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DEVELOPING SYSTEMICALLY-ORIENTED SECONDARY CARE MENTAL HEALTH SERVICES

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**DEVELOPING SYSTEMICALLY-ORIENTED SECONDARY CARE
MENTAL HEALTH SERVICES**

by

FRANK ROBERT BURBACH

A thesis submitted to Plymouth University
in partial fulfilment for the degree of

**DOCTOR OF PHILOSOPHY
on the Basis of Published Works**

School of Social Science & Social Work
Faculty of Health, Education and Society

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Director of Studies: Prof. Rudi Dallos

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LIST OF PUBLISHED WORKS

1. Burbach, F.R. (1996) Family based interventions in psychosis - an overview of, and comparison between, family therapy and family management approaches. **Journal of Mental Health, 5(2):**111-134.
2. Burbach, F.R. and Stanbridge, R.I. (1998) A family intervention in psychosis service integrating the systemic and family management approaches. **Journal of Family Therapy, 20 (3):** 311-325.
3. Burbach, F.R., Donnelly, M. and Stanbridge, R.I. (2002) Service Development Through Multi-Disciplinary and Multi-Agency Partnerships. **The Mental Health Review, 7 (3):** 27-30.
4. Stanbridge, R.I., Burbach, F.R., Lucas, A. and Carter, K. (2003) A Study of Families' Satisfaction with a Family Interventions in Psychosis Service in Somerset. **Journal of Family Therapy, 25:** 179-202.
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DECLARATION

I hereby declare that I have been a full-time clinical psychologist, employed by the Somerset Partnership NHS Foundation Trust (and its predecessors) since 1988, and a partnership teacher with the University of Plymouth since 1996, and that the study and research on which the published works were based was undertaken in Somerset while in the above roles. At no time during the registration for the degree of Doctor of Philosophy by staff candidature on the basis of published works has the author been registered for any other University award without prior agreement of the Graduate Committee.

My first publication in the field (Burbach, 1996) was a review of the family interventions literature published in the *Journal of Family Therapy*. Although based on earlier work undertaken as part of a Diploma in Marital and Family Therapy, which I completed at Exeter University 1991-1993, the published paper required substantial reworking subsequent to my completion of the part-time Diploma. My final submission (Burbach, 2013) is a book chapter which can be viewed as a theoretical follow-up to my first publication. Although I wrote this in 2009/10, and the book is currently with the publishers, Routledge has decided to publish it early next year.

I gratefully acknowledge the contributions of my colleagues to the subsequent development of the 'Somerset model'. Many of my published works are the result of collaboration with colleagues, particularly Roger Stanbridge, Consultant Family Therapist, with whom I developed the clinical approach and the training methods.

My personal contribution is clear, however. Having initially reviewed the two main family intervention fields and proposed their integration, I adapted and developed our 'cognitive interactional cycles' diagram (which I presented at a family interventions conference in 2000), and I took the lead in the research and audit of our approach. Together Roger and I jointly developed our 'service development through in-situ whole-team training' approach and jointly created and delivered the Family Interventions: Research, Skills, Theory (FIRST) course. As the projects grew I focused on Early Interventions in Psychosis service development and Roger took the lead on increasing the involvement of families and carers in mainstream services. The publications where Roger is first author reflect this (Stanbridge & Burbach 2004, 2007a, 2007b; Stanbridge et al., 2009, 2012), but I was an equal partner in the research involved and the writing of these articles.

The research described in the Bailey, Burbach & Lea (2003) article was designed and supervised by me. The Stanbridge, Burbach, Lucas & Carter research also involved major research design input from me. I played a major role in the successive drafting of both articles.

I also played a major role in the design of the research methods described in Stanbridge et al. 2009 and 2012), and in the writing of these papers.

My role was less central in the research conducted by Jo Allen for her D.Clin.Psych. dissertation (Allen, Burbach & Reibstein, 2012). However, I contributed to the research design, data analysis and preparation of the paper for publication.

This thesis consists of 3 main sections- a Critical Appraisal (8278 words excl. tables), a General Discussion (1995 words excl. tables) and 18 published works.

Frank Robert Burbach

Signed: *Frank R. Burbach*

Date: 17 January 2013

ACKNOWLEDGEMENTS

I would like to thank my family for their support and forbearance while I have been pursuing the work encapsulated in this thesis. I am especially grateful to Sandy for her many years of support and editorial assistance!

I would also like to thank the Somerset Partnership NHS Foundation Trust for providing financial support to enable me to undertake this PhD and for the managerial support to enable the development of family-based services, and Plymouth University for support in developing the first Partnership Course. Many people made important contributions but I'd like to especially thank Diana Rowe, Director of Operations and Deputy Chief Executive, for her astute support over many years.

I would also like to acknowledge the contributions of my clinical colleagues to the development of the 'Somerset model' and to thank them for the many years of stimulating discussion and therapy which we have undertaken together. Many of my published works are the result of collaboration with colleagues, particularly Roger Stanbridge, Consultant Family Therapist, and I feel privileged for our ongoing partnership.

I would also like to acknowledge Harry Procter, whose integration of Personal Construct and Systemic therapies provided the foundations on which we have developed our approach.

Finally, I would like to thank Rudi Dallos for his support and for inspiring me to consider the future theoretical development of the 'cognitive-interactional' approach.

ABSTRACT

DEVELOPING SYSTEMICALLY-ORIENTED SECONDARY CARE MENTAL HEALTH SERVICES

Frank Robert Burbach

Research has indicated that offering support and services for people who experience mental health problems and their families is a complex and contested area. Despite the controversies surrounding therapeutic interventions with families, it has now been recognised that relatives and other supporters of people with mental health problems should be included in their care. Whole- family interventions and partnership working with carers and families is now central to secondary care UK mental health policies and clinical practice guidelines. However, for many families/ carers this remains an aspiration rather than a reality. The way in which we successfully developed family focused mental health practice, as well as specialist family interventions (FI) for people who have been given a diagnosis of psychosis, has therefore aroused considerable interest.

The Somerset Partnership NHS Foundation Trust has adopted a Strategy to Enhance Working Partnerships with Carers and Families, developed best practice guidance and has established two complementary workforce development projects - the development of specialist family intervention services and the widespread training of mental health staff to create a 'triangle of care' with service users and their families. This has resulted in widespread adoption of systemically informed, 'whole-family' practice.

In response to the widespread difficulties experienced following other staff- training initiatives we developed specialist family interventions (FI) services by means of an innovative one-year course delivered in partnership with Plymouth University. This training initiative has been widely acknowledged for its novel integration of psycho-educational and systemic approaches and the effective in-situ, multi-disciplinary service development model. An advantage of this approach is that by the end of the course a local FI Service has been established and staff experience fewer difficulties in applying their new skills than people trained in other programmes. We then ensure the continued development of clinical skills by means of a service structure that emphasises ongoing supervision. Regular audits of the service and in-depth research studies clearly indicate that the service is effective and highly valued by users. Our 'cognitive-interactional' approach, which integrates systemic therapy with psychosocial interventions (individual- and family-CBT) within a collaborative therapeutic relationship, enables us to meet the needs of families in a flexible, tailored manner. The FI teams are able to deliver early interventions for people with first episode psychosis, as well as meeting the NICE guidelines for people with longstanding symptoms.

Recognising that many families do not require formal family interventions/ therapy, we also have been designing 'stepped-care' family intervention services.

We have developed, and extensively evaluated, short training packages to enhance working partnerships with families throughout our mental health services. We have used this three-day package to train a range of community and inpatient teams. We have also encouraged family-inclusive practice with the establishment of a trustwide steering group, practice guidelines and the establishment of 'family liaison' posts to facilitate family meetings on inpatient units, as part of the assessment process.

Both training initiatives explicitly focus on developing systemic thinking, by integrating CBT and systemic therapy. The involvement of families/ carers in the design and delivery of both training initiatives is also crucial.

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CRITICAL APPRAISAL

INTRODUCTION

Recent national policy guidance has emphasised the need to ‘think family’ (Cabinet Office, 2008)¹⁴, to create a ‘triangle of care’ (Worthington and Rooney, 2011)¹⁷ and to develop specialist family interventions (NICE, 2009). Somerset has been recognised as being one of the few areas of the UK to have successfully developed services in line with this policy guidance.

