Effectiveness of the Social General Practitioner.
The case of the Enschede neighbourhood coaches

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Introduction

The performance of service delivery by professionals and its determinants of success are long-standing themes in academic research. Many scholars have investigated this issue, and probably will continue to do so, as research outcomes are controversial. One of the concepts that has become ever more important in our understanding of professional service delivery deals with cross-boundary working. Professionals working in service and provision organizations increasingly have to work across organizational, sectoral, professional and thematic boundaries. This new landscape requires local service providers[1] to collaborate in network arrangements of various types to solve 'wicked' problems that cannot be solved or easily solved by single organizations. Already in 1993 Alter and Hage (1993: 10-13) pointed to the increasing relevance of interagency coordination of community-oriented activities in the public sector. In the course of the last decade the need for interagency collaboration and coordination became ever more obvious in the light of changes in systems of (local) governance. Contemporary local governance is to a lesser extent than before synonymous with what municipal government 'does' (under the direction of its elected council; Leach and Percy-Smith, 2001, p. 1). This implies a new division of roles, where especially in the case of cross-cutting issues like environmental sustainability, crime and social inclusion successful collective action has to be undertaken by a myriad of public and private actors (Sullivan and Skelcher 2002, pp. 56-79). This is particularly true for local service delivery. Interorganizational, cross-boundary collaboration is most important in deprived neighborhoods where residents often place a tremendous burden on local service providers, because of the multiple and/or complex problems these residents are struggling with. While their problems are multifaceted, intractable and entwined, service delivery usually is fragmented due to high levels of specialization and differentiation. Policy makers increasingly have turned to social policy reforms to encourage or to introduce collaboration across organizational, sectorial, professional or thematic borders. Such collaboration goes beyond social relationships or recurring relationships within and outside organizations; it involves real-life entities of legally autonomous organizations that work together to achieve not only their own goals but also a collective goal that provides the network with a distinct identity (Provan and Kenis, 2008: 231).

[1] In this paper the term local service providers refers to all local professionals responsible for governing or serving people in need of help or support to deal with social problems in different spheres of their lives, including local government agencies.

An experimental program in the Velve-Lindenhof neighborhood in the Dutch city of Enschede uses a rather unique approach to deal with a broad range of multifaceted and intricate community issues. The overall aim of this program is to improve the life-chances of neighborhood residents of one the most deprived urban neighborhoods by providing for the appointment of neighborhood coaches, each of whom will act as an individual counselor for a limited number of residents. They replace the common system where typically residents with multiple or complex social problems are catered for by a small army of highly specialized professionals working for a host of local service providers. The experimental program involves both innovation in the process of service delivery, organizing services around the needs of local residents rather than professional demarcations, and innovation in the governance of collaborative efforts, by introducing one general professional: the social General Practitioner, who provides services regarding a broad range of social issues.

In this paper we study the effectiveness of this model of social service provision. To what extent does the model that might look 'promising in theory' also 'work in practice'? In order for the model to 'work', the general practitioners have to be able to operationalize and implement their role in the (inter)organizational field and they must realize results at the level of the residents. Against this background the central question reads: *How effective is the social general practitioner model in providing social services?*

This paper proceeds as follows. First we present a general outline of the experimental program. In order to study its effectiveness, we next have to specify the particular goals of the model in terms of the situation of the residents and the work process that should result in reaching these goals. This section contains a description of the specific sub questions that we will answer in the empirical part. Next we will describe the data that we have collected and the methods that were used. In the results section we subsequently answer our research questions. In the conclusion we summarize our findings.

General outline of the experimental program

In recent years neighborhoods have become the center of attention, identified by policy makers as appropriate sites for innovation in service delivery. Some neighborhoods suffer from persistent social problems, harming the full development of people, their quality of life and public security (Holsbrink, 2009). Among these neighborhoods is the Velve-Lindenhof neighborhood. It is part of the city of Enschede, a town of approximately 160,000 inhabitants in the East of the Netherlands. To address social problems in this neighborhood various programs and policy initiatives have been commenced. These pertain to a broad range of community issues, including the improvement of the quality of the housing stock and the physical infrastructure in the neighborhood; of the quality of the social infrastructure, the social cohesion and the (subjective) safety and livability of the area; and of the socio-economic life chances of individual neighborhood residents. The programs and policy initiatives are underpinned by three dominant Dutch policy

perspectives. First, it is held that to address problem accumulation a targeted intervention of a limited number of neighborhoods is required.[2] Second, problems of deprivation and social cohesion are considered to be in need of a top-down 'social recovery' strategies.[3] And third, policy initiatives should include the creation of more stepping stones on the societal ladder to improve individual life chances of residents and, ultimately, the social climate of the neighborhood.[4]

The policy perspective that individual life chances need to be taken into account is a relatively new element in Dutch social policies. It is based on the presumption that a structural improvement of neighborhood conditions also requires action resulting in socio-economic emancipation of residents. Starting from this perspective in 2008 a new approach is tried out in the Velve-Lindenhof neighborhood. The city of Enschede and three local housing associations provide for an experimental program where so called neighborhood coaches are appointed to be active as *social General Practitioners*, to use a metaphor. Like medical GP's the coaches act as individual counselors to people in order to deal with almost all aspects of their multiple and/or complex problems. It is up to the neighborhood coaches to decide what people and their families need in terms of professional help and support 'to regain control over their lives' and in a next step to 'climb the social ladder'. The neighborhood coaches provide services 'in the first line', referring clients to specialized workers 'in the second line' only when the problems a client faces requires expertise that the coaches cannot provide for themselves.

The overall aim of the experimental program is to improve the life chances of local residents with respect to key spheres of their life (health, housing, education, security, welfare and/or employment). To advance this ambition a quite assertive institution-led 'go for it' approach is applied.[5] Through house calls local residents are actively approached to see whether they are in need of help or support. The use of active house calls was part of the predecessor of the social GP model. In 2006 the city of Enschede initiated a pilot using house calls as a strategy for neighborhood regeneration and local service delivery. The goal of these house calls were support of people living at the addresses (Holsbrink, 2009).

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[2] In the 1980s the central government initiated the Problem Accumulation Area Program which involved a selection of deprived neighborhoods for targeted intervention. This program inspired a series of subsequent programs, again targeting a selection. The latest program started in 2007 and contains 40 priority areas. The Velve-Lindenhof neighborhood is one of the 40 priority areas targeted by the central government because of their problem accumulation.

