants ($M = 37.8$, $SD = 24.36$).

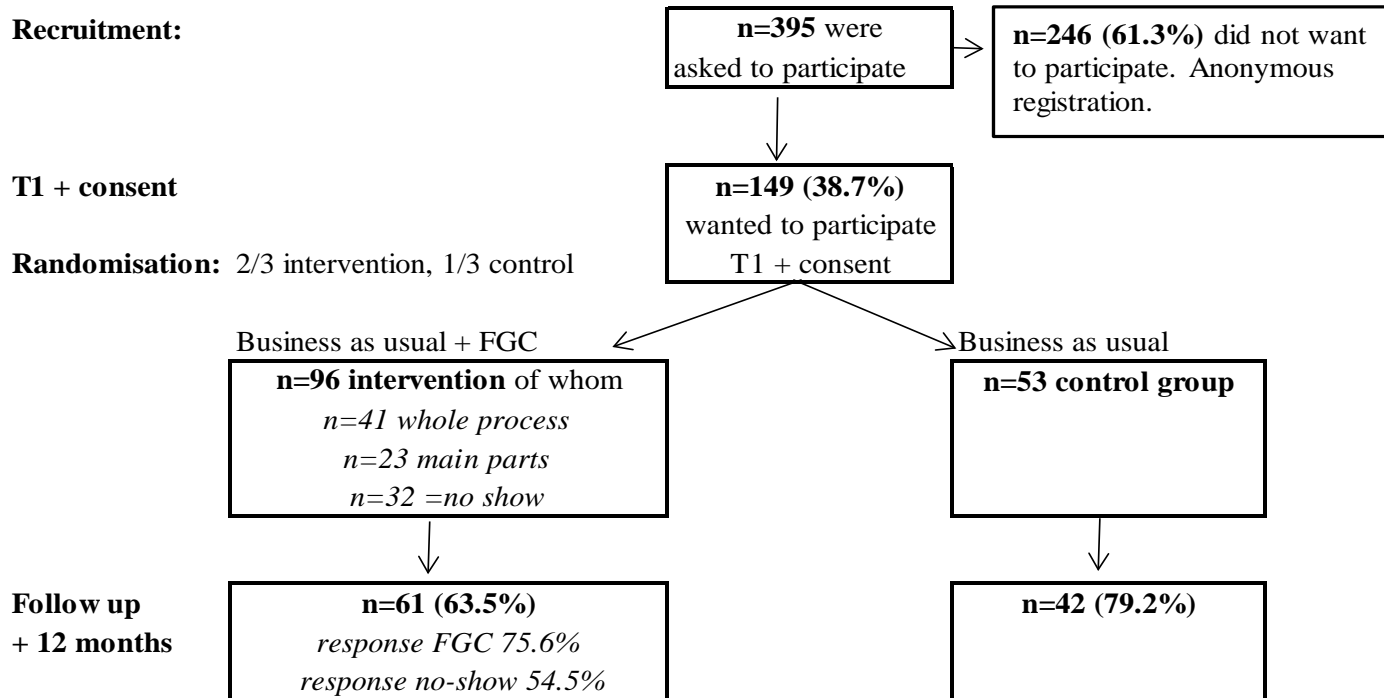
Of the 149 people who returned the consent form and T1 questionnaire to the researchers, two-thirds (96) were randomized to the intervention group and one-third (53) to the control group. A larger proportion was randomized to the intervention group to avoid loss of power due the risk of a high share of invitees who decline to participate (Dumville *et al.*, 2006). Participants in the intervention group then began the FGC process; in addition, both groups continued to receive their usual social services. Whereas 60% of study participants did not participate in any kind of activities at T1, the rest was involved in labour market measures, job training or other activities.

Researchers conducted all the follow-ups in the study, social workers did not participate in the follow-up procedures. The intervention group received the first follow-up (T2) questionnaire two weeks after completing the FGC process, while the control group received it 12 weeks after responding to the baseline questionnaire (T1). Study participants received the second follow-up (T3) 12 months after T1.