The submitted publications detail the way in which this has been achieved and, in particular, two distinctive contributions: the innovative use of training programmes to create new services and the integration of systemic and cognitive-behavioural approaches.

The submitted published works span 16 years and their contribution to the field has been incremental (see Table 1 for an overview). This appraisal will therefore take the form of a contemporary review of the field, within which my contributions will be situated. The review will cover both of the unique aspects of our work in Somerset but begins with an overview of the needs of families, which has led to the development of these initiatives. It then focuses on the difficulties experienced in translating training into practice before considering theoretical issues and describing how our integration of systemic and psychoeducational approaches has contributed to the field. The review includes personal reflections and a consideration of my role as a Clinical Psychologist.

The General Discussion provides an overview of the services in Somerset and considers the emerging literature regarding the organisation of family intervention services in stepped care models. It describes how the Somerset ideas have influenced early intervention guidelines and considers future theoretical developments.

Throughout this dissertation **bold text** is used to indicate the relevant submitted papers listed on pages 2 & 3.

References used but not cited in the published works are listed in the References section. Other references can be found in the submitted papers indicated in superscript following the reference in the text.

Table 1: PUBLICATIONS: OVERVIEW OF MY CONTRIBUTIONS TO THE FIELD

<u>Paper</u>	<u>Key contributions to the field</u>
Burbach (1996) Journal of Mental Health	Literature review comparing the Systemic/ Family Therapy and Psychoeducational/ CBT/ Family Management approaches and arguing for integration of the field.
Burbach (2013) Gumley, Gillam, Taylor & Schwannauer (Eds)	Chapter in ISPS book series that develops a systemic understanding of the Expressed Emotion literature. The EE research is reviewed, critiqued and represented in 'Cognitive Interactional' diagrams.
Burbach, Donnelly & Stanbridge (2002) The Mental Health Review	Paper proposing a radical new approach to meet the workforce development requirements of the National Service Framework and illustrating the multi-disciplinary and multi-agency partnerships (incl. the first University of Plymouth- NHS partnership course) required to develop the Somerset FI service
Burbach & Stanbridge (2008) Journal of Mental Health Training, Education and Practice	Paper describing the complementary workforce development projects in Somerset - the development of specialist family intervention services and the training of all mental health teams to work in partnership with families.
Burbach & Stanbridge (1998) Journal of Family Therapy	First paper describing the Somerset Family Intervention (FI) service, the development of the service by in-situ whole team accredited training, and the integrated family therapy and management approach.
Burbach & Stanbridge (2006) Journal of Family Therapy	Update on the Somerset FI service summarising research and audit data and developing the 'Cognitive Interactional' approach.
Burbach & Stanbridge (2009) Lobban & Barrowclough (Eds)	Chapter that provides further details about the development of the Somerset FI service, elaborating the clinical approach with particular reference to formulation and supervision.
Bailey, Burbach & Lea (2003) Journal of Mental Health	Research study that found that staff trained in Somerset experience fewer difficulties in applying their new skills than people trained in other programmes. This study was carried out under my close supervision by an undergraduate on placement.
Stanbridge, Burbach, Lucas & Carter (2003) Journal of Family Therapy	In depth user semi-structured interview study that indicated high levels of satisfaction with the Somerset FI service and highlighted the aspects of the approach that were highly valued. This study was conducted by Roger Stanbridge but I was centrally involved in its design, validation of themes elicited, and in the drafting of numerous versions before publication.

<u>Paper</u>	<u>Key contributions to the field</u>
Allen, Burbach & Reibstein (2012)	Qualitative research study (IPA) exploring the experiences of seven Somerset FI service users with psychosis. This study shed further light on aspects of the approach and the contribution of FI to recovery. This study was conducted by Jo Allen but I was involved in its design and contributed to the analysis and preparation of the paper for publication.
Burbach, Carter, Carter & Carter (2007) Velleman, Davis, Smith & Drage (Eds)	Chapter written in collaboration with a family seen in the Somerset FI service. The roles of the Assertive Outreach and FI services are discussed, and the cognitive interactional approach is illustrated.
Burbach, Fadden & Smith (2010) French, Read, Smith, Rayne & Shiers (Eds)	Chapter on family interventions for first episode psychosis written with internationally renowned authors Grainne Fadden and Jo Smith. An important contribution to a key text for Early Interventions in Psychosis, providing guidance regarding FI services. Somerset, Worcester and the West Midlands Meriden Programme are used as examples of effective services.
Burbach, Grinter & Bues (2009) Early Intervention in Psychiatry	Paper describing the development, approach and outcomes of the Somerset Team for Early Psychosis. This paper presents extensive audit data and discusses the emphasis of the service on working with families.
Stanbridge & Burbach (2007) Froggatt, Fadden, Johnson, Leggatt & Shankar (Eds)	Chapter in the World Schizophrenia Society's guide to family interventions focusing on the importance of collaboration with families in service development and the delivery of training, providing examples from our work in Somerset.
Stanbridge & Burbach (2004) The Mental Health Review	Paper which reviews government policy regarding family inclusive mental health services and makes the case for trustwide strategies to achieve this change in routine practice
Stanbridge & Burbach (2007) Journal of Family Therapy	Paper which details the Somerset Partnership Strategy to Enhance Working Partnerships with Families and the associated 3-day team training programme.
Stanbridge, Burbach & Leftwich (2009) Journal of Family Therapy	Paper describing the training of staff in Somerset's 5 adult inpatient wards in family-inclusive practice and the evaluation of this training programme.
Stanbridge, Burbach, Rapsey, Leftwich & Mclver (2012) Journal of Family Therapy	Paper describing the evaluation of the training of staff in Somerset's older peoples wards and the development of the family liaison service. It includes cognitive-interactional cycles illustrating confabulation and elder abuse.

THE NEEDS OF FAMILIES

When someone is seen to have a severe mental health problem such as psychosis there are numerous benefits to working collaboratively with families and other members of the social support network, and numerous rigorous research studies have shown that formal family interventions (FI) result in significantly superior clinical outcomes for people with psychosis (Pharoah et al, 2010).

Family members are crucial to optimal recovery of the person with psychosis, as they are often the ones who initiate and maintain contact with the specialist services, and physically provide the bulk of the care. Medical and psychosocial interventions often require ongoing encouragement, support and reinforcement, and the family is a valuable resource in this regard. When the lives of people with psychosis are chaotic and they are poorly engaged with services, working with family members is sometimes the best way to maintain therapeutic input. In addition, research (e. g. Raune et al, 2004¹⁵) has shown that family members experience a significant amount of stress in caring for someone in the early stages of a psychotic disorder, and that this can develop into unhelpful, critical or over- intrusive behaviours (McFarlane and Cook, 2007¹⁸; Patterson et al, 2000¹⁵, 2005¹⁸; Stirling et al,1993¹⁸) which, in turn, can contribute to subsequent relapse (Butzlaff and Hooley,1998¹⁶). For further information about the extensive research literature examining the family emotional climate associated with relapse, and the associated theoretical debates, see **submitted paper 18**; Keen, 1999; Read, Mosher, Bentall, 2004.

Although caregiving can involve positive aspects, many caregivers find that caregiving is time-consuming and stressful. They often have difficulty in accessing services and are forced to cope with challenging situations and high-risk behaviour without adequate support and guidance. Some caregivers have to deal with numerous crises, sometimes involving contact with the police, ambulance and other services. Many carers find that they cannot continue their previous work and leisure activities and their social networks shrink. The stigma associated with severe mental health problems in many communities often contributes to caregivers becoming socially isolated. Many caregivers also experience a complicated grief reaction as they struggle to come to terms with their

relative's ongoing difficulties, and many experience depression as a result of hopelessness and loss.

Although caregivers commonly experience stress, exhaustion and distress; mental health services have traditionally focused on treating the patient's symptoms. More recently it is encouraging to note increased acknowledgement both of the fact that carers need support in their own right (to support their physical and mental wellbeing) and that family members need to be enabled to provide care, in order to optimise recovery of their relative. Additionally, it is now being recognized that the meeting of carers' needs may require an appreciation of the factors pertaining to their particular situation - an individually tailored approach.

Family caregivers can be parents, partners, siblings or even children; they will have a range of understandings about the situation they find themselves in; they will have a range of resources and coping strategies available to them; and they will have had a range of 'premorbid relationships' with the person experiencing psychosis. There is therefore no simple formula that can be applied to determine the needs of family caregivers. The needs of particular family members will also change over time.