[3] In its report 'Trust in the Neighborhood' the Dutch Scientific Council for Government Policy (WRR 2005) contends that in the past urban regeneration approaches have not been able to create sustainable improvements. It among other things advised to distinguish between more top-down 'social recovery' strategies to address problems of deprivation and social cohesion, and bottom-up 'opportunity-driven' approaches in more stable and cohesive neighborhoods (WRR, 2005)

[4] In a recent advice of the Vrom-council (Vrom-raad, 2006), for instance, policymakers are urged to address problems at a level where they are most persistent: that is, by providing labour market en educational opportunities for less fortunate residents and by providing and orchestrating contact possibilities with middle class groups through social mixing.

[5] Typical of common service provision is that people have to come forward with a problem; they need to formulate what question they have and address it to the proper organisation. The 'go-for-it' approach acknowledges this for various reasons stops people from asking for help. To make sure that people get the help they need and that they are entitled to, workers take initiative to get in contact with residents to find out if they have problems that they would like to solve with professional help.

The initiative for the pilot was taken as part of a project to facilitate collaboration among governmental and nongovernmental organizations involved in local service delivery (including education, healthcare, housing, policing and security, welfare and employment). In 2004 the city of Enschede, with consent of 25 service providers and local government departments, drastically reduced the number of meetings that were organized on a regular basis to integrate decision making processes and to coordinate subsequent action. A so called Neighborhood Care Team was established to work toward integral, efficient and effective care provision with a focus on multi-problem families. Members of the team were assigned to families, acting as case managers, to provide these families with a single 'point of access'. In a covenant the strategic top of 25 organizations agreed to collaborate in providing services to these families. In 2005 the first Neighborhood Care Team was introduced in the Velve-Lindenhof neighborhood.

Although both the house calls and the Neighborhood Care Team have proved to be, and still are, of value to improve service delivery, these initiatives were unable to redress some major concerns in the interorganizational cross-boundary collaboration. Participation in the Neighborhood Care Team helped and helps professional workers to improve their responsiveness to the needs of their clients. However, in spite of its strength in terms of joined-up working, a number of problems remain unaddressed (Weggemans and Meiberg, 2009: 4; Weggemans, Jonker, Smits, 2010: 9). The most important ones are, first, that case managers can coordinate action, but lack decision making power to impose actions on network partners. Consensus about the course of action has to be reached among team members that subsequently need to have the decisions authorized by the back offices of the organizations involved in the actual implementation. This not only renders decision making processes inefficient in terms of time and energies, but also imposes on the effectiveness of joined action as team members have to balance interests of the network, their organization and their clients. Second, case managers offer a 'single access point' to multi-problem families, which allows them to build a relation of trust with their clients, but their inability to take immediate action when required leaves these families 'empty handed' in situations of crisis. From a service delivery perspective this implies that resources are not used to their full potency, since research has shown that quick responses to meet immediate needs is a precondition to get and keep clients motivated to work on their problems (Katz et al, 2006). In short, the attempts to facilitate interorganizational cross-boundary collaboration have brought progress, but cannot prevent that service delivery in practice still mainly occurred in organizational 'silos'. The members of the Neighborhood Care Team, ultimately, find themselves representing organizations rather than people.

The experimental program introducing neighborhood coaches took stock of these experiences. The strategic top of the collaborative network consented to a new approach that endows the neighborhood coaches with real, though from a legal point of view informal, decision making power. Legally the decision making authority remains within the organizations participating in the experimental program, but the strategic top agreed that the neighborhood coaches make decisions about what professional help or support people need and which organizations are involved in the process of service delivery. The coaches have been assigned one or more contact

persons (referred to as ‘buddies’) in the partnering organizations. They help the neighborhood coaches to get access to key persons in their organization and make sure that required actions are authorized and implemented. The decisions of the neighborhood coaches are formalized by those authorities in the organization that bear legal responsibility. The strategic top agreed that this formalization is not subject to negotiation, which gives the coaches real power to make a difference for their clients. As their decisions also may involve enforcement of sanctions if local residents are unwilling to consent to promises made on their part, the neighborhood coaches have power over these residents as well. By entrusting neighborhood coaches with time and resources across functional, professional and thematic boundaries the project intends to orchestrate the service provision to people and households. Moreover, the pooling of resources allow the neighborhood coaches ‘to do business’. It is generally agreed that inter-organizational networks are important vehicles for knowledge expansion as the most significant element of the resource base (Agranoff, 2006: 57, 58). The experimental program, however, adds to this a strong new feature: the strategic top agreed that resources of the one domain or sector, say housing, may be used a positive incentive to encourage people to climb the social ladder in another domain or sector, say education. This is rather unusual as it implies that GP’s are really ***General*** practitioners, combining all the resources that a resident might need in order to improve his or her situation.

To summarize, the experimental program involves innovation in terms of literally ‘first use’ of new structures of authority and cooperation to allocate resources and to coordinate and control joint action across different organizations. Both the governance and large parts of the actual social service provision are in the hands of a single general professional: the social GP. In the next section we describe the goals of the GP-model and formulate our specific research questions.

Specific goals and research questions

In order to measure the effectiveness of the GP-model we first have to conceptualize effectiveness in the context of this model. As effectiveness can be regarded as the level of goal attainment that is the result of a policy, this implies that we have to specify the goals of the GP-model. Ultimately these goals refer to the situation of the residents as the final *outcome* of the policy: is the social situation of the residents improved or not? However, the GP-model also specifies that the support plans (so called ‘action plans’) should have certain characteristics. These plans and the social services that are indicated by them can be regarded as the policy *outputs*. Additionally the GP-model contains a number of goals regarding specific characteristics of the work process. The activities that the neighborhood coaches actually undertake in order to produce these outputs can be regarded as the *implementation* of the GP-model. This conceptualization implies that there are three general research questions regarding the outcome, outputs and implementation of the GP-model. We will start with a further conceptualization of the implementation question and subsequently discuss the output and outcome questions.

The ***implementation*** question can be formulated as:
1. To which extent is the intended way of service provision in the GP-model realized in practice?

As has been indicated in the section above, the GP-model puts the neighborhood coach in a central position in terms of service delivery. This implies that the coach has to have both sufficient professional *expertise* and sufficient *mandates* at his disposal in order to decide about the services a resident might need. As the coach has to decide about a very broad range of services, he or she needs at least a general level of expertise regarding all relevant social issues on which residents might face problems. This expertise should at least enable the coach to identify the relevant issues and decide about the question on whether to provide services to the resident by him- of herself, or to decide that consultation with and possible reference to a specialist service provider is necessary. It is by no means clear in advance that the neighborhood coaches will all have a level of expertise that meets these ambitious standards. Next to the expertise, the coaches also need sufficient mandates. As has been indicated in the previous section, the mandates are provided on an informal basis, by means of a covenant that was signed by the participating organizations. It was agreed that the organizations would formalize the decisions for which the neighborhood coaches had a 'mandate. This raises the question whether the agreements on these mandates are actually implemented by these organizations, providing the coaches with sufficient mandates to fulfill their tasks.