Of the 96 study participants randomized to the intervention group, 41 (43%) completed the FGC intervention process. In addition, 23 people (24%) participated in major parts of the FGC process, while the rest of the intervention group, 32 people

(33%), failed to participate in the intervention. The percentage for failure to participate is similar as in other studies. Of existing randomized studies where a no-show rate is noted, Baffour (2006) demonstrate a no-show rate of 37.4%.

Comparing participants with non-participants based on baseline information (T1) reveals that those who failed to complete the FGC intervention had been inebriated more often over the previous month than had those who completed the FGC process ($p = 0.043$). Nevertheless, to preserve the integrity of the randomized design and to prevent selection bias, the Cook and Campbell (1979) guidelines were followed and all analyses were conducted on an intention-to-treat basis, including those of the intervention group who both did and did not participate in the intervention (Smeeton & Goda, 2003). Power analyses were conducted based on the mental distress variable (GHQ-12). The power analysis estimates indicated that 104 participants were needed to detect a significant treatment difference in mental distress with a probability of 80% in a two-sided study. Due to attrition between T1, T2, and T3, as well as some internal attrition, the numbers in the final analyses of this study vary between 98 and 103 participants. The flowchart of the study is presented in Figure 1.



Demographic characteristics of study participants (n = 149)

The study participants were aged 18–63 years, with a mean age of 39 years (SD = 10.46).

The study participants were 62% men and 38% women, and 22% of them were of minority background. The vast majority of participants (93%) were single, divorced, or widowed, while only 7% were married or cohabiting. 52% of study participants had no vocational qualifications, 36% had secondary-level education, and 12% had tertiary-level education. They had been unemployed for an average of 38 months over the previous five years. The vast majority (78%) claimed to be in poor or very poor economic circumstances, and more than two-thirds claimed to suffer from chronic

disease (68%). Finally, 26% admitted to having used illegal drugs daily or almost daily over the month before completing the T1 questionnaire (Malmberg-Heimonen, 2011).

Previous comparisons have shown that the participants in this study have lower education and poorer mental health than Norwegian longer-term social assistance recipients in general (Malmberg-Heimonen 2011). The duration of the FGC process was on average fourteen weeks. Over this period the FGC coordinators worked on average 24.3 hours (SD 8.52) with each participant. On average 3.9 (SD 1.64) persons from the participants extended network participated in the FGC. Only nine of 41 who finished the FGC process had participated in a follow-up FGC. Some participants did not want to participate even though offered a follow-up FGC, whereas other participants were not offered an FGC.

Randomization and attrition

The success of randomization is estimated based on no significant baseline differences between the intervention and control groups. Table 1 shows that there were no significant differences in any of the T1 variables between the intervention and control groups. None of the background variables, i.e. gender, age, education, civil status, ethnicity, employment duration, economic situation, percentage of participants with (self-reported) chronic disease, or any of the variables related to life satisfaction or mental health, differed significantly between the groups.

Table 1 Comparison of background and study variables between the intervention and control groups by baseline (T1) data ($n = 142-149$)*

Variables	Intervention group	Control group	p-value
<i>n</i>	96 (64%)	53(36%)	
Municipality (%)			0.131
<i>Oslo</i>	71.7	28.3	
<i>Bergen</i>	59.6	40.4	
Gender (%)			0.134
<i>Women</i>	42.7	30.2	
<i>Men</i>	57.3	69.8	
Age (M)	37.9	40.2	0.181
Married/Cohabiting (%)	8.3	5.7	0.533
No vocational education (%)	48.9	52.8	0.255
Ethnic minority (%)	24.0	18.9	0.467
Unemployment, months (M)	36.83	39.50	0.535
Poor economic situation (%)	80.0	75.5	0.781
Chronic disease (%)	66.3	71.7	0.503
T1 Life satisfaction (M)	2.66	2.77	0.603
T1 Social support (M)	14.13	14.27	0.854
T1 Mental distress, GHQ-12 (M)	27.98	28.35	0.782
T1 Anxiety and depression, HSCL-10 (M)	24.74	24.92	0.887

