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# Into the swampy lowlands. Evaluating family group conferences

## In moerassige laaglanden. Over het evalueren van Eigen Kracht-conferenties

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### ABSTRACT

A recent debate in the UK on the merits of randomised controlled trials in evaluating Family Group Conferencing is a reason to bring this debate to a wider audience than the UK. Other countries are also struggling with accountability and the desire to know what works in the light of public spending. This paper explores, debunks and rethinks ways of evaluating FGCs and how it is connected to our desire to predict and control future circumstances. For the latter insights of the Dutch philosopher Kunneman are used to understand what is going on. The rise of personalised medicine, however, holds practical reasons to rethink the value of population-based randomised controlled trials in social work in general. Where the field of medicine is moving from 'one cure for all' and population-based RCTs to individually tailored therapy and N-of-1 studies in order to meet the complexity of particular cases, some fields in the social sciences seem to have difficulties in moving from reductionism towards a more integrated view of life.

### SAMENVATTING

Een recent debat in het Verenigd Koninkrijk over de waarde van randomised clinical trials bij de evaluatie van Eigen Kracht-conferenties is reden om dit debat onder de aandacht van een breder publiek te brengen dan alleen het Verenigd Koninkrijk. Andere landen worstelen ook met verantwoording en de wens om te weten wat werkt in het licht van beperkte overheidsuitgaven. Dit artikel is een kritische zoektocht naar manieren om Eigen Kracht-conferenties te evalueren en vervolgens hoe de behoefte om de impact te achterhalen verband houdt met onze wens om toekomstige omstandigheden te voorspellen en te beheersen. Er wordt gebruik gemaakt van de inzichten van de Nederlandse filosoof Kunneman om dat laatste te begrijpen. Er is echter ook een praktische reden om de waarde van op populatie gerichte gerandomiseerde studies in het sociaal werk te heroverwegen: de opkomst van personalised medicine. Waar het vakgebied van de geneeskunde verschuift van 'één therapie voor iedereen' en 'op de populatie gerichte RCT's' naar individueel op maat gemaakte therapieën en N-of-1-studies om aan de complexiteit van individuele gevallen tegemoet te komen, lijken de sociale wetenschappen moeite te hebben om het reductionisme achter zich te laten.

### KEYWORDS

Eigen Kracht-conferentie;  
randomised clinical trial;  
personalised medicine;  
complexiteit

### SLEUTELWOORDEN

Eigen Kracht-conferentie;  
gerandomiseerd  
gecontroleerd onderzoek;  
gepersonaliseerde  
geneeskunde; complexiteit

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## Introduction

The What Works Centre (WWC) in the UK is currently preparing to evaluate Family Group Conferences (FGCs) for children on the edge of care. The ten What Works Centres in the UK form a network of more or less independent associations supplying decision-makers with 'robust evidence' in order to 'shape decision-making at every level' and so serving their accountability of public spending.<sup>1</sup> Academics from different countries with experience of FGCs have concerns about the WWCs proposals for studying them and have written an open letter to the WWC asking them to rethink aspects of their proposals.<sup>2</sup> The use of a randomised controlled trial (RCT) is central for their objections considering that FGCs are a deliberate choice of families. FGCs are mediated formal meetings between family members and other officials such as social workers and police in regards to the care and protection or criminal offending of a child or adolescent. The meetings are facilitated and co-ordinated by people independent of casework decisions in the agency working with the family. The conference itself has different stages including a meeting where professionals inform the family of the concerns they have, followed by private family time, where the family alone develops a plan that addresses the concerns that have been raised.<sup>3</sup> The academics call it unethical to randomly allocate families of vulnerable children on the edge of going into care to either getting the benefit of an FGC or going without one. Furthermore, they criticise the narrow focus on testing 'what works' in terms of the number of care proceedings avoided by an FGC disregards the intrinsic value of FGC's as a fundamentally ethical way of working with families in its own right, regardless of the outcome. Although there is a long-lasting discussion in social work on the value of RCTs or more broadly on the value of evidence-based practice (EBP) in this field, beginning with the appreciation of it by Macdonald (2008) and Hobbs et al. (2008), the plea for pragmatic controlled studies of Mullen (2016), its application with barriers and question marks in Scandinavia (Bergmark et al., 2012; Ekeland et al., 2019) to the critical stance of Biesta (2010) and many papers with positions in between, this paper focusses on the objections and pitfalls of RCTs in evaluating FGCs, more specific in the light of the recent rise of personalised medicine. In this paper, I want to explore, debunk and rethink ways of evaluating FGCs and how it is connected to our desire to predict and control future circumstances. In a way, this paper illustrates and deepens the understanding of the three deficits Biesta (2010, p. 491) described: 'In the epistemological domain there is a knowledge deficit, in the ontological domain an effectiveness or efficacy deficit and in the practice domain an application deficit'.