A helpful heuristic may be to consider families' needs in terms of a hierarchy (Pearson, Burbach & Stanbridge, 2007¹⁵), although it must again be emphasised that families' needs will not necessarily be present in discrete categories and will not necessarily develop in a step-wise manner. When first involved with services, families tend to require information (about mental health issues, treatment options, how services work etc.) and the opportunity to talk about their traumatic experiences. This commonly includes a need to discuss their experiences related to the development of psychosis; their difficulties in accessing appropriate help; and feelings of fear, anger, loss and grief. Many will also welcome further help with solving problems (for example about roles, chores or achieving goals) and improving communication (eg. when misattributions result in patterns consisting of criticism and withdrawal), and some will seek more in-depth exploration of issues. (This model is described further on pages 37-38.)

TRAINING INTO PRACTICE

Despite the evidence- base for family interventions and the clear policy and guidelines regarding working in partnership with families, many mental health services have found

it difficult to meet the basic needs of carers and, in particular, to provide specialist family interventions.

In adult mental health services the focus tends to be on the individual, both in terms of how presenting problems are formulated and also the policies and procedures. This can be understood in terms of both the wider culture and the health service context. In the health service setting the relationship between professionals, especially doctors, and people using services ('patients') is predicated on the individual's right to confidentiality. The default position, therefore, is to provide assessment and treatment for the 'autonomous' adult and to have a strong boundary around this professional relationship. It is not surprising that in this context many people would find it challenging to also acknowledge the rights of family members and to involve relatives as equally important members of this professional relationship.

Furthermore, it is still the case that, in spite of evidence and policy supporting family work, most mental health professionals do not develop skills in working with families as part of their basic training (Stacey and Rayner, 2008¹⁷; Fadden, 2006¹⁵). It is also interesting to note that many of the mental health professionals who subsequently undertake training in working with families find it difficult to work with families in practice. The main reasons given for this are related to the unsupportive service context - including lack of management support, lack of supervision, and difficulty in prioritising family work due to workload demands - but many newly trained FI practitioners also report feeling ill-equipped to meet the range of needs presented by families (Brooker, 2001; Dixon et al, 2001; Fadden, 1997; Kavanagh et al, 1993)¹³.

We were fortunate that we were able to develop our Family Intervention for Psychosis Service in a context where systemic family therapy was relatively well established in the adult mental health services (eg. Procter & Pieczora, 1992²; see **submitted papers 2 & 13**). The novel method by which we created clinical teams (**submitted papers 3, 13**) was partly based on our positive experiences of traditional family therapy services, as well as a realisation that in order to be able to offer evidence-based FI we needed to develop new training methods and service structures to overcome the low rates of skills-generalisation identified following completion of other training courses (e.g. Brennan & Gamble, 1997; Fadden, 1997; Kavanagh et al, 1993)¹¹. Our approach to training - a longer training in generic systemic therapy skills as well as cognitive/ behavioural / psychoeducational skills - has enabled staff trained in Somerset to feel more equipped

to respond to the diverse needs expressed by families where one person experiences psychosis (**submitted paper 5**). This was recognised in a National Institute for Mental Health in England (NIMHE) review (Brooker & Brabban, 2005)¹¹:

“A team training approach to family intervention has been introduced in Somerset. Eighteen practitioners from the Family Support Service attended a one-year training programme that taught an integrated cognitive-systemic approach to family interventions. Bailey *et al* (2003) evaluated trainees’ implementation of family work up to three years post training. A mean of 3.5 families had been seen per trainee in an average of 26 months since completing training. However, unlike other studies that have examined implementation of family interventions, 80% of the trainees in the Somerset study rated the overall level of difficulty in implementing family interventions as ‘not at all or a little difficult’” (see table 2). “Bailey *et al* concluded that a number of factors appeared to facilitate the implementation of family interventions in their service; in particular, the flexible nature of the family service, the multi-disciplinary nature of the teams and the use of co-working and supervision. They also believed that the provision of an effective service was linked with having a critical mass of staff trained in family interventions. Nevertheless, when problems were encountered, there was consistency between this study and the others in reporting primary barriers to implementation” (see table 3).

Brooker & Brabban, 2005: 28

Table 2: Overall level of difficulty reported implementing family interventions in five Studies

Study	Difficulty Rating		
	Not at all or a little difficult	Moderately or Very difficult	Extremely Difficult or impossible
Buckingham, UK (Fadden (1997))	44%	45%	11%
Manchester, UK (Baguley <i>et al.</i> , 2002)	20%	55%	35%
Somerset, UK (Bailey <i>et al.</i> , 2003)	80%	20%	0%
Sydney, Australia (Kavanagh <i>et al.</i> , 1993)	31%	48%	22%
West Midlands, UK (Campbell, 1999)	36%	50%	14%

Brooker & Brabban, 2005: 28

Table 3: Rating and ranking of difficulty experienced in implementing family intervention
 Brooker & Brabban, 2005: 27

Study	Mean Rating (and Ranking out of 31 items) in each area of difficulty implementing family intervention ¹		
	Allowance of Time from service to do intervention	Integration with Caseload or other responsibilities at work	Availability of appropriate families
Buckingham, UK (Fadden, 1997)	1.56 (4)	1.76 (2)	2.18 (1)
Manchester, UK (Baguley <i>et al.</i> , 2002)	3.05 (1)	2.95 (2)	Not available (Reported as a difficulty by 20% of sample)
Somerset, UK (Bailey, <i>et al.</i> , 2003)	1.6 (1)	1.53 (2)	1.20 (8)
Sydney, Australia (Kavanagh <i>et al.</i> , 1993)	2.3 (2)	2.4 (1)	1.9 (3)
West Midlands, UK (Campbell, 1999)	2.10 (2)	2.43 (1)	1.92 (3)

¹ Amount of difficulty was rated on a scale from 0 (no difficulty) to 4 (extreme difficulty)

Our research study (**submitted paper 5**), which was conducted in 2000, also demonstrated that our 'graduates' worked with more families post training despite the fact that, unlike the comparison studies, time constraints prevented us from following them up for similar periods post- training. These findings have been confirmed in subsequent audits.

In addition to our novel integration of systemic and behavioural approaches, our training approach has a number of other features which have led to its success: a whole team training approach, integrating service development as part of the training, a careful consideration of service contexts and the need to develop partnerships, involvement of families in the training, and a focus on supervision following the course (**submitted papers 2, 3, 8, 10, 11, 13**). It is interesting that our training course was the first course to be developed by a mental health trust and delivered in partnership with Plymouth University (**submitted paper 3**).

Our success in training staff in Somerset has contributed to an emerging consensus about the key factors which are required to develop sustainable family interventions

services and ways to facilitate practice following training (cf. Brooker & Brabban, 2005¹¹; Froggatt et al., 2007 and see submitted paper 15 and Table 4).

Table 4: Recommendations to develop sustainable Family Interventions services

- Ensure support for the programme of training and service development at all levels of the organisation, including the highest level of management and lead professionals
- Agree a service development strategy to ensure an appropriate service context and the availability of sufficient resources to enable practice post training (protected time; smaller caseloads; practical support for clinicians)
- Establish robust supervision structures to ensure post-training expert clinical supervision is available
- Use a team training approach or ensure that there is a local 'critical mass' of trained practitioners who can support one another
- Involve families/carers in the training programme and in the design and governance of the service
- Appoint local service leads/champions who are responsible for the development and maintenance of the service
- Use audit and ongoing update training to maintain quality once the service is established
- Ensure that the service remains valued by managers and commissioners through the provision of reports, testimonials, publications etc.

Burbach, 2012:11

THEORETICAL DEBATES REGARDING MODELS OF FAMILY INTERVENTION

The original Family Intervention studies (Leff et al, 1982, 1985, 1989, 1990; Falloon et al, 1982, 1985; Anderson et al, 1986)¹ were based on earlier research into the family emotional atmosphere and relapse conducted by George Brown and colleagues (1962,1972)¹. The predictive validity of the rating scales they developed- the Expressed Emotion (EE) index- has been confirmed by numerous studies, with few negative results. Following their meta-analysis of 26 studies, Butzlaff & Hooley (1998)¹⁶ concluded that EE was now established as a robust predictor of schizophrenic relapse (High-EE relapse rate = 65%; Low-EE = 35%) and other studies have confirmed that EE is significantly associated with relapse in a range of other health and mental health problems (see Wearden et al, 2000)¹⁸.