After several reminders (postal and telephone), the response rate was 69% at T3. Of T3-respondents, 26.2% ($n=27$) responded by telephone, while the rest responded by mail. T3 respondents were generally older than non-respondents ($p = 0.018$), though no other significant differences were found between T3 respondents and non-respondents. At T3, the response rate was higher in the control group (79%) than in the intervention group (64%) ($p = 0.047$). This difference was explained by the lower response rate among non-participants (54%) than among those who participated in the FGC process (76%). The

problem with non-participants was that, in many cases, neither the social services nor researchers could locate them, although several attempts were made to do so (Figure 1).

Measures

Life satisfaction was assessed using one question: 'All things considered, how satisfied are you with your life in general?' The response options ranged from 1 = 'very satisfied' to 5 = 'very dissatisfied'. The scale was reversed before the analyses were conducted.

Social support was measured using a four-item scale. The respondents were asked to assess whether they had someone to talk to if they felt down or depressed, someone who listened to what they said, someone with whom they could be themselves, and someone who really appreciated them. The response options ranged from 1 = "not at all" to 5 = "very much". The items were then added to a scale ranging from 4 to 20 (M = 14.2, SD = 4.48). The reliability of the measure was high (T1 Cronbach's alpha = 0.88). The scale has been used in previous studies (Dahl and Malmberg-Heimonen, 2010).

Mental distress was measured using the 12-item version of Goldberg's (1972) General Health Questionnaire. This includes questions such as: 'Have you recently been able to concentrate on whatever you're doing?' and 'Have you recently been able to enjoy your daily activities?' Respondents rated their responses on a scale ranging from 1 = 'not at all' to 4 = 'more than usual'. The reliability of the scale, which ranged from 12 to 48 (M = 28.1, SD = 7.66), was high at 0.91 (T1 Cronbach's alpha).

Psychological symptoms were assessed using the Hopkins Symptoms Checklist on Anxiety and Depression (Derogatis *et al.*, 1974). The respondents indicated how often in the previous two weeks they had experienced symptoms such as sleeping disorders, lack

of energy, or feelings of worthlessness. Respondents rated 10 items with answers ranging from 1 = 'not at all' to 4 = 'very much'. The reliability of the scale, which ranged from 10 to 40 ($M = 24.8$, $SD = 7.47$), was high at 0.91 (T1 Cronbach's alpha).

Longstanding illness was measured using the following question: 'Do you suffer from any longstanding illness/chronic disease, i.e. an illness/disease that you were born with, that you have had at least six months, or that you think might become a longstanding illness/chronic disease?' The response options were 1 = 'yes' and 2 = 'no'. The scale was reversed before further analyses were conducted.

Economic situation was assessed using one question: 'How is your/your family's economic situation at the moment?' The responses ranged from 1 = 'very good' to 5 = 'very poor'.

Length of unemployment was measured in terms of the total number of months the respondent had been unemployed over the previous five years.

Standard survey questions were used to register gender, age, ethnicity, education, and civil status.

The qualitative data

All 41 people who completed the FGC in the randomized study were invited to be interviewed. Many of these people were, however, difficult to reach because of changed or missing contact details. People who were intoxicated or had major psychological problems when contacted were not interviewed. A total of 15 people were willing to participate in the interviews. The sample consisted of nine men and six women aged 24–63 years. Three were married, and ten had children. Two were of minority background. All stated that they had some kind of psychological health problem, such as anxiety and

depression. Seven informants spoke of previous or present drug abuse, and two said that they had a criminal record.

The informants were interviewed approximately three months after their FGC. In addition, six of them were re-interviewed one year later. The interview guides contained questions concerning: 1) experiences with preparing for the FGC, 2) experiences with the FGC itself, and 3) experiences in the time after the FGC. The interviews lasted 1–2 hours and were recorded and transcribed. In the present study, the qualitative data were analysed with the intention of understanding the longer-term effects of FGCs. A grounded theory approach was applied for the analysis (Strauss & Corbin, 1998). This inductive method is appropriate for exploring areas in which previous knowledge is scarce, when the aim is to relate analytically generated categories to each other to develop explanatory models or theories about the subject.