## Background

Recently BBC Breakfast covered a dramatic item on a mother of two sons with severe epilepsy faced to pay thousand pounds or breaking the law to import cannabis-based medicine, despite having it prescribed by a British doctor. Both her sons suffer hundreds of seizures daily and had benefited greatly from it. The reason for not granting this medicine via the NHS was that there is not enough clinical evidence.<sup>4</sup> After a public outcry, two cannabis-based medicines used to treat epilepsy and multiple sclerosis have been approved for use by the NHS in England only a few weeks later. Although the involved family welcomed the move, thousands of other people with chronic pain also benefitting from tetrahydrocannabinol, the psychoactive ingredient in cannabis, were left in limbo.<sup>5</sup> This state of affairs illustrates the difficulties of authorities to allocate or refuse public money to interventions that obviously benefit particular patients. The preoccupation with performance, accountability and risk-adversity gears governments to base decisions on the allocation of therapies, medicines and interventions on certain and unambiguous facts. To obtain certain and unambiguous facts is however difficult and surrounded by pitfalls and myths, especially when it comes to research into social practices and exceedingly when the impact of FGCs is assessed. Two questions are central for this paper. First, how can we evaluate FGCs considering that inputs, like the joined effort of civil and professional society, like the throughputs of circumstances and stimuli during the process of the genesis to the recovery of problems and all outcomes are

contextual, fluid and multifaceted? On top of that, the categories in which they are communicated are value laden. When not value laden, they are assumption-laden reifications of conditions, forces, capacities, limitations, requirements or manifestations that are transient by definition. Second, how can this desire to control and predict be understood?

### ***Set-up of the paper***

First, the importance of a cumulative program is described. When researchers not only look for ‘what works,’ but also ‘why things work’, the need for other kinds of methods follows naturally. Next, the value of population-based RCTs is assessed in relation to the rise of personalised medicine shedding light on why RCTs in social work cannot make similar truth claims to randomised research in medical science.

Finally, our desire to proof and predict and how it hinders learning is explored by using two metaphors of Kunneman (2017): staying on the high ground or descending into the swampy lowlands. Making use of his ideas, I conclude that the hunger for technical rigour coincides with the longing of being the pivotal point in the life of others for both researchers and care professionals.

### **Population-based RCT’s and the emergence of ‘personalised’ medicine**

Although randomised controlled trials (RCTs) are perceived to yield causal inferences and estimates of average treatment effects that are more reliable and more credible than those from any other empirical method, Deaton and Cartwright (2018, p. 2) argue that any special status for RCTs is unwarranted. In their view, RCTs can play a role in building scientific knowledge and useful predictions but they can only do so as part of a cumulative program, combining with other methods, including conceptual and theoretical development, to discover not only ‘what works,’ but also ‘why things work’. Applied to this topic: to explore why FGCs work one needs to know how a particular FGC works and why it worked. The case studies of multiple FGC’s can reveal patterns of manifestations and generate theories on how FGC works and why they do or do not bring about child safety, social support, less children looked after, or whatever treatment effect is assessed. So RCTs need to be complemented with other methods to know what contributed to the impact it might have. Despite its power to draw inferences about causal relationships between an intervention and patient outcomes, Schork (2018, p. 71) argues that personalised medicine, in which interventions are chosen for an individual patient based on that patient’s nuanced and possibly unique genetic or biochemical profile, has called into question the value of population-based RCTs. Population-based RCTs are in his view assumption-laden and not necessarily the most appropriate or compelling strategy to assess treatment effects in many settings. In two previous papers, we argued that RCTs deployed to evaluate FGC’s in the complex context of multiproblem families cannot make truth claims similar to randomised research in medical sciences because:

1. FGCs are a mixed form of intervention due to the coalescence between professional interventions and the doings of primary groups; professional interventions and civil activities are fused by definition. In other words, a strict division between the group receiving the experimental intervention and a control group receiving care as usual is not possible. In both cohorts, informal caregivers and professional caregivers join forces while defining characteristics to discriminate between the two are difficult to establish.
2. Participants cannot be randomly assigned to either an experimental treatment or care as usual. Sharing your problems in a social group is distressing and associated with fear and shame, especially when it is connected to abuse, neglect or domestic violence. FGCs are always a choice, a choice preceded by an intensive process of overcoming this reluctance. This forms the background of the many retrospective and the few prospective studies into FGCs (Dijkstra et al., 2016).

3. Blinding is not possible. Michelle Janas (2019) underlines that a key element of RCTs is blinding, either the participants do not know which group they have been assigned to (single-blind) or the participants nor researchers are aware of the allocation (double-blind). The participants – either the families in the care as a usual cohort or the extended social group in the experimental cohort – will obviously know which group they are in.
4. FGCs depend heavily on the professionals' attitude towards this process. If professionals do not support clients to overcome feelings of shame, if they do not have the ability to explore the reluctance to participate in an FGC, then conferences will not start up in the first place or will eventually not succeed. Moreover, the long term impact of FGC's is deeply connected to the professional attitude towards FGC. When professionals see themselves as key agents to change and do not support the plan or in case of crises take over again instead of re-convening the social network, conferences are bound to fail. What worked and why this particular FGC worked is deeply connected to other factors than the social intervention at hand (De Jong et al., 2015; De Jong & Schout, 2018).

To sum up, RCTs do not provide evidence for the underlying factors that caused the (lack of) treatment effects, they do not shed light on 'what works,' and 'why things work' in studying FGCs. Actually, the words 'treatment effect' do not fit here very well in the first place. Is an FGC a treatment? Does it have the well-defined, unambiguous, concise form of a treatment that is put into operation when a certain aetiology, confirmed by a set of signs and symptoms, is present? In fact, an FGC is a gathering of professionals, family members, neighbours and friends, engaged in a process of exploring, thinking, negotiating, mediating, supporting, widening social circles, restoring contacts, tightening bonds and sometimes loosening others, constructing a plan, revising expectations, making appointments and so on. As such it is more an institution, in the sense of a stable, valued, recurring pattern of behaviour. It has more the character of a social process, a civil right, a practice, a working method; but it is not a treatment or a condensed program. This intangible nature makes it hard to conduct a robust prospective experiment too.

But there are more fundamental reasons to rethink the ways of assessing the impact of FGCs. Following Sue White in a Twitter debate, David Wilkins (2018) points out that FGCs should

[ ... ] not be considered a 'magic bullet' for keeping children at home but as a way of involving families in decision-making. Not because of arguments about effectiveness or outcomes, but because collaborative engagement between families and professionals lies at the heart of good practice. [ ... ] In the same debate, several people noted it can often be the right decision to bring a child into care, and if families are more involved in such decisions and children are kept safe as a result, why should that be considered a form of failure?

In other words, what is considered a common treatment effect appears to be not only value laden, but also ambiguous, arbitrary and bound to specific contexts. To address specific situations, goals, desires and values, the move from one-size-fits-all to targeted, personalised therapies for patients in medicine and adjacent disciplines has far reaching implications for research. In evidence-based medicine, the combination of RCTs and meta-analyses were long seen as the major tools for evidence on average treatment effects for heterogeneous groups of patients. But as Horwitz et al. (2017) argue, the clinician's question – 'Will a given therapeutic regimen help my patient at a given point in her/his clinical course?' – is unanswered'. This, and the ascent of big data, has given rise to a another line of thinking; personalised medicine. Where in population-based RCT's the values of rigour, proof and certainty are dominant, personalised medicine is concerned with unique characteristics, tailored interventions and participatory medicine.<sup>6</sup> With the help of data-intensive biomedical technologies, such as DNA sequencing, proteomics, imaging protocols, and wireless health monitoring devices it is possible to match a specific generic make up, age and gender with precise therapies (Schork, 2018, p. 71). These technologies will urge medical professionals to support patient decision-making based on a wide range of complex biological data, environmental information, life style

and specific needs (Pavelic et al., 2015, p. 133). Already many cancer patients do profit from the lighter, shorter and less nauseating therapies that have become available through this methodology (Biankin et al., 2015). The example of the rapid allocation of cannabis-based medicines to treat epilepsy after public outrage illustrates how allotment agencies are struggling with this context of proof.