Consequently we can formulate a first sub-question regarding the implementation of the GP-model:
1a. To which extent do the neighborhood coaches have sufficient expertise and actual mandates in order to implement their role as general practitioners?

Although the neighborhood coach has a central position, the GP-model still implies that a fruitful cooperation with the partner organizations is necessary. The coach takes the initiative for actual service provision and has considerable room for taking decisions, but there still will be many instances where specialists from the 'second line' of service organization will be consulted and in many cases these will also play an important role in actual service provision (for instance regarding medical and psychological support). This raises the question as to which extent the coaches succeed in cooperating with the specialists from these organizations. The specialists might have their own professional ideas about the services that should be provided to the residents and these might be different from the ones that the coaches would provide taking the entire situation of the residents into account. Given the experience from the pilot that it is sometimes difficult to reach inter-professional agreement when professionals form a team, it is by no means certain that the GP-model will not result in conflicts between the 'empowered' coaches and the specialists in the different partner organizations. We therefore formulate a next sub-question:
1b. To which extent do the neighborhood coaches succeed in cooperating successfully with the professionals from the partner organizations?

The GP-model contains a number of specific objectives that refer to the intended characteristics of the work process (Weggemans and Meiberg, 20094; Weggemans, Jonker, Smits, 2010). These characteristics can be summarized as:

- The *decision making* regarding the needed service provision is *fast*. No more delays because of long debates between different professionals and time consuming gathering of information from different sources;
- The *implementation* of decisions is *fast*. The coach makes sure that decisions are quickly implemented, by either his own activities or prioritizing activities of service provision by partner organizations;
- *Information* is *easily exchanged*, as the coach has a central information position and has durable relations with actors that can provide information;
- The process is *flexible*, as coaches are able to adapt the steps taken in the process to the specific situation of the residents;
- The process is characterized by *smooth mutual adjustment* between the different professionals engaged in indicating the best solution for the problems of the residents;
- The process is *non-bureaucratic*, as the coach is to a large extent liberated from specific protocols that are used by the different partner organizations;
- The process is *efficient*, as the centralization of tasks in the hands of one coach makes the work of many specialists and the management of their contributions redundant.

To a reader of the implementation and organization literature these objectives may read as 'too good to be true', so it may come as no surprise that the third sub-question can be formulated as:
1c. To which extent are the objectives regarding the process characteristics actually realized in the implementation process?

The research question regarding the ***output*** of the work of the neighborhood coaches can be formulated in a single question:
2. To which extent are the objectives regarding the characteristics of the plans of action actually realized?
The coaches' diagnosis of the situation of the residents and the (if necessary) consultation of the professionals of the partner organization should result in a plan of action that specify the services and support that are to be delivered to the resident. In the working model for the coaches a number of objectives for these plans are formulated. These are:

- The plan is *tailor-made*, which means that it is adapted to the specific situation of the resident in his or her household;
- The plan is *integrated*, meaning that all relevant social services are taken into account and the plan contains a coordinated effort to improve the situation of the resident;
- The plan is *effective*, meaning it will result in an actual improvement of the situation for the resident;

- The plan is *flexible*, meaning that it can be adapted in case changes in the situation of the resident demand a change in the services to be provided;
- The plan is *backed with sanctions* in case the behavior of the resident is not in line with the agreements made in the plan or with general rules of behavior;
- The plan is *responsive*, meaning that specific needs and preferences formulated by the resident are incorporated in the plan;
- The plan is *activating*, meaning it will stimulate the residents to (become able) solve their own problems.

At the ***outcome*** level of the GP-model the general research question can be formulated as:
3. To which extent is the social situation of the residents improved by the services provided by the neighborhood coaches?

The concept of social improvement in the GP-model has three dimensions. The first is the idea that residents should be empowered to cope with their situation themselves. This refers to the abilities of residents to deal with their possible problems. This can be seen as a form of social competences. If social services are to have a durable effect on the situation of the residents, than they need to be(come) able to take care of their future situation without subsequent support from professionals. Thus a first sub-question can be formulated as:
3a. To which extent are the social competences of the residents improved by the services provided by the neighborhood coaches?

Improvement of the social competences can be seen as a first step toward improvement of the actual social situation of the residents. The social situation is, in terms of the GP-model of the city of Enschede, first defined by the level of *social participation*. Participation is indicated by what is called 'the participation ladder', an index of participation containing six steps. The first three steps of this ladder (bottom) can be seen as an indication of three levels of social participation:
1. Social isolation (no social contacts and thus no social participation);
2. Social contacts outside the own household (incidental contacts with others);
3. Participation in organized activities (regular and durable contacts with others).

The second (top) part of this ladder contains three steps that refer to participation in the workforce:
4. Unpaid work (work as a volunteer, without payment but on a regular basis);
5. Paid work with support (support by social services or financial compensation);
6. Paid work (regular work in a job or as a private entrepreneur).

Social improvement can be indicated by a rise on this participation ladder (moving from lower to higher steps). The matching research question can be formulated as:
3b. To which extent is there a rise of the residents on the participation ladder due to the services provided by the neighborhood coaches?

The final aspect of the outcomes is defined as the improvement of the situation of the residents in a number of possible 'problem fields'. The GP-model refers to a number of social issues where residents could face problems that are explicitly to be

treated by the neighborhood coaches. These fields are: housing, finance, education, family relations, relations with professional organization, relations in the neighborhood, health, safety, participation and work (the last two field overlap with the participation ladder). The work of the neighborhood coaches should result in actual improvements in these social areas, which lead us to the final sub-question:
3c. To which extent has the provision of services by the neighborhood coaches resulted in improvement in the residents' situation in the specified social fields?

Before we answer these questions we will first describe the data that were collected and the methods used to collect them.