The analysis of the transcribed interviews started with micro-level interpretation of the data. The aim is to obtain a comprehensive pool of concepts and meanings, and to make the researcher aware of the multiple interpretations of each phrase when carrying out the remaining analysis. In the next step, an inter-case analysis was undertaken by comparing all interviews, in order to grasp the predominant concepts. These concepts were then categorized according to their cumulative frequency within and between the interviews.

Throughout the analysis, the aim is to label and conceptualize themes deriving from the data. An important step is to ask questions that stimulate the discovery of properties, dimensions, and consequences of the phenomena and concepts developed. The last stage of the analysis was to compare and group the central concepts in search of patterns and possible relationships between them (Strauss & Corbin, 1998).

Results

Longer-term effects of FGCs on social support, mental health, and employment

At the one-year follow-up study, 56% of intervention participants reported that their quality of life had improved because of the FGC process. 31% of intervention participants reported that the FGC process had improved their labour market chances. Also, 36% reported that the FGC process had improved their basis for dealing with their life situation, and 31% reported that the FGC process had improved their opportunities to change their life situation. Those who had had a post-conference follow-up, either formal FGC or informal, gave more positive assessments of whether the FGC process had improved their quality of life ($p = 0.003$) and opportunities to change their life situation ($p = 0.044$).

At the one-year follow-up, the effects were estimated by measuring changes based on unadjusted mean differences between T1 and T3 with regard to life satisfaction, social support, mental distress, anxiety and depression, and employment (Table 2). Mental distress or anxiety and depression did not change significantly between T1 and the T3 follow-up. With respect to social support there was a positive trend for the intervention group, however insignificant. Life satisfaction did change positively between T1 and T3, however, the change being significant for both groups. Finally, 19% of the intervention group and 12% of the control group were employed at T3. Although this result favours the intervention group, the difference between the groups is not significant ($p = 0.318$). Adjusted mean differences were analyzed using analyses of covariance (table not shown), nevertheless there were no changes with respect to the findings demonstrated in Table 2. Hence, qualitative data will be analysed in order to understand the neutral longer-term effects of the intervention.

Table 2 Comparison of baseline and one-year follow-up values for intervention and control groups; unadjusted means, standard deviations, and confidence intervals (95%) for mean differences ($n = 93-98$).

Variables	T1 <i>M (SD)</i>	T3 <i>M (SD)</i>	Mean difference T3-T1	<i>p-value</i>
Life satisfaction				
Intervention group	2.56 (1.19)	2.98(1.15)	0.42	0.039
Control group	2.64(1.27)	3.13(1.25)	0.49	0.019
Social Support				
Intervention group	13.83(4.15)	14.57(4.59)	1.19	0.227
Control group	14.36(4.47)	14.64(5.44)	0.28	0.770
Mental distress (GHQ-12)				
Intervention group	28.67(7.75)	26.68(6.22)	-1.99	0.195
Control group	28.79(6.72)	27.05(7.50)	-1.74	0.095
Anxiety and depression (HSC-10)				
Intervention group	25.02 (7.28)	23.85(7.73)	-1.17	0.111
Control group	24.82 (7.41)	23.45(7.16)	-1.37	0.063
Employment				
Intervention group	0.19		NA	0.318
Control group	0.12			

Psychological and social vulnerability as barriers to reciprocity

Analysis of the qualitative interview data indicates that psychological and social vulnerability, such as mental health problems, drug abuse, and/or loneliness, was common: Some of the interviewees had conflicting relationships with family members, others had lost contact, and, in one case, most family members were alcoholics. Many informants also felt that they were a burden to their social network and that they were responsible for their loneliness:

I can't blame anyone but myself. I've managed to destroy that [i.e. family contact] myself. (Man, 24)