Where the field of medicine is moving from 'one cure for all' and population-based RCTs to individually tailored therapy and N-of-1 studies in order to meet the complexity of particular cases, the field of social sciences seems reluctant to move from reductionism towards a more integrated view of life. This is not surprising considering the pressure of governments to produce evidence for how money from taxpayers is spent on social care. The recent intention of the What Works Centre in the UK to use RCTs for evaluating FGCs underlines this reluctance. However, a vibrant evidence ecosystem – as Micheal Sanders (2019) hopes for – will not emerge when we cling to the past. But how can we study FGCs and its impact then?

### Addressing complexity

The previous paragraph described the normative calibre of what is seen as effect or outcome, but also what happens when professionals do not move beyond standardised interventions and cling to methodologies that expects participants to be locked up in cohorts and bear these prefixed programs. Would this methodology deliver practical knowledge in matching specific needs to helpful interventions in youth care or social work in general, then I would hold my tongue. But it is not. Two different recent RCTs into FGCs (Dijkstra et al., 2019 and Corwin et al., 2020) come up with completely different outcomes and future RCTs will probably not bring clarity. Science is obviously unable to act as a referee in truth claims. How can we understand our desire for control and prediction leading to expensive prospective studies that will not bring the intended certainty? To understand this phenomenon I want to reflect on a recent film *Hors Normes* directed by Éric Toledano and Olivier Nakache.<sup>7</sup>

The film tells the story of some fifty autistic children with severe aggression, self-injury and socially disturbing behaviour. These children cannot be kept in institutions with formal protocols and standardized interventions. They are referred back as too difficult to their parents who in turn cannot cope either. Two friends Bruno and Malik – a Jew and a Muslim – offer them a home. They take care of them by training young people from difficult neighbourhoods to guide these children. The creativity, the patience, the perseverance of these youngsters needed to win trust and overcome numerous difficulties seems so natural. How come? In one way or another they can endure the otherness and patiently look for the approach these pupils need. None of these youngsters may fit well in mainstream society, probably that equips them well to leave the beaten track, avoid coercion and seek creative solutions, exactly what the pupils need. Helping these pupils means a way out of the ghetto but there is more. The young people and the pupils both have to do with exclusion and discrimination. By helping these pupils, these young people seem to help themselves. Probably this explains their exceptional commitment.

A second storyline is about the constant struggle of Bruno against the authorities. The inspectorate threatens to close the house if it does not comply with the regulations, including that staff members must have certain diplomas. This shelter flourishes however due to this unregulated approach and this improvising style.

Although the film is derived from reality it is still a dramatised story, it holds nonetheless clues for the argument I want to make. The film demonstrates how on the one hand a standardised medical approach drives pupils and staff in a regime of coercion and sedation and on the other hand how an adventurous practice opens up opportunities to learn from each other. But there are numerous other less tangible forces at work like mutual recognition, subtle forms of reciprocity, belonging, tolerance for variation, a sphere of pleasure and hope that contributes to the decrease of self-injury and aggression. Similar forces in many variations are at work in FGCs as well. The diversity of voices from neighbours, aunts, uncles, friends, professionals, grandparents and others, but also the extra ordinary commitments that come with family life, sharing a neighbourhood, being part of someone's life-cycles, reciprocity (or the anger of missing it), belonging (or the fear for it) and other potencies

illustrate the presence of less tangible forces (Meijer et al., 2019). Where the professionals bring in expertise of all kinds of disciplines like pedagogy, psychiatry, debt assistance, the social circle offers knowledge of the informal pathways, what helped in the past, the habits, the core values and cultural dimensions they embrace.