Data and methods

The research on the project has consisted of a number of studies regarding different aspects of the work of the neighborhood coaches.[6] There has been a study focusing on the *work process* and the *cooperation* between the coaches and the professionals from partner organizations. This study uses measurements on a number of process and output indicators in two moments in time: in 2010 (somewhat more than 1 year after the start of the project) and 2012 (at the end of the project). It used a written survey that was send to all coaches (4 coaches and their manager) and all professionals that had a possible link to the team (97). All coaches responded and the response rate for other professionals was 54% in 2010 and 41% in 2012. Results from the survey questions in 2010 were discussed in three group discussions with coaches and partners, in order to provide context and additional information regarding possible interpretations and background of results.
The services delivered to the residents and their outcomes have been studied in two ways. First by a written survey among the *residents* that have received some form of support by the coaches and were able to answer such a survey in the beginning of 2012. From 110 questionnaires that were send a total of 44 were returned (40%). The questions were on the social fields where they have experienced problems, on whether they had been given support from the coaches and on the effects of this support. Additionally there were general question on their perceived quality of the work of the coaches. A second study made use of the information from the database that the coaches used to administer their work. This database contains data on the services that were provided to residents and the results of these activities, both in terms of the residents' social situation and their social competences. The social competences of the residents were indicated and recorded on a quarterly basis by the coaches, both as a diagnostic instrument and as a measurement of results. These data enable a description of the level of competences over the period that the residents have been supported by the coaches during the 3 year of the project.
Additionally, the outcomes of the project have been studied by a general survey in the *neighborhood of the project* in 2009; 2010 and 2011 and in a comparable *'control' neighborhood* in 2009 and 2011. These data used general samples of residents and interviews using fixed survey questions as a method of data collection.

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[6] The full reports of the research project (in Dutch) are available at:
http://www.utwente.nl/mb/pa/research/completedprojects/wijkcoaches/

Response rates are around 50%, resulting in 60 to 85 cases per measurement. These data enable a comparison between the neighborhood in which the coaches were active and a neighborhood where they were not active, but the regular forms of social service provision were used.
In the next section we will subsequently answer our research questions using these data.

Results

Implementation

The research question on implementation has been divided in three sub-questions, of which the first is: *1a. To which extent do the neighborhood coaches have sufficient expertise and actual mandates in order to implement their role as general practitioners?*
Regarding the expertise of the coaches the professionals from partner organizations are rather positive. On a five point scale ranging from 0-4 their expertise on the situation of the residents and the neighborhood scores high (on average 3.1 and 3.3).[7] When asked about the necessary expertise to cope with all the different problem fields, the specialists provide the GP's a somewhat lower score (2.4), but this is still higher than the 'medium' category score of 2, so there are no indications of widespread lack of expertise. Partners also have a high level of trust in the coaches. Coaches see themselves also as sufficiently competent to do their jobs (3.0 in 2010, 2.7 in 2012, again on a scale from 0-4).
This image is confirmed by data from the studies on residents. Residents that were clients of the coaches, provide their competences on different indicators with scores of around 0.90 on a scale from 0-1. Trust in the coaches is also high: 0.88 on a scale form 0-1. Data from the neighborhoods show that general trust in social service providers has risen in the Velve neighborhood and is in 2012 higher than in the control neighborhood (whereas it was at the same level in 2010).
Regarding the mandates the coaches conclude that in general these are sufficient and enable them to perform their central role in the service provision on an adequate level. Some questions on the scope of the mandates have been resolved in the first stages of the project. However, in some fields (health, psychiatry) strict privacy regulations inhibit the exchange of information with specialists in partner organizations.

Overall, we can conclude that the coaches had sufficient expertise and mandates to implement their role as general practitioners.

1b. To which extent do the neighborhood coaches succeed in cooperating successfully with the professionals from the partner organizations?
The professionals from partner organizations indicate that the coaches have a high willingness to cooperate and a large majority (75%) indicates that there are very few

[7] Data from 2010, but scores in 2012 where practically the same.

differences of opinion on which services to provide to the residents. In case there are differences of opinion, a huge majority (88%) says that the initial differences are solved in mutual consultation, resulting in consensus. These results are the same in 2010 and 2012. From the group discussions we learned that the coaches are very well aware of the fact that although the informal mandates give them a strong position in deciding about service delivery, they still need to cooperate with specialist professionals. Specialists remain important as source of information, a source of expert advice and as possible treatment specialist for certain services. This implies that the coaches need to use their mandates in a prudent way, as they are aware that cooperation will improve the quality of their services. Additionally it is important that the mandates are only informal, so in case of (enduring) conflict the coaches are still depending on the formal decisions by the professionals in the partner organizations. Both coaches and partner professionals indicate that this has resulted in an implementation style that has been cooperative from both sides. A further indication of cooperation is that during the 3 years of the project not a single case for conflict resolution has been taken 'up' to the top management level (a procedure that had been put in place in case such a situation would have occurred).
The coaches indicate that they are quite successful in convincing partners and coming to agreements with partners on what services to deliver (scores of 3.2 in 2010, on a 0-4 scale). In 2012 they are somewhat less positive on coming to agreements (2.7), but this is still well above the 'medium' value of 2.

Overall we can conclude that the coaches have been able to cooperate successfully with the professionals from partner organizations.

1c. To which extent are the objectives regarding the process characteristics actually realized in the implementation process?
The process characteristics described in the section on specific goals have been measured in the process studies. The results for the 2010 study are presented in figure 1.

The results show that the professionals from partner organizations give relatively high sores on all characteristics (ranging from 2.6 to 3). The coaches agree with the other professionals on indicators of speed and flexibility, but are somewhat less positive regarding smooth mutual adjustment, efficiency and non-bureaucracy (although scores remain well above 2). A possible explanation that we took from the group discussions is that the coaches are at the center of all activities, which means that they do the bulk of the work, relieving the other professionals of a lot of work (efficiency) and taking a lot of effort in adjustment and putting organizational protocols aside (aware of the fact that some improvements in this field are realized, but whishing things would be more easy).
In the 2012 measurement the partner organizations are in general even more positive than in 2010. In 2012 the coaches respond in a similar way as in 2010, with the exception of the characteristics efficiency and non-bureaucratic: on these criteria the scored have decreased slightly towards scores of 2