Although the EE research has contributed to the widespread recognition of the benefits of working with relatives of people with psychosis, the focus of the research effort on relapse has had some unfortunate effects. The consequent schism between psychoeducational and systemic therapy; lack of consideration of functional, holistic

outcomes; insufficient focus on family member outcomes; and the perception that causation is linear rather than circular, are discussed below:

1. A distancing of the new psychoeducational behavioural family approaches from systemic family therapy.

The early systemic and family therapy researcher-clinicians' focus on communication patterns associated with the onset of psychosis (e.g. Bateson, Lidz, Wynne, Bowen)¹ resulted in a backlash by carers organisations who felt that these family therapists were blaming them for having caused psychosis (see **submitted paper 1**; Bertrando, 2006). As a result the next generation of clinicians sought to distance themselves from this earlier work and most family therapists turned their attention to other presenting problems - as William McFarlane (1983:1) put it: "Family therapy ... abandoned its mother".

The new generation of clinicians developed family interventions based on the original EE research- they developed methods to reduce unhelpful responses to the person with psychosis in order to reduce relapse. They expressly accepted that psychosis was an illness and attempted to provide information and guidance to reduce stress levels. The term 'psycho-education' was adopted to further emphasise the difference between the new approaches and family therapy (Anderson, 1983)¹. Although contemporary family therapy, with its focus on social constructionism and collaborative practice, has moved a long way from the early systemic therapists (Dallos and Draper, 2005), most psycho-educational practitioners have continued to view systemic approaches with suspicion. Having recognised that the family therapy and family management approaches both had merit (Burbach, 1995)^{2,13} I published a review of the field (**submitted paper 1**) in an attempt to overcome the lack of understanding between the two camps. This work has been recognised in the review by Simpson and Benn (2007)¹³:

"Sadly, there was often little engagement and some tension between advocates of behavioural psychoeducational and systemic family therapy interventions (Johnstone 1993, Leff and Vaughan 1994, Keen 2003). However, Frank Burbach, a clinical psychologist from Somerset where systems-theory based family therapy with schizophrenic families has been developed since 1980, attempted to begin a process of bridge-building in an excellent review of the issues (Burbach 1996). Bertrando (2006) suggests that we are probably now in a new, 'integrative' stage of family interventions, with the different approaches to family dynamics being 'bridged and blended', in order to give more effective help to all members of families with schizophrenia,

as reflected in recent papers by the likes of Fadden (2006), Burbach and Stanbridge (2006).” (page 30)

2. More holistic, functional outcomes have largely been ignored.

Most family intervention outcome studies have focused solely on psychosis relapse rates, and very few have examined the potential benefits in terms of other symptoms (e.g. anxiety, depression) or functional outcomes such as occupation, social networks or quality of life. An extensive consultation with UK Carers' bodies, managers and practitioners (Arksey, 2002) revealed a more rounded and holistic view of outcomes, in contrast to the narrow approach of effectiveness adopted in most studies of carers of people with mental health problems.

Systemic approaches have broader aims than the development of coping skills which is the main focus of most psychoeducational approaches. For example, the Open Dialogue (OD) family and network approach developed in Finnish Western Lapland (Seikkula et al., 2001) appears to demonstrate the additional benefits of continuity of care and the active mobilization of the wider support network (eg. employers and fellow employees). This community-based crisis intervention approach puts the family and social network at the centre of the treatment, with the team aiming to establish contact within 24 hours of a crisis and subsequently involving them in all treatment discussions and decisions. The same team takes responsibility for the entire treatment process, whether the patient is in hospital or the community, and aims to follow the themes and ways of speaking of the family members in order to create a dialogue that increases their sense of agency. In a descriptive research study (Seikkula et al., 2006¹⁵) the OD approach appears to result in better functional outcomes for people with first episode psychosis than those achieved by other approaches. Although the 5-year relapse rates did not differ significantly between the comparison approaches, the evidence appears to show that the OD group recovered more quickly, had fewer days in hospital, was more likely to have returned to education or employment and had used less antipsychotic medication. Although the OD approach differs in its philosophical basis to psychoeducational approaches, the superior outcomes may be due to the quality of the family-based intervention- a highly skilled treatment team is able to respond flexibly and creatively to the needs of the family, uses medication sparingly in a carefully targeted way, focuses on functional outcomes, and brokers acceptance in the wider social network. Although it may be unattainable in many current service settings, the comprehensive service provided in this area of Finland illustrates the principles that an optimum service might aspire to. It

also highlights the importance of focusing on recovery (building a life beyond illness), including self-sufficiency and participation in social, educational and employment activities (British Psychological Society, 2008; Royal College of Psychiatrists, 2009).

3. Insufficient focus on the needs of family members and insufficient evaluation of the outcomes of FI for relatives.

As the purpose of psycho-educational family interventions is to reduce relapse rates for people with psychosis, they do not focus directly on addressing family members' needs. As Simpson and Benn (2007: 43)¹³ point out: "Whilst it is intended that these interventions will benefit family members and relieve some of the stress and help family members develop new coping skills, they are not intended to provide direct support to carers". This means that the carers' emotional, psychological and practical support needs are often overlooked (Walker and Dewer, 2001¹⁷; Bee et al 2005). Rose et al. (2004) identified a number of concerns regarding the focus on client outcomes:

"Where family care programs exist, they are seriously hampered by a lack of attention to family outcomes. For example, few programs exist to address the need for family roles in care continuity. Moreover, families' needs related to stress management and quality of life have not been systematically addressed in these programs. Lack of understanding of ethnic minority and low income families' needs is a particular concern and lack of attention to personal and historical relationships within families is a serious gap in family centred care" (p40).

As a result of these concerns, writers such as Hatfield (1997), Simpson (1999) and Kuipers (2010) have called for staff to work collaboratively with carers, to respect their unique perspectives and to offer support tailored to the carer's individual needs. This has been the focus of our work in Somerset - to create collaborative partnerships with families and carers as part of routine care **(submitted papers 11, 6, 9, 10)**.

4. A widespread, over-simplified perception of expressed emotion (EE) as a negative, unidirectional concept.

One of the originators of the field, Julian Leff (1989)¹⁸, has acknowledged that it was "unfortunate that the general term Expressed Emotion was applied to (the) index" (p135) as it has led to assumptions that any emotional expression by a relative is harmful to the person with psychosis. Leff goes on to review the psycho-physiological evidence that Low-EE relatives may be "providing active emotional support which enables the patients

to habituate to an arousing situation” (p135), which recognises that relationships are more nuanced.

In their development of the EE index Brown and colleagues included the Criticism, Hostility and Over-Involvement scales (but excluded the Warmth scale) for pragmatic reasons. It is interesting to speculate what might have occurred if the ‘Warmth’ scale had not been excluded from the EE index, or other positive scales such as ‘compassion’ or ‘tolerance’ had been included. Perhaps the research effort would have had an equal emphasis on resilience or recovery and the field would not now be dominated by studies of relatives’ attitudes negatively impacting on the person with psychosis.

Many clinicians’ understanding of the field is also limited to the original research findings, which were disseminated through the training programmes designed to implement these approaches in mental health services (Thorn, COPE, Meriden). Most psychoeducational family workers are unaware of the more recent research studies concerning EE. The most important developments in this research field involve the exploration of appraisals (Barrowclough & Hooley, 2003¹⁸; Scazufca & Kuipers, 1996), coping styles (Birchwood & Cochrane, 1990¹⁸; Magliano et al, 1998, 2000; Scazufca & Kuipers, 1999; Kuipers et al, 2006) and the interactional nature of the unhelpful emotions and behaviours identified by the unidirectional EE index (Lobban et al, 2006; Miklowitz et al., 1989; Rosenfarb et al., 1995; Strachan et al., 1989)¹⁸. It is interesting that EE is increasingly recognised as reflecting interactions between the person with psychosis and their relative/care-giver, but relatively little use has been made of systemic theory to guide research in this area.