Where in personalised medicine doctors, bio chemists, human biologists and others are searching their way in the labyrinth of 1,000 different human genomes, the many differences between them, the more than 79 million variant sites that include biallelic polymorphisms, indels, short substitutions and other structural variant<sup>8</sup>, knowing that 'a single sequence cannot explain the multitude of disease symptoms and pathogeneses (Pavelic et al., 2015, p. 133)'. Similar to this complexity problems of child abuse, neglect and domestic violence are connected to a vast variation of life stories and the interactions of physical, psychological, social, cultural, historical circumstances. Views on problems, diagnosis, outcomes and treatments are embodied, contextual, normative, socially constructed, negotiated and deeply connected to power. Or in the words of Kunneman (2017, pp. 22–23)

[...] I mean there is a simultaneous presence and activity of different, mutually conflicting potencies, forces, principles and dynamics, which are not predetermined and standardised by one fundamental principle, one essential characteristic or one ultimate destination, but which constitute an open actuality'. [...] 'The absence of underlying ground structures and the enormous complexity of interference patterns, form an interplexity, meaning that our own representation of these multiple constellations that we are trying to analyze interferes with it. Our language and our desires are not outside it and are partly constitutive of the "being" that we would like to describe or understand objectively "from outside".'

The decline of brainpower connected to poverty is an example of such complex interactions.<sup>9</sup> There may be strong evidence that poverty and economic disadvantage are associated with child maltreatment (Lefebvre et al., 2017), the manifestation of it is deeply connected to particular life stories and transitory circumstances like the presence or absence of support or a sense of hope. It is nevertheless remarkable that there is so much attention for research wherein professional are key agents and so little on other antecedents like poverty alleviation and societal change. This raises all kinds of questions. Are professionals key agents in achieving outcomes? Is their repertoire of treatments and interventions the determining factor, also in matters of child safety and the complex antecedents that form the background of it? If not, can we as professionals live with the uncertainty and the limited amount of control we actually have? These questions refer to a wider context than the sole interventions of professionals.

In their report 'No evidence without context' the Dutch Council for Public Health and Society (2017) acknowledges this uncertainty underlining the importance of 'learning care organisations'. The desire to proof and predict hinders learning, moreover it hinders professionals in dealing with an open actuality of fleeting and conflicting potencies. Where knowledge in evidence-based practice (EBP) is seen as universally applicability, impersonal and context free, the Council underlines that the right thing to do can vary with the patient and the situation and that opinions of what constitutes good care are subject to change. In their view EBP is based on a simplification of reality; good, patient-oriented care cannot be reduced to what has been proven. This desire for evidence is pushing care practice in the direction of whatever can be investigated and substantiated using the EBP methodology 'at the expense of care elements for which this is difficult or impossible, and of care that is commercially not interesting'(p. 8). Exactly these less tangible elements play such an important role in a FGC. The report concludes that evidence as the basis of good care is an illusion (p. 8) and pleads for a shift from an evidence-based to a context-based practice wherein various sources of knowledge are integrated into practice:

Although EBP is formally the result of integrating external knowledge, clinical expertise and patient preferences, the EBP movement has not paid sufficient attention to how this must be done. In addition to external knowledge, good and patient-oriented care requires other sources of knowledge that EBP underutilises: clinical expertise, local knowledge, knowledge from the patients themselves, knowledge of the context – the living conditions and preferences of patients and the setting within which care is given – and of the values that are involved. Because any decision involves a specific request for assistance that is given in a specific context,

decision-making in the care sector can be seen as an experiment in linking together the various sources of knowledge. (p. 8)

Where the Council is pleading for active input from patients, the practice of FGC moves beyond shared decision-making to what Pathare and Shields (2012) describe as supported decision-making. All knowledge including professional knowledge is shared so the extended social group can make decisions and come up with a plan that meets their needs, their resources, their values, their goals.

FGCs share the ideals and practice of personalised medicine in the sense that it embraces the particularity of each case, the unique tailored plan and the participative process even beyond shared decision-making. Moreover, the supported decision-making of a diverse group is an attempt to address not only the physical makeup, the contextual and historical makeup but also the relational and existential complexity that forms the background of the problems at hand. The cooperation between formal and informal care and the horizontal relations it entails are however a source of tensions, tensions that are present in conducting and evaluating FGCs as well. To explore these tensions I introduce the writings of the Dutch philosopher Harry Kunneman.