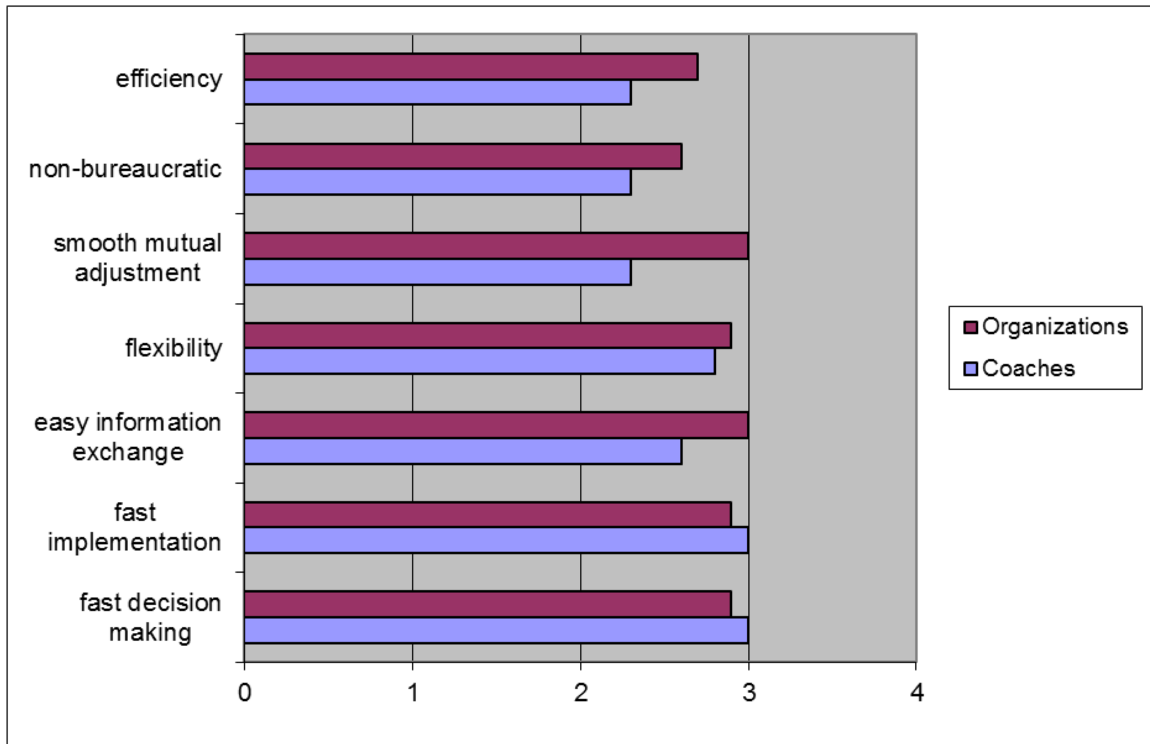

Figure 1: *characterization of the work processes according to the respondents in 2010, scale from 0 to 4.*

The rather positive scores on process characteristics from the involved professionals are backed by perceptions of the neighborhood residents. They indicate that the neighborhood coaches are really helping them in a flexible, non-bureaucratic and efficient way, with scores between 0.8 and 0.9 on a 0-1 scale.

Overall we can conclude that the objectives that were formulated for the work processes have been realized to a large extent. Additionally we can conclude that, *to a large extent, the intended way of service provision of the GP-model has been realized in practice*.

Outputs

Regarding the outputs we have formulated a single research question:
2. To which extent are the objectives regarding the characteristics of the plans of action actually realized?
In the process-surveys respondents were asked to assess the plans of action that the neighborhood coaches have been developing in the context of the project. These plans of action contain the combined support measures for each neighborhood resident household. Respondents assessed the plans according to the list of characteristics that were seen as objectives of these plans (described in the section on specific goals). Results from the 2010 measurement are provided in figure 2.

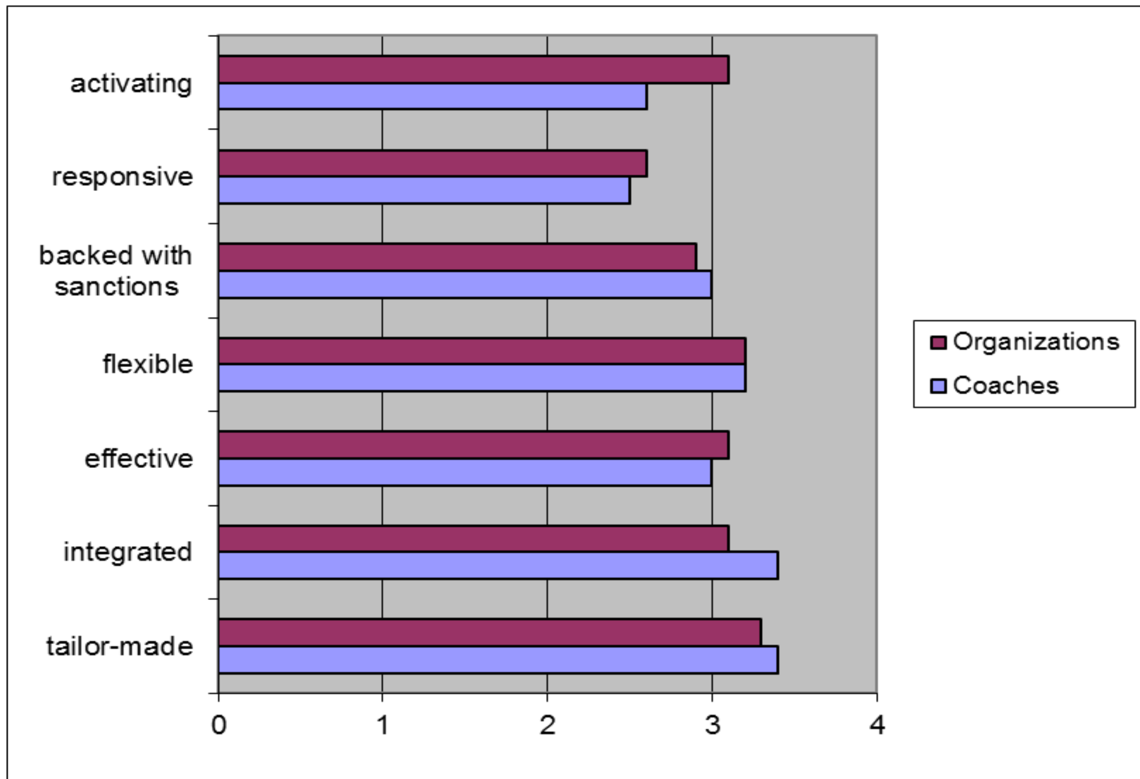

Figure 2: *characterization of the plans of action according to the respondents in 2010, scale from 0 to 4*

Our findings reveal that the neighborhood coaches and the members of partnering organizations share a similar perception of the plans of action's qualities. The plans of action score high on most characteristics, though the scores are more moderate-high regarding the extent to which the plans of action are perceived as activating clients (especially by the coaches) and their being responsive to the needs and demands of clients. The respondents are particularly positive about the flexibility and effectiveness of the plans of action and their capacity to provide for integrated and tailor-made service provision (scores above 3). The responses of the respondents in 2012 provide a similar picture, but in this case the coaches become a bit more positive, particularly on the aspects 'activating' (3.2), 'responsive' (3.0) and 'backed with sanctions' (3.8). This indicates that the coaches experience their plans of action at the end of the project as slightly more in line with the objectives than after the first year.