However, some therapists have overcome problems inherent in the earlier linear psycho-educational approaches by integrating systemic family therapy and psycho-educational family management (Burbach & Stanbridge, 1998; 2006 (**submitted papers 2, 7**); Meddings et al, 2010¹⁸; Wright et al, 2004), and have made particular use of techniques such as Circular Questioning (therapeutic questions which reveal relationships between members of a family). Many contemporary systemic therapists also adopt constructivist or social constructionist approaches, exploring how people use language in a way that shapes and defines appraisals. There is a particular interest in the way in which family members both construe one another, and behave in a way that is coherent with that construction; and how the actions of each validate or invalidate the other’s construction of their relationship. These elegant approaches are therapeutically

useful and compatible with the emerging literature on appraisals, interactions and family emotional atmosphere.

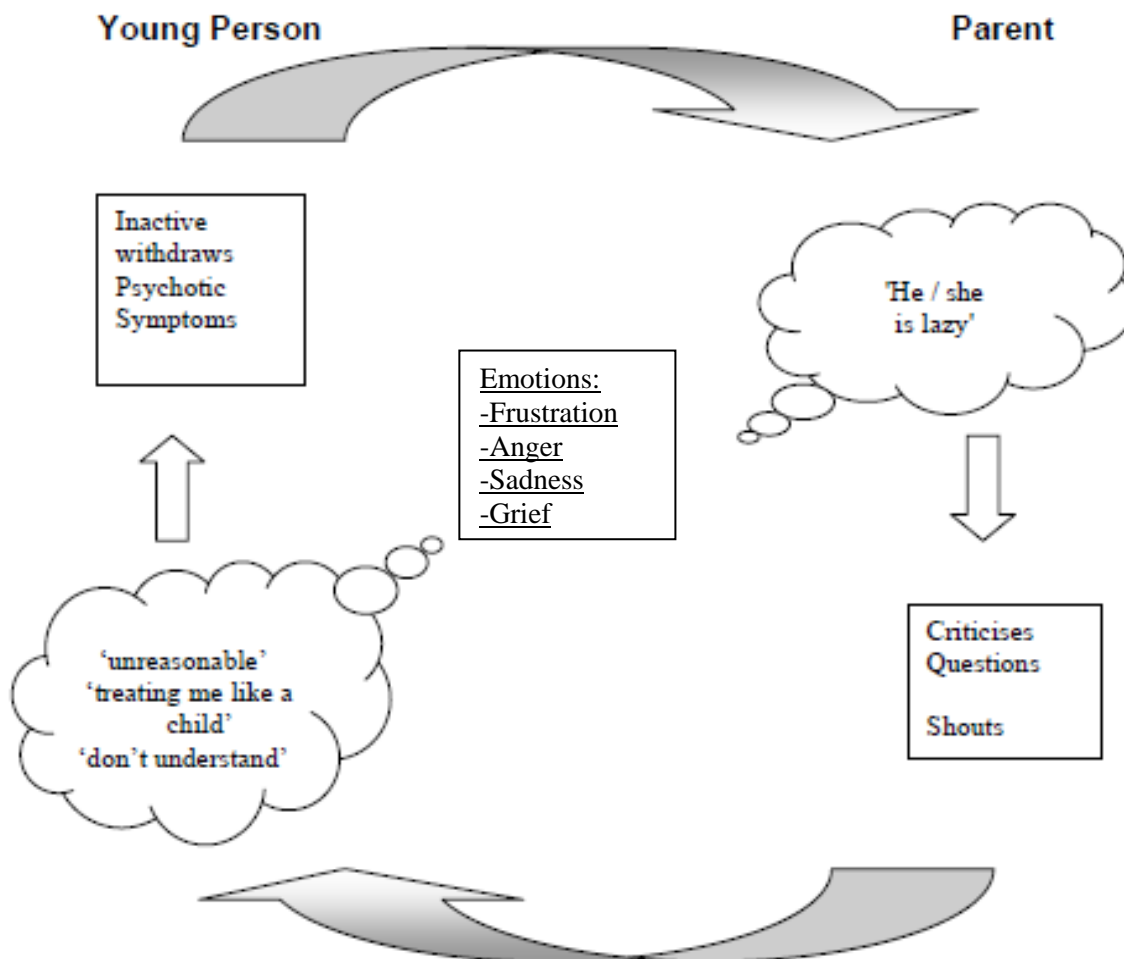
Although their classic cognitive-behavioural family interventions text (Barrowclough and Tarrier, 1997)¹ has not been updated, Barrowclough and Lobban (2009)¹⁸ presented a format for the formulation of problem behaviours in the context of family interactions, reflecting the more recent research on appraisals and interactions. They describe their approach as a 'basic family CBT model' of 'linked vicious circles' with behaviours of one person triggering thoughts/beliefs, feelings and behaviours of another. Their joint formulation diagram mirrors the earlier work of Harry Procter (1985, 1987)¹⁸ who integrated George Kelly's personal construct therapy and systemic therapy. His bow-tie diagram and interview format link "the individual processes of meaning making to the delicate social ecology of intimate personal relationships that sustain them" and is "particularly useful as a means of clarifying complex interactive sequences in conflicted couples and families, and in suggesting a road map for intervention" (Neimeyer, 2009: 41)¹⁸. Our integration of systemic and cognitive behavioural models, the 'cognitive - interactive approach', which was developed for clinical use in the Family Interventions Service in Somerset is a way of conceptualising similar ideas. (See also Dallos, 1991⁷ and Eron & Lund, 1996⁷ who also present similar models).

THE SOMERSET 'COGNITIVE – INTERACTIONAL' APPROACH

The Somerset 'cognitive – interactional approach' has been a significant contribution to the field of family interventions in psychosis (**submitted papers 7, 8, 17,18**). Prior to our presentation of this model at the Family Work for Psychosis conference organised by the Meriden BFT programme (Burbach, 2000)⁷ the vast majority of practitioners were behavioural or cognitive-behavioural in orientation, perceived their role in the rather narrow terms of preventing relapse via education and skills training, and believed systemic approaches to be inappropriate for work with families with psychosis. The model was presented at the conference in terms of the inter-connection between two CBT formulations. This straight-forward model led to increased understanding and use of systemic ideas in clinical practice.

We use 'cognitive-interactional' diagrams clinically with families to explore unhelpful patterns of interaction, thereby enabling reconsideration of attributions and desired behavioural change (**submitted paper 7**). The example in Fig. 1 illustrates a complementary pattern of interaction which is likely to become increasingly entrenched over time: The more frustrated, critical or intrusive the parent becomes, the more the young person feels overwhelmed and hopeless, and consequently does less and withdraws. Sustained or increasing inactivity and withdrawal strengthens the parents' belief that their child is lazy and results in increased attempts to control their behaviour through criticism or intrusiveness. In Fig. 1 the increasing emotional temperature is indicated by the word 'shouts' and in using it for teaching purposes we emphasise the increasingly polarised, entrenched views. However, we now feel that feelings are not sufficiently acknowledged in our diagram and more recently we have added in a central 'emotions box'.

Figure 1. A cognitive interactional diagram of a pursuit – withdrawal cycle.



Of course, other psychological models can be used to describe such patterns of behaviour:

In behavioural terms, these processes can be described as intermittent reinforcement of the parents' behaviour (e.g. the young person sometimes complies with demands) and negative reinforcement of the young adult's behaviour (e.g. withdrawal reduces exposure to parental criticism).

In systemic terms, the family members could be described as being caught up in a pursuit – withdrawal cycle which is fuelled by escalating emotions and attachment dilemmas (e.g. Young adults' need to be independent whilst simultaneously requiring parental support and nurturance).

In Personal Construct Theory terms the parents can be said to be locked into 'lazy vs. ill' construing, while the young person reverts to an 'I can't help it, I am ill' position ('ill vs. well' construing).

In 2009 I was invited to contribute a chapter to an ISPS (international Society for the Psychological treatments of Schizophrenia and other Psychoses) book on Psychosis and Emotion (**submitted paper 18**) in which I presented a systemic understanding of the Expressed Emotion literature. In this chapter I highlighted the research by the UCLA (University of California, Los Angeles) group which found that High-EE (critical) relatives tend to become locked into chains of negative interactions with their offspring with schizophrenia (Hahlweg et al, 1989)¹⁸. They found that High-EE-critical families became locked either into symmetrical critical interactions or complementary interactions (Miklowitz et al., 1989)¹. It may be hypothesised that both parties become locked into this pattern due to escalating emotions. Such high states of arousal would have an adverse effect on cognitive processes such as reflection and problem solving. Dallos (2003; 2012, personal communication) has pointed out that systemic theory is a descriptive rather than causal theory, and has few developmental models. Because it does not have a psychological theory of human motivation and cannot explain why the escalating interactions occur, further theorising regarding attachment narratives and emotional processes in families may be useful (see Discussion).