### Into the swampy lowlands

Ney et al. (2013) describe the tensions that arise when two opposite discourses interact: the democratic, participatory discourse of FGC with the legal and bureaucratic discourse of conventional youth care. These discourses are competing with each other and become armed in a neoliberal context in which liability and avoiding risks reinforce and recall each other.

In his classic analysis of panoptical power in *Discipline and Punish*, Foucault (1977) makes extensive use of the opposition between vertical, asymmetric relations instigated by the 'panoptical gaze' and more horizontal, reciprocal relations that are impeded by disciplining and normalisation. Disciplining aims to neutralise the effects of countervailing power that can arise out of horizontal connections introducing asymmetries and excluding reciprocities. To this end, panoptical or 'disciplinary' power combines the hierarchical, 'vertical gaze' that sees without being seen with a broad range of scientific measurements and classifications. Youth care provides a good example, based as they are on one-sided observations and on empirically validated categories discriminating between 'good enough parenting' and 'poor parenting' (see, for example, Valentine et al., 2019). These provide the experts involved with knowledge and insights that are beyond the cognitive reach of parents (see, for example, Boyd, 2019). Professionals are by definition better informed and equipped than parents, so there is a power imbalance (Ney et al., 2013).

Timo Müller (2010) introduces the concept 'vertical epistemology' referring to a type of knowing that converts moral issues into predefined objective categories. The implicit standard of truth is absolute while horizontal epistemology refers to relative and relational views on truth (p. 117, p. 139). Building on ideas from Foucault and Schön, Kunneman describes the attractive power of this vertical epistemology in professional practice using two metaphors: the attractiveness of staying safe on the high ground and the avoidance of messy problems in the swampy lowlands. On the high ground, we can rely on what is proven 'evidence-based', on technique and what is prescribed in protocols; in the swampy lowlands, things are messy, contextual and not at all obvious. According to Schön, there are those professionals who opt for the high ground:

Hungry for technical rigor, devoted to an image of solid professional competence, or fearful of entering a world in which they feel they do not know what they are doing, they choose to confine themselves to a narrow technical practice. [ ... ] Other professionals however choose the swampy lowlands:

They deliberately involve themselves in messy but crucially important problems and, when asked to describe their methods of inquiry, they speak of experience, trial and error, intuition, and muddling through (Schön, 1982, p. 43).

In the mindset of the high ground, the swampy circumstances of capricious fellow people are kept out of sight focussing on matters that can be solved. Descending into the swamp means enduring



situations that cannot be fixed, at least not quickly. It implies the confrontation with interrelational emotions and the relational hassle that occurs down there. Questions arise for both researchers as for social professionals: How can I, as a social worker or researcher, leave the high ground? How can I become someone who no longer sees himself as the pivotal point of change? Can I let go of the hero role that is connected with helping (caring, recognition for being the pivotal point) or researching (proving, predicting, controlling)? Could I enjoy the results achieved by the primary group without attributing the results to my intervention? What remains of my profession as a social worker if instead of helping I support clients to help themselves and to help each other? How can we proceed as a team when blueprints are no longer leading? Are we able to improvise? Do we dare to trust people and what they might accomplish in the processes? In the swampy lowlands risks are accepted, even embraced; but how do I handle my own uncertainty when there are no more blueprints? Enduring swampy conditions is a relational undertaking. In a relational approach that is connected to this swampy environment care providers that have doubts about child safety do not immediately report this to an Advice and Reporting Centre on Child Abuse, but instead consider this as a relational challenge to connect, to make contact, to gain trust, to discuss concerns. The relational challenge lies in the search for common ground, knowing that professionals and parents both want the best for the child. Parents' anger and distrust can be more easily overcome when professionals have the firm will to empathise with the feelings of indignity, fear, panic and hostility that parents experience when care providers convey such worries, especially when there is an understanding for the impotence that may have preceded the occurrence of maltreatment. In a relational approach, there is an appreciation for the swampy conditions that cannot be suppressed by checklists or protocols. In fact, there is love for the erratic process, the intense emotions, the uncertain outcomes, the risks, as there is also joy when it is possible to get on the same wavelength or when the cooperation with parents bears fruit. But how can the scientific community support such a descent into the swamps? To be more specific, how can I as a researcher serve such a relational approach with my expertise?