We also asked the respondents from partner organizations to compare the plans of action developed in the Velve area with conventional plans of action developed elsewhere in the city of Enschede. Our findings reveal that they consider the experimental approach to produce better plans in terms of all seven characteristics. This was already the case in 2010, but the differences were even larger towards the end of the program in 2012 (figure 3).

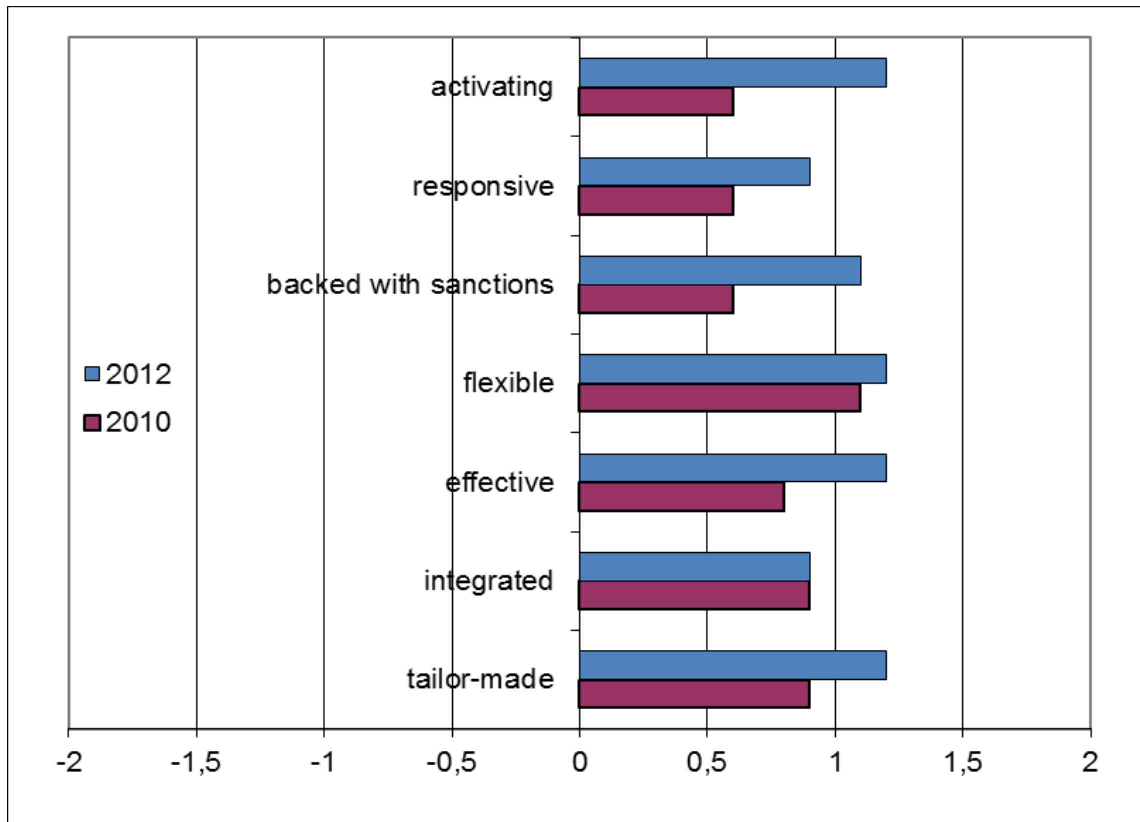

Figure 3: *Comparison between Plans of action in Velve and in other parts of the city in 2010 and 2012 (positive scores indicate plans in Velve score higher on the characteristics, scale from -2 to 2).*

Overall we can conclude that the objectives regarding the plans of actions are realized to a large extent.

Outcomes

Regarding the outcomes three sub-questions have been formulated, of which the first one is: *3a. To which extent are the social competences of the residents improved by the services provided by the neighborhood coaches?*

The plans of action are only an intermediary step towards the final outcomes of the project: an improvement in the social position of the residents. A first step in their improvement is the increase in social competences, enabling the residents to take care of their problems in the future. This is at the heart of the goal of 'empowerment'. For the project six competences were distinguished that were measured on a quarterly basis:

- problem awareness, the ability of residents to see and understand their social situation;
- motivation for improvement, the willingness of residents to take action in order to improve their situation;
- self-respect, having a positive self-image;

- knowledge of options for improvement, the ability to think of actions that can improve the situation;
- the ability to cooperate with relevant others, including professionals.

Factor analysis showed that these competences refer to one single dimension, after which a single scale has been constructed as the mean of the sum of the items. This social competences scale ranges from 1 to 10 and can be regarded as a grade in the Dutch grading system, meaning that a 6 can be seen as 'sufficient' in terms of competences.

In order to understand the results that have been achieved by the neighborhood coaches it is vital to realize that the duration of the support of the residents shows a large variation. At one end of the time-scale we find residents that have been supported for the full duration of the project: three years. These are residents that were on the radar of the coaches at the start and have been in need of support since that time. At the other end of the scale we find residents that have been supported for only a couple of months. This group is rather diverse for there are different reasons for short support. In some cases the residents were put at the attention of the coaches at the very end of the project, meaning their support plan was just being formulated. In other cases the residents moved to another area and were no longer seen as a potential client for the coaches. In some cases it was immediately clear that residents would need specific specialist treatment where the input of the coaches would not have additional value (for instance treatment in a closed psychiatric hospital or even imprisonment). Finally there are a number of cases where a short intervention by the coaches produced quick results and support could be terminated because the residents were able to take care of themselves. Because of the diversity of the group with short support and the limited support that has usually been provided by the coaches to this group, it is difficult to indicate how many results have been realized for this group. This group contains about one third of the residents that have been provided with support by the coaches.[8] About 30 percent of this group was regarded as needing no further support after a short intervention. For this group the average rise on the competence scale was 1.2. In the remainder of our analysis we will focus on the residents that received support for a longer period.

Analysis of the scale for social competences shows that many residents have increased their competence level. The average improvement is higher for residents that started the project having a low level of competences and is higher for residents that were supported over a longer period of time. Figures 4 and 5 indicate the increase of competences for the groups of residents that are supported for a medium-long period of time (between 9 and 15 months, 54 residents) and for a long time (more than 18 month, 53 residents).