In the Somerset approach our theorising originally had a cognitive and behavioural focus although we have always emphasised the therapeutic relationship (Rogerian qualities of empathy, genuineness and acceptance), the development of 'shared understandings' (collaborative formulations- see **submitted paper 13**), as well as a collaborative, gently

facilitative stance (This is discussed further on page 24/25 and see Table 6). In addition, we explicitly designed our service to provide a 'secure base' (Byng-Hall, 1995) as we were concerned about the fragmented and short term nature of many aspects of the mental health services. We do not restrict the number of sessions, reflect on the therapeutic process and renew the therapeutic contract on a session-by-session basis (at the end of each session we evaluate its usefulness, agree whether another is required and decide what to focus on and the type of conversation/ technique to use), invite families to contact us directly after our sessions have finished if required, and called our service the 'Family Support Service' (**submitted paper 2**).

In the ISPS chapter (**submitted paper 18**) I represented the UCLA research findings as 'Cognitive Interactional' cycles which explicitly included 'affect' as well as 'appraisal/beliefs' and 'behaviour'. This is the first time I have presented the interactional cycles in this format but the importance of emotion has been alluded to since 2003/4. For example, our Family Inclusive Practice (3-day) training package includes an example where a parent visiting a ward becomes increasingly angry while a staff member becomes more guarded and distant (**submitted paper 9**).

The interactional cycles illustrating the EE research are reproduced below. Figure 2 illustrates the complementary pattern, in which the young person with schizophrenia is self-denigrating and appears to have internalised the criticism. Figure 3 illustrates a symmetrical pattern of mutual criticism. These examples are of simple dyadic relationships, however, young people who have been given a diagnosis of psychosis commonly receive different messages because various family members perceive them differently, e.g. Figure 4. (For further details see **submitted paper 18**.)

In other approaches such as Attachment Narrative Therapy (ANT, Dallos, 2006; Dallos & Vetere, 2009) it is cogently argued that emotional processes and attachment seeking is the engine that drives family life and interactions. See also Diamond and Doane (1994). This is an aspect of our theorising and therapeutic practice that will receive more attention in future (see Discussion for details of Estelle Rapsey's recent research including a focus on attachment issues).

Figure 2. A cognitive – interactional diagram of a complementary transactional pattern.

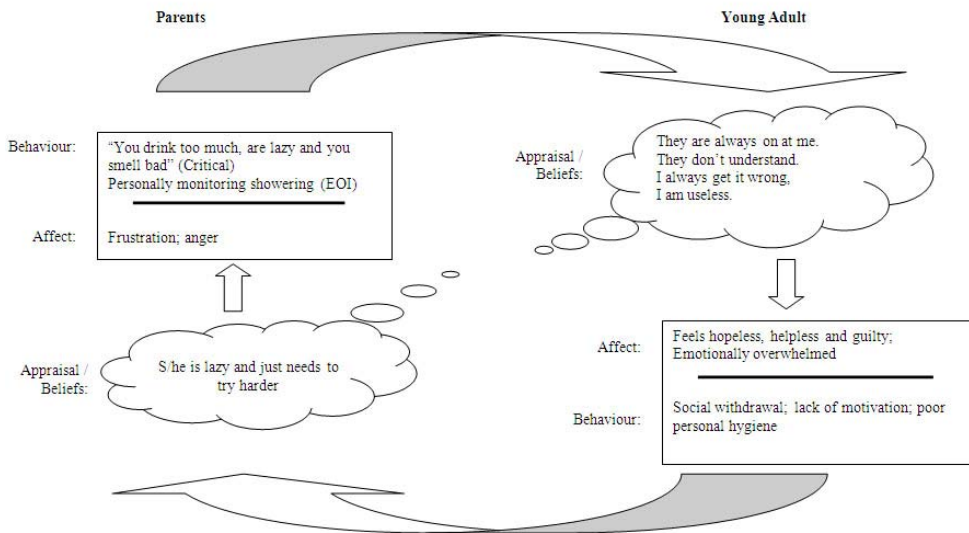


Figure 3. A cognitive – interactional diagram of symmetrical counter – criticism.

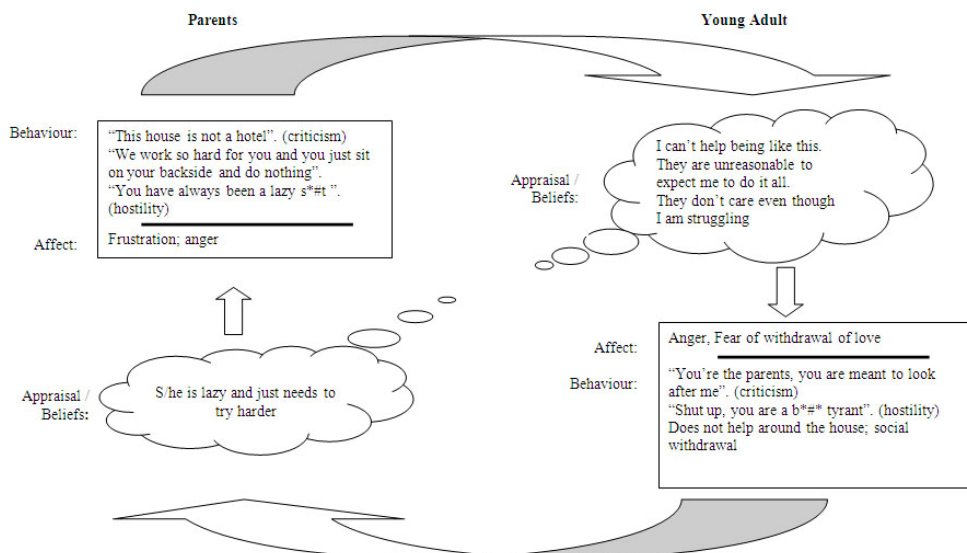
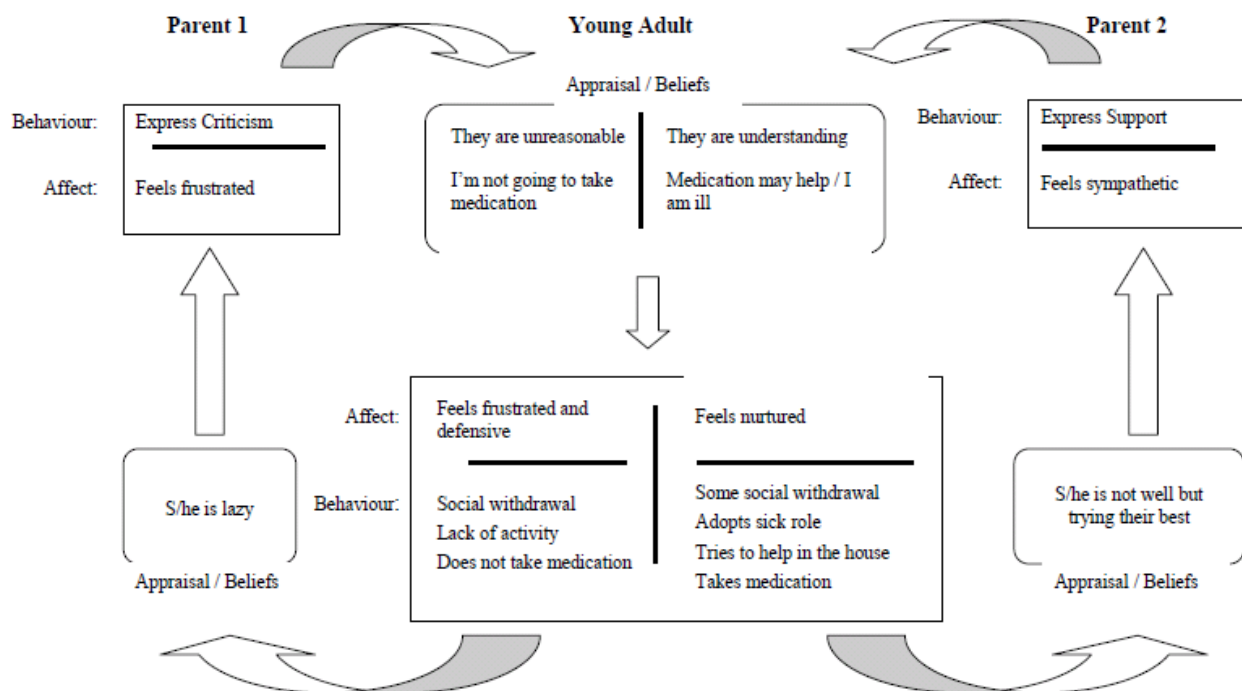


Figure 4. A Cognitive interactional diagram illustrating mixed messages and resultant confusion.