## Conclusion

The hunger for technical rigour coincides with the longing of being the pivotal point in the life of others for both researchers and care professionals. The horizontal relations characterising FGC are at odds with the asymmetrical relations and the dependencies connected with the vertical epistemology dominating youth care. Dealing with the enormous attraction of the high grounds is difficult for both practitioners as researchers and means grieve and mourning over the loss for not having a roadmap that offers a way out of the labyrinth. To serve the field of youth care and to serve those who dare to descent into swampy lowlands, implies dealing with overwrought promises of prove, prediction and control. These conferences are actually about getting lives back on track; whether this succeeds with FGCs can only be validated by those involved. Meanwhile, FGCs are no one's friend: researchers for not being able to deliver certainty and proof over what exactly caused the success; professionals for not being the ultimate guide out of the labyrinth; family members and loved ones shy away in view of the commitments it might bring; civil servants and alderman because they can't administer informal helpers; and finally clients who hesitate to share their problems with their relatives. The truth-power nexus Foucault envisions is not only produced by authorities and their servants; all actors seek from time to time the vertical, asymmetric relations, freeing themselves from obligations and close proximities. Nevertheless, they are key to connect, to maintain relationships and to bear responsibilities. Staying on the high ground and clinging to prove, checklists, protocols and population-based RCTs, feeds the overwrought claims of prediction, control and professional potencies. It is, however, possible to establish learning care organisations in youth care and adjacent fields, practices where researchers learn and listen, practices where clients (parents, adolescents) and former clients are co-researchers in the quest for child safety. In such a learning environment the social circle is encouraged to overcome fear for commitment and

proximity. The knowledge derived from these practices will not produce context free and timeless wisdom, but merely practical and local clues. In the end it is also necessary for the scientific community to reflect on the context of poverty and economic disadvantage that form the background of neglect and maltreatment. FGCs and other efforts to strengthen communities should not be a stopgap for failing systems, nor should research closes their eyes for the swampy conditions and the unequal chances of ending up there.

## Notes

1. See: <https://whatworks.blog.gov.uk/about-the-what-works-network/>. See also: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/677478/6.4154\\_What\\_works\\_report\\_Final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/677478/6.4154_What_works_report_Final.pdf)
2. See the full text of the open letter: [https://eur04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sheffield.ac.uk%2Fpolopoly\\_fs%2F1.882538.1583506804!%2Ffile%2Ffgcfurtheropenletter.pdf&data=02%7C01%7Cg.schout%40amsterdamumc.nl%7C69ba69c4f9e64dca1cb708d7c1ee18a5%7C68dfab1a11bb4cc6beb528d756984fb6%7C0%7C1%7C637191100690947560&sdata=nu999h9ieo%2FMcFwYo8yTAeOdi1o4oqQb7tp015MHu4%3D&reserved=0](https://eur04.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sheffield.ac.uk%2Fpolopoly_fs%2F1.882538.1583506804!%2Ffile%2Ffgcfurtheropenletter.pdf&data=02%7C01%7Cg.schout%40amsterdamumc.nl%7C69ba69c4f9e64dca1cb708d7c1ee18a5%7C68dfab1a11bb4cc6beb528d756984fb6%7C0%7C1%7C637191100690947560&sdata=nu999h9ieo%2FMcFwYo8yTAeOdi1o4oqQb7tp015MHu4%3D&reserved=0)
3. [https://en.wikipedia.org/wiki/Family\\_Group\\_Conference](https://en.wikipedia.org/wiki/Family_Group_Conference)
4. <https://www.bbc.com/news/uk-england-manchester-49742305>
5. <https://www.theguardian.com/society/2019/nov/11/first-cannabis-based-medicines-approved-for-use-on-nhs>
6. Zie: [https://www.youtube.com/watch?time\\_continue=337&v=PkcWCxI2lio&feature=emb\\_logo](https://www.youtube.com/watch?time_continue=337&v=PkcWCxI2lio&feature=emb_logo)
7. [https://www.natlab.nl/programma/2838/Olivier\\_Nakache\\_Eric\\_Toledano/Hors\\_Normes/](https://www.natlab.nl/programma/2838/Olivier_Nakache_Eric_Toledano/Hors_Normes/)
8. <https://www.internationalgenome.org/announcements/initial-phase-3-variant-list-and-phased-genotypes-2014-06-24>
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