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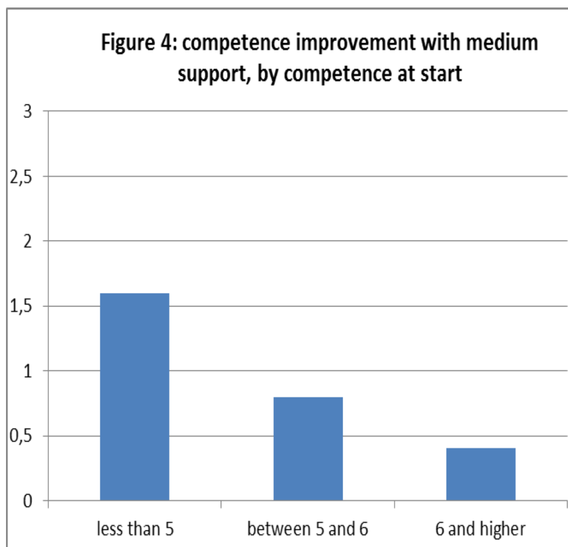
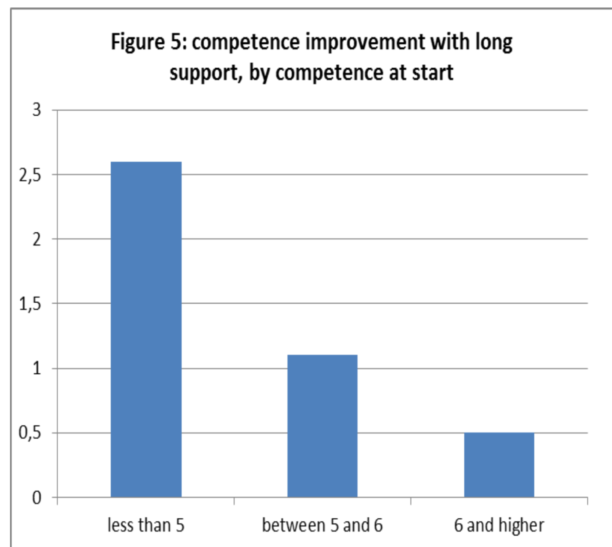
[8] In total 117 residents have been treated half a year or less, of which 54 have only one measurement on the competences scale. For these residents no improvement on this scale is possible, as only one measurement is available. In total 63 residents have two or three measurements.





In both figures we see that those residents that needed most support (started with a competence level of less than 5) have improved more than residents that started with levels between 5 and 6, who in turn have improved more that residents who started with a level of 6 or higher. A rise in competence level was of course less necessary for the last group, as their level was on average already 'sufficient' at the start.[9] Comparison between the same groups in figures 4 and 5 (in terms of their starting position) shows that those residents that have been supported for a longer period (figure 5) also show more increase in their competences. This is an indication that the support of the coaches has played a role in bringing the increase in competences about.

The results of the work of the coaches can not only be indicated by the average rise in competence levels, but can also be indicated by the proportion of the supported residents that have sufficient competence levels. These data are presented in figure 6. It shows that 40% of the residents that were supported for a medium-long time (middle), already had a sufficient level of competences at the start of their treatment. By the end of the support a total of more than 80% of this group had a sufficient level of competences. For the group that received support for a long time we see an effect that is even more pronounced: just over 10% had a sufficient level at the start, whereas 75% has a sufficient level at the end.

[9] An average level of 6 on a scale of six items can of course imply that some competences are still below 6.

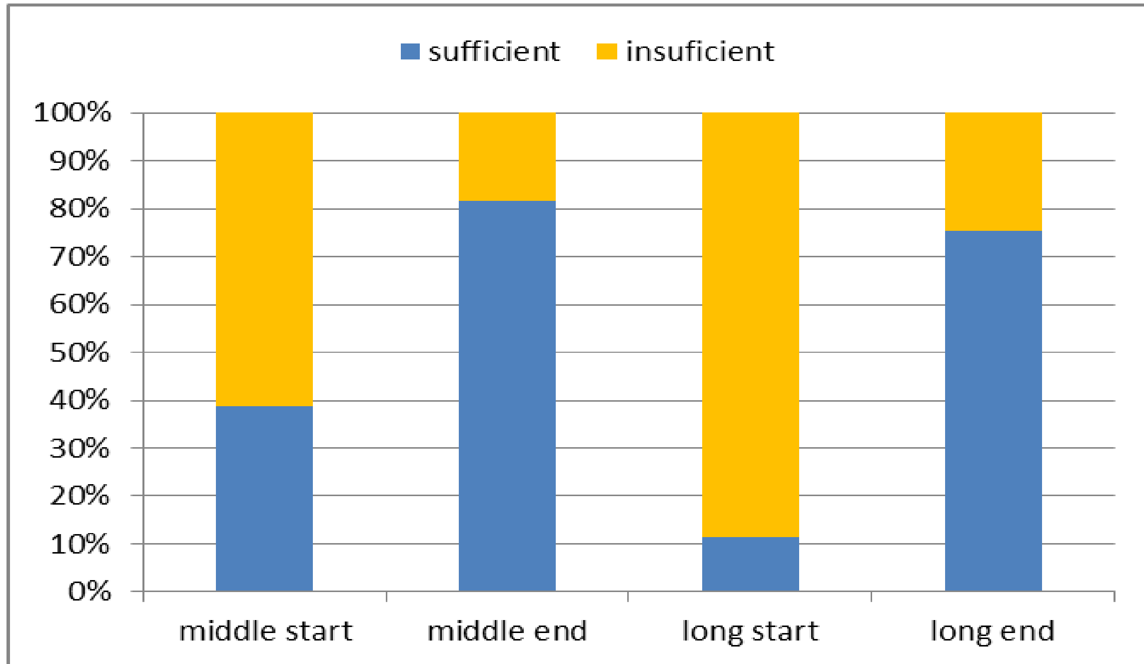


Figure 6: *percentage of residents with sufficient competences at the start and end of the project for residents with medium time (middle) support and residents with long support.*

Overall we can conclude that the support by the neighborhood coaches has resulted in a considerable increase in the competences of the residents.

Although the rise in competence levels can be seen as a valuable outcome in itself, it can also be regarded as a first step towards an improvement of the social situation of the residents. Regarding this situation we have formulated a first sub-question:
3b. To which extent is there a rise of the residents on the participation ladder due to the services provided by the neighborhood coaches?
As has been indicated above, the participation ladder consists of six steps, ranging from isolation (step 1), to paid work (step 6). For 91 residents we have data that allow us to measure their possible change in their position on this ladder.