Informants generally described difficulties taking initiatives to contact their social network. Some informants had difficulties due to feelings of guilt and shame because of their drug abuse, whereas others did not want to be a burden. Poverty was also experienced as a barrier to maintaining contact, as informants could not afford to go out or attend common social activities, for example, going to cafes or pubs. One informant emphasized that the lack of common references and memories among family members, due to many years of broken contact, was one reason why it had become so difficult to pursue social contact after the FGC:

We have been so much apart from each other for such a long time during several periods that we kind of don't know how we should act, really. After we have talked about the latest news, we don't have any more to talk about. (Woman, 42)

There are complex reasons why the positive processes initiated in the FGC may fail. The qualitative data indicate that social and psychological vulnerability, particularly mental health problems and drug abuse, challenged a reciprocal social interaction, adding attitudinal barriers to seeking and receiving social support (Cutrona & Cole, 2000). Some informants said that social contact, not only from the participant but also from his social network, was lacking:

They [i.e. the family] were very eager at the beginning. [They were] very good at making phone calls, at least. A bit [good] at e-mailing, and less good at seeing and meeting each other. But then it [i.e. the social contact] died out. (Woman, 42)

In this case, the poor contact probably occurred because the subject and her family had drug/alcohol addiction problems. In another case, the informant had psychological health problems, and she had invited mostly friends, not family, to her FGC:

I was so discouraged. It didn't seem like anybody showed any consideration for me. Everybody was occupied with their own businesses – “No, it doesn't fit today” – there was always something. When we were about to make plans, there were always some hindrances. So, then you feel kind of discouraged, like you mean so little, right.

(Woman, 46)

This finding supports the assumption that more peripheral contacts are less likely to persevere in the face of social relationships that are unbalanced in terms of reciprocity.

The importance of follow-up

Several informants emphasized the importance of arranging a follow-up meeting within 1–2 months after the first FGC as a way to follow up on the action plan and each person's commitment to fulfil it. One informant explained that the process of making desired changes started well after the FGC, but that the support from his network declined after a while. He felt alone with the responsibility, and the initially positive process began to languish:

We started a process [with his child]. But then it stagnated. The first 3–4 weeks, there was active attention to it, right. Then ... It would have been ok to have a short follow-up to add more fuel, get it going. Instead, it just ... I run out of energy because I promise and promise, and then I'm not able to keep them [i.e. the promises]. And then I lag behind, right. So that's what's happening now. I try, but ... (Man, 43)

Here the informant describes a lonesome process of working with the action plan, and reflects on the possible importance of an early follow-up meeting to remobilize the network. Another informant, who had very positive experiences with the FGC meeting, found that the desired interaction with her family collapsed shortly after the FGC:

It was great the first two weeks afterwards, and then it collapsed ... In retrospect, it hasn't worked. It was terribly nice there and then. But I think there should have been a follow-up afterwards. We planned a follow-up meeting [about six months after the first], but I think that's too long. It should have been after one month, to see how things were working out. ... [After six months] it becomes so hard to catch up again, right. (Woman, 45)

Despite this disappointment, she was very satisfied with the FGC, which she said was like 'hitting the jackpot'. Scheduling the follow-up meeting too far in advance often impeded achieving desired changes. An informant who received no offer of a follow-up meeting, due to budget restrictions at her social service office, felt that the FGC was her 'one chance' to re-establish the lost contact with her family and that they were then left alone in their efforts to change the social interaction. She explains:

It [the FGC] was a very good idea. And it was a very good start. But, kind of, what happens afterwards? I was hoping that the FGC could be the link between, what should I say, neither the social service, nor treatment, but something in between, that picks you up when the “system” is finished with you, when you’re kind of expected to manage alone. But since there turned out to be just one family group conference meeting and nothing more, the family got one chance. But they got only that one chance that one day, kind of. And then we were left on our own. If we fail, we wouldn’t get another chance. That’s how I feel a bit now. (Woman, 42)

These informants emphasize the importance of an early follow-up meeting, both to evaluate the plan and to mobilize more support. The follow-up meeting was perceived as a means to evaluate the action plan, and to remind all participants to follow up on their part of it. Another informant acknowledged his responsibility to implement the action plan; his network also held him responsible and requested reciprocity in their shared effort to achieve the goals of the plan:

I have been challenged – “you have to ask for help”. I too have been held a bit responsible. “If you want help, then you have to ask for help”. (Man, 26)

Committing to a follow-up meeting appears important, as it can help the network and the service user advance the processes and fulfil the tasks agreed on at the FGC.