REFLECTIONS

Working therapeutically with families where a member has been given a diagnosis of psychosis could be seen to be inherently complex and controversial for ideological, political and practical reasons and it is interesting to reflect on the challenges involved in developing family services that integrate CBT and systemic approaches.

Despite being a BABCP accredited Cognitive Behavioural Psychotherapist it has been particularly difficult to propose systemic ideas in the field of FI for psychosis. The fact that my colleague, Roger Stanbridge, and I are qualified Systemic Psychotherapists may have contributed to the suspicion we have aroused in particular academic circles but the key objection appears to have been to the successful job we were doing to 'rehabilitate' systemic ideas/ family therapy in the field of psychosis. Although we have been welcomed by some (e.g. Gráinne Fadden's Meriden Programme), there have been times when senior researchers/ clinicians have advised against inviting us to present at conferences and I know of one occasion when staff members were not allowed to attend a workshop I was presenting "because the approach is not evidence-based". Richard Bentall (2003:484) refers to a similar incident in his book 'Madness Explained':

“When I recently gave a talk about my research on paranoid patients’ perceptions of their parents, a much respected psychologist – ironically, a researcher who studies expressed emotion – became very heated and said that she thought my ideas were ‘dangerous’. Indeed, the suggestion that environmental influences could be important has been so effectively censored over the last few decades that these kinds of effects were scarcely mentioned in most textbooks of psychiatry or clinical psychology.”

Keen’s (1999) balanced review of the dominant discourses about schizophrenia (‘the orthodoxy’) and the alternative ideas and practices (‘the heresies’) also describes how the latter “receive reactions ranging from short shrift to contempt” (p422). He calls for “open minded research” (p421) and recognition of the evidence for successful systemic FI approaches, specifically referencing its long tradition in Somerset:

“Systemic approaches to schizophrenic families have been routinely and effectively applied in community mental health centres in the UK since 1980 (Proctor & Stevens 1984; Proctor & Pieczora 1993). Neutral enquirers can at least offset any unintentional academic or clinical cleansing by reading Carr’s (Carr 1991) review of empirical studies of systemic therapy and Burbach’s (Burbach 1996) attempt to begin a rapprochement between systemic therapy and family management.” (Keen, 1999: 421)

As discussed in **submitted paper 1**, the issue of ‘blame’ is one that separates the family management and family therapy approaches. Lucy Johnstone (1993), cogently argues that “the whole issue of blame is an area of enormous contradiction and confusion in the Family Management literature” (p260), which she links to a need to bolster the biomedical model:

“...a powerful hidden ideology underpins and shapes this body of research and practice, i.e. the need to maintain the status of “schizophrenia” as an illness and hence to support the basic *raison d’etre* of psychiatrists.” (Johnstone, 1993: 266)

This issue has recently come to the fore again with the work of John Read and colleagues (eg. Read et al., 2005) and the increasing research evidence that child abuse is a causal factor for psychosis. In their 2004 book they consider the psychological, social and biological approaches to psychosis and discuss the ideological, political and economic barriers to the social causes of psychosis being adequately addressed by researchers, clinicians and policy makers (Read, Mosher & Bentall, 2004). They also cogently argue that families should not be forced to accept either ‘a simplistic illness-blaming model that says it’s *not at all* their fault, or an equally simplistic family-blaming

model that says it's *all* their fault' (Read, Seymour & Mosher, 2004: 264, italics in the original).

However, these issues may not only apply with regard to psychosis. Stratton (2003; Bowen et al., 2002, 2005) has argued that an avoidance of issues of causality is common amongst all family therapists:

“Families want to know why they have come to treat each other as they do and they want an informed opinion about the causal theories by which they apportion blame. Yet our theories appear to be moving progressively to avoid confronting issues of causality.” (Stratton, 2003:137)

Nonetheless, it appears that issues of responsibility and blame are particularly acute when the family has to deal with someone who has psychosis. Most people intuitively grasp that trauma and family dynamics may contribute to the development of 'madness' (Furnham & Bower, 1992; Holzinger et al., 2003; Read & Haslam, 2004; Wahl, 1987) and clinicians are aware that this is a sensitive area. Indeed, there is some evidence that parents who maltreat children tend to attribute their children's behaviour to dispositional and stable causes (i.e. they locate the problem in the child- Corcoran & Ivery, 2004). Because these parents tend to see their children (and not themselves) as responsible for their problems they often drop out of therapy (Morrissey-Kane & Prinz, 1999). In an attempt to sidestep these issues and engage families that might be sensitive to implications of blame, psychoeducational models emphasise illness and focus on helping families to learn skills to manage the condition. Unfortunately these issues are not that simply resolved, family management approaches and the Expressed Emotion literature is still often perceived as blaming:

“Families who have long protested the idea that they are pathological agents in the cause of mental illness are now faced with the notion that they are the pathological agents in maintaining it. Is it surprising that they object?” (Hatfield, 1987: 341).

Any involvement of family members in treatment as well as the evidence that this improves outcomes can be perceived as an implication of causation and can induce/exacerbate feelings of guilt and blame. In common with other systemic therapists we would argue that this is an expected reaction and needs to be addressed directly.

Bertrando et al. (2006) makes a similar point:

“...psycho-educational interventions stresses the biological determinants of illness and the need for the patient to ‘be a patient’, whereas systemic intervention attempts to relocate symptoms in a network of relationships and to reinstate them in the family’s story and development. In both cases, however, family members’ emotions can be given a name and a meaning, and so be modified or reduced.” (Bertrando et al 2006:98)

We would agree with Coulter & Rapley (2011) that issues of involvement, responsibility and blame can be distinguished and that we can view “*parental involvement* in the genesis of madness in a way that recognizes that ‘being in some way responsible for’ an outcome does not, inevitably and necessarily, imply the *intent* to cause it (and hence attract the moral opprobrium that is ‘blame’).” (p172)

The Somerset approach: How we have negotiated the contested territory of responsibility and blame

Although most family interventions clinicians have adopted a psychoeducational approach that emphasises illness, in Somerset we have been concerned about the possibility that this might increase stigma and reduce hope, and therefore negatively affect outcome. Our position is supported by research (e.g. Read & Harre 2001; Walker & Read, 2002; Read et al., 2006) indicating that medical/ illness explanations do not increase public acceptance of people with severe mental health problems. Somewhat surprisingly this had already been recognised in a review published 30 years ago:

“The notion that psychological problems are similar to physical ailments creates the image of some phenomenon over which afflicted individuals have no control and thereby renders their behavior apparently unpredictable.” (Hill & Bale, 1981:290)

It is interesting that a review of the literature in an edition of the British Journal of Psychiatry linked to a Royal College of Psychiatrists’ anti-stigma campaign (‘Changing Minds: Every Family in the Land’) also recognised the possibility that “propagation of the medical model will perpetuate stigma: information on genes and ‘chemical imbalances’ implies that those with mental illness have no control over or responsibility for their actions” (Byrne 2001:284).

These issues are not pertinent solely on a societal level; presenting a psychosocial, social learning orientation to clients leads to greater efforts to change than presenting a disease explanation (Fisher & Farina, 1979). Similarly, another study found that “patients who accepted their diagnosis reported a lower perceived control over illness,” and that

depression in psychotic patients was “linked to patients’ perception of controllability of their illness and absorption of cultural stereotypes of mental illness” (Birchwood et al., 1993: 387).

Although one could argue that psychoeducation with a particular family allows one to tailor the information to reduce unhelpful attitudes, and there are many anecdotal reports of people’s relief on finally receiving a psychiatric diagnosis, the potentially harmful effects of stereotypes associated with biomedical explanations of psychosis need to be considered in a more nuanced way by all who work in the FI field. These issues are usefully summarised by Phelan (2002), see Table 5.

Table 5: Effects of Attributing mental health difficulties to genetics (based on Phelan, 2002)

In our work with families we expect, and normalise, family members’ search for

<u>Positive effects</u>	<u>Negative effects</u>
<p><u>Perceptions of causal responsibility are reduced:</u></p> <p>Less likely to think that ‘bad parenting’ is to blame</p> <p>Less likely to think that the person did anything to cause the problem/ attribute mental health problems to ‘weak character’/ ‘amorality’</p> <p>More likely to express pity or sympathy and to exhibit more positive behaviours towards the person</p>	<p><u>Optimism for full and permanent recovery is reduced:</u></p> <p>Parents are more likely to view their offspring as biologically and genetically ‘defective’</p> <p>Possibility of blame for passing on ‘bad genes’</p> <p>Less likely to believe that the person can improve with appropriate help</p> <p>More likely to believe that the problem lies dormant in the person and could recur</p> <p>Person’s behaviour is more likely to be seen as severely disturbed</p> <p>More likely to think other family members may develop the same problem (family members seen as ‘carriers’ or ‘at risk’)</p> <p>More likely that those with mental health problems are seen as physically distinct (us-them distinction)</p> <p>Person is more likely to be linked to undesirable characteristics (eg. ‘dangerous, worthless, bad, weak’)</p> <p>Person is less likely to develop intimate relationships (others less willing to date or marry people with mental health problems)</p> <p>Family members may be discriminated against in employment and health insurance, or rejected in intimate relationships</p>

understanding and their need to ascribe/accept responsibility for the development of their relative's psychosis. This is usually linked with a discussion of the stress-vulnerability model and the family life cycle, which allows particular predisposing, precipitating or maintaining factors to be 'diluted' ('your contribution was only one of many factors'). In addition, families are helped to accept 'responsibility' rather than apportion 'blame' by emphasising how, despite good intentions, they have inadvertently contributed to interactional patterns which have been unhelpful. Discussions about circular causality are also often linked to the intergenerational transmission of beliefs as this also helps family members to develop an understanding which emphasises responsibility rather than blame.

Byng-Hall's (1995) idea of corrective scripts (once again, 'intentions were positive although the consequences may not be') as well as the replication of scripts ('due to a lack of appropriate role models') can aid this process.

New research in Somerset may be able to contribute to the literature. Andy Newman, a trainee psychologist, conducted four focus groups with clinicians working in the Somerset Family Intervention (FI) service to explore how they discuss causality. Another study by Sarah Amos will analyse session transcripts to examine the way in which causality issues are negotiated.

The challenges of working with issues of blame were one of four main themes that emerged from the analysis of focus groups with Somerset FI clinicians (Newman et al., 2012). The therapeutic style of 'explorative conversation' integrated with the stress-vulnerability model; as well as genograms, interactional-cycles and formulation; were identified as key aspects of the integrated approach that enabled clinicians to address and transform blaming into a more helpful shared understanding. The Somerset clinicians are taught to value multiple perspectives and to be curious about the implications of different understandings rather than to adopt an 'expert' stance and to approve/ disapprove of family members' views. They are able to provide information about all aspects of psychosis and its treatment but only do so when invited, and do not follow a set 'script' or provide 'one truth' – the biomedical explanation is thus only one of many stories about psychosis (**submitted papers 2, 7**). All four focus groups identified that causality discussions generally took place within the style of exploratory conversation. They approached causality from a curious, 'not knowing' stance, ensuring that no one causal factor was over-emphasised. However, some clinicians valued the

flexibility to switch to a psychoeducational style in certain situations, such as when substance misuse is discussed. Although this did not emerge from the research, we teach our clinicians to switch to a more 'expert' psychoeducational style when *invited* to do so by family members (Burbach & Stanbridge, 2001). Our postmodern collaborative therapeutic stance (see Table 6; Burbach & Stanbridge, 2001; **submitted paper 7**) enables us to integrate cognitive behavioural psychoeducational techniques with our non-blaming, supportive exploration of beliefs, feelings and behavioural patterns associated with problems, and to explore alternative (preferred) narratives.

The theme of 'explorative conversation' is similar to a therapeutic stance of 'not knowing', a key aspect of contemporary family therapy (Rivett & Street, 2009). It is also similar to the social constructionist approach to causality of the Open Dialogue (OD) approach (Seikkula, Alakara & Aaltonen, 2001). In OD all people involved in the life of the person experiencing psychosis gather together with the aim of moving away from rigid, polarized viewpoints (a 'stuck monologue') towards a more deliberately 'open-to-all dialogue' about the different perspectives on the problem. Seikkula, Aaltonen, Alakara, et al. (2006)¹⁵ found interventions that claim there is a truth about the cause of psychosis, which they describe as a '*stuck monologue*,' are linked to poorer recovery and higher rates of medication prescribing compared to OD. OD views the problem not as psychosis but rather the language that is used to describe it and encourages people to '*tolerate uncertainty*' as different perspectives are heard and discussed (Seikkula, et al. 2006:215¹⁵). However, other authors such as Jones (2002) and Smith, et al. (2007) argue that it is uncertainty regarding causality that angers families and can lead them to feeling blamed.

The debate regarding the best way to reduce stigma and blaming attributions is far from over. Family management clinicians can point to a considerable literature focusing on how families believe the public views them (for a review see Corrigan and Miller, 2004). It is clear that stigma harms individuals with mental health problems as well as their family members, and that complex relationships exist between stigmatising attitudes such as shame, blame and contamination, and discriminating behaviours. Advocates of

Table 6: Somerset's Family Service for Psychosis therapeutic stance

- We aim to work collaboratively with family members rather than adopting an 'expert' position.
- We assume that family members are the most knowledgeable about their own situation.
- We value multiple perspectives.
- Where possible we are open about the source of our ideas which may include other users' experiences, research literature and personal experience if appropriate.
- The focus of sessions is largely determined by the family's needs.
- We see therapy as an enabling process.
- The therapist is thus influential but not dominant in the therapeutic process.
- We aid families to construe their situation in a more helpful, flexible manner and to develop their coping resources.
- Ideas and techniques are offered rather than prescribed.
- Family members choose those techniques or ideas that 'fit' their values and needs.
- We utilise a range of therapeutic techniques in a manner which is congruent with our values.

WHAT THIS MEANS IN PRACTICE

- Medical discourse is only one 'story' among others, we are therefore able to explore other perspectives (eg. Hearing Voices Network).
- Whilst acknowledging the severity of the distress, we aim to de-catastrophise the situation, eg. exploring competencies or normalising.
- Engender cautious optimism/maintain realistic hope in the face of stigmatising views of mental illness prevalent in our culture.
- We elaborate the family's story/narrative.
- We share knowledge rather than providing 'the expert opinion/solution'.
- The information we provide is tailored to fit the family members' construal of their situation.
- We do not routinely educate people regarding diagnosis unless asked by the family.
- We usually discuss the individual's particular symptoms and use the term 'psychotic episode'.
- When questioned we respond fully, acknowledging the source of our information and its current status, and admitting our own lack of certainty.

psychoeducational approaches such as Lefley (1989, 1992) and Terkelsen (1983) have argued that the public has learned about parental blame from mental health practitioners, particularly those espousing systemic family therapy theories. Goldstein (1981, in Lefley, 1992) described the message sometimes conveyed to families: "the patient's illness (is) their fault and they should go away, shrouded in guilt, and leave the professionals to undo the damage" (p2). As a result an increased emphasis on biological models, particularly the genetic causes of mental illness, has been called for in order to

reduce stigma (e.g. Terkelsen, 1982). There has also been research into the effects of ‘illness attributions’. In a number of studies less personally controllable causal attributions, such as biological/ genetic explanations, have been associated with more positive emotions (e.g. sympathy rather than anger) and more positive behaviours (e.g. support) towards the person (e.g. Corrigan et al., 2000).

However, research suggests that a focus on genetics may have “both positive and negative effects for the stigma of mental illness as it affects both ill individuals and their families” (Phelan et al., 2002:159). Emphasising biological causes may reduce perceptions of causal responsibility (i.e. reduce blame) but it may also increase stigma along other dimensions - ‘course’ and ‘peril’ (Jones et al., 1984).

Dissemination of our ideas

We have now presented these ideas at local and international conferences and in numerous workshops throughout the UK and in the state of Victoria, Australia. These events have been organised by universities, mental health trusts, the Association for Family Therapy, the