Table 1: *Increase on ladder by level at start.*

Start level	Mean increase
1	1.73
2	1.26
3	0.56
4	0.00
5	-0.75
6	-0.64
Total	1.00

Table 1 shows the average increase on the participation ladder for residents at different steps at the start of the measurement. For the entire group the increase is exactly 1 step, but it shows that the increase is larger for residents that started at a low level. Residents that started at a high level even show a slight decrease. However, as 6 is the highest level of the scale, for those that started at the top, the only possible change is 'down' (meaning they have lost their paid job).

Table 2: *Percentage residents on steps at start and end.*

step	start	end
1	33%	3%
2	38%	31%
3	10%	27%
4	2%	14%
5	4%	7%
6	12%	18%

Just as with the level of competences it is interesting to indicate the proportion of the residents that reside on the different steps of the participation ladder at the start and the end of the project, for those residents where two or more measurements are available. Table 2 shows at the start a large proportion resided at levels 1 and 2 of the ladder. At the end there are only very few residents that are isolated and we can see that more residents are on higher steps of the ladder.

From these data we can conclude that there has been an improvement of the situation of the residents in terms of their position on the participation ladder.

We can now turn to our final sub-question:
3c. To which extent has the provision of services by the neighborhood coaches resulted in improvement in the residents' situation in the specified social fields?
Regarding the fields of *work* and *participation* we can be brief, as this field is already discussed using the participation ladder. However, from the specific files of residents we can conclude 20 residents have been able to get or maintain a job in situations where they have had support by the coaches. For 53 residents we see specific results in terms of voluntary work or jobs with assistance. The comparative research between the two neighborhoods shows that in 2011 the residents in Velve are more positive about the development of their work situation than the residents in the control neighborhood. However, this difference was also present in 2009, at the start of the project.

In the field of *housing* we find 53 residents with specific results, mainly in the field of home improvement, finding a specific home, or improved relations with their housing corporation. The study on residents that were supported by the coaches also shows clear results in this field. Residents indicate that in many cases they were supported in issues on housing and that the support has resulted in improvements in their situation. These results are only partially supported by the comparative research. Residents in Velve are not more positive about the development of their housing situation than residents from the control area. However, they are more optimistic about the future, which might be related to the fact that many of them will move to new houses in the Velve area as part of the infrastructural redevelopment in the neighborhood.

Regarding the *financial* situation we see clear results in the files of 65 residents. These results are mainly indications of stabilization of the financial situation (preventing the situation to get out of control) and improvement of financial overview. In 14 cases the financial situation has actually improved. The coaches indicate that it usually takes a lot of time for residents with severe debts to actually get rid of these debts. The research on residents that were supported by the coaches

does not show clear result in this field. Many residents indicated that they have been supported, but they see more deterioration in their financial situation than improvement. They do feel very confident about the future, which could be another indication of the fact that it takes a long time to solve financial issues. The comparative research however does provide clear indications that the financial situation of the residents in Velve has improved, whereas the situation in the control neighborhood has deteriorated. Residents in Velve are also more optimistic about their finances in the future.

Concerning the *health* situation we see only a few indications of specific results in the files. For 14 residents we see specific results, mainly in the field of psychological problems. The research on supported residents indicated that there are more situations of deterioration than of improvement of the health situation. However, residents that have received support in this field are more optimistic about the future. These findings are supported by the comparative research. Residents from both neighborhoods perceive a deterioration in their health situation, but this change is stronger in the control neighborhood. This could be an indication for the fact that the support by the coaches might have prevented an even stronger deterioration in the health situation.

In the field of *relations* in the *neighborhood* the files indicate 8 specific results, but it is also clear that only 10 residents had problems in this field, so only a few result could be expected. This field has not been researched in the supported residents survey, but we do have results from the comparative research. Residents from Velve indicate that the situation in their neighborhood has improved in both measurements (2009 and 2011). However, this was also the case in the control neighborhood. With regard to social capital we see a clear improvement in Velve that is not met by the control neighborhood (in that area social capital does not increase over time).

In the field of *education* and *family* relations we find 31 specific results in the files regarding family relations and 12 in the relations of children to their schools. Relations with *professional organizations* improved in 32 cases. In these fields we have no additional data from other sources.

Overall we can conclude that many results have been booked in different social fields. Some of these are supported with different types of data, for others the results of the surveys are mixed. However, this does not indicate that all problems have been solved for all residents. Results from the files show that there is a group of about 20% of the residents where no clear results were realized.

Conclusions

Social services are in many instances provided by professionals in an inter-organizational setting. The model of the social General Practitioner can be regarded as a form of innovation of the governance of the provision of these services. This model has been used in the Velve-Lindenhof Neighborhood in the Dutch city of

Enschede. It is concerned with an ambitious experimental project that aims to improve the life chances of residents. Like medical GP's the neighborhood coaches act as individual counselors to the neighborhood residents. They make service delivery decisions, provide help and support 'in the first line', refer to specialized local service providers 'in the second line' when necessary and take charge of the governance of the network of professionals as a whole. In this paper we have shown that the GP's were able to implement the rather ambitious model to a large extent. They had sufficient expertise and competences to fulfill their central role and they were able to cooperate with professionals from partner organizations. They were also successful in realizing the ambitious objectives regarding their work process. Moreover they produced outputs that were largely in line with the objectives of the model. They achieved real outcomes in terms of improvements in the social competences of the residents. These outcomes where particularly produced for those who really needed them and it was shown that longer support resulted in larger improvements. Finally they succeeded in realizing many improvements in the social situation of the residents, although more results and stronger indications for effectiveness were found in some fields than in others. It was also concluded that the rather positive results do not mean that all problems for all residents are solved. For a group of around 20% of the residents no clear results were booked.

In order to judge the real value of the GP-model it has to be noted that this project consisted of a specific project, in a small neighborhood with additional budgets that enabled to appoint a few carefully selected neighborhood coaches as an additional group of professionals, without reducing the number of specific professionals in partner organizations. It is obvious that such a generous arrangement is not available in regular working conditions. After the success of the GP project the city of Enschede decided to enlarge the working model to cover the entire city, using the basic principles regarding the central role of the neighborhood coach in service provision. However, the coach to resident ratio has increased substantially (more residents per coach) and the number of mandates and the time for inter-organizational consultation has been decreased. Further research will have to show whether the GP-model will also be successful under these conditions.

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