Discussion

This study evaluated the longer-term effects of the FGC process on social assistance recipients in Norway. The main finding of this study is that, compared with the several significant positive short-term effects, the longer-term effects are neutral. This is in line with previous research demonstrating stronger short-term than long-term effects of FGCs (Sundell and Vinnerljung, 2004; Cosner Berzin, 2006; McGarrell and Hipple, 2007). Nevertheless, positive short-term effects and participant evaluations at the one year follow-up in addition to the findings from the interviews demonstrate the potential FGCs can have, also in a longer-term. However, as this study demonstrate, post conference follow-up is crucial in order to succeed in the longer-term, as the FGC meeting is only a start of a process.

The qualitative findings demonstrate that psycho-social vulnerability and lack of follow-up were central issues which seem to have explained stagnation in the initially positive FGC processes. Although FGC meetings were like “hitting the jackpot” for some participants, maintaining contact over time proved difficult due to lack of reciprocity in social relations both from their own part and their networks` part. Most participants had difficult life situations, with broken social contacts and isolation preventing reciprocal interaction. Adding to this, the resources of their social networks were often limited maybe preventing reciprocity from their part too. Cutrona and Cole (2000) argue that an explicit focus on attitudinal barriers is necessary if network interventions are to achieve results. This is in line with the relationship-oriented position in social support theories, which argues that social support processes are influenced by complex and dynamic sets of factors, such as past or present relationship conflict and/or the duration and degree of reciprocity of relationships (Cohen *et al.*, 2000; Pinkerton & Dolan, 2007).

Despite the strength of the randomized design of this study, some limitations should be considered. A limitation is that the number of participants was fairly small. Nevertheless, with 41 conducted FGCs, including both quantitative and qualitative data, this study is still one of the largest studies of FGCs in adult contexts. Study participants were recruited by the social workers to the evaluation study and, hence, also the generalizability of the findings might be limited. However, comparisons with earlier studies of long-term social assistance recipients have shown that the participants recruited to this study had lower education and a higher degree of mental health problems than Norwegian long-term social assistance recipients generally have (Malmberg-Heimonen 2011). As all analyses were conducted on an intention-to-treat basis, it is important to note that the effects may be somewhat underestimated. Further, the follow-up period of this study is not as long as for some of the existing studies, where the follow-up period is between two and three years (Sundell and Vinnerljung 2004; Mc Garrell and Hipple 2007; Weigensberg et al 2009). **Finally, it should be noted that all measurements were based on self-rated scales. Although, study participants received the same attention from researchers despite of experimental condition, it was not possible to blind or double blind participation in the intervention or control group. In individual based or community based experiments within social work, blinding is seldom ethically or practically possible, as participants in the experiment have to know whether they take part in the intervention or not (Solomon et al 2009, 119-120).**

Thus, future studies should focus on families' and network members' experiences with FGCs and how and why reciprocal interaction is difficult to maintain over time. There is also a need to identify areas of the FGC model that should be strengthened in order to achieve longer-lasting effects. Our findings indicate that **one or several FGC follow-up meetings** should be offered and that they should be arranged in a close

dialogue between the **various actors of a FGC**. To have a follow-up meeting **shortly after the first FGC is important and seems** to serve several purposes, such as reducing feelings of single-handed responsibility, supporting the maintenance of reciprocal interaction, and making all participants of an FGC accountable for advancing and fulfilling the action plan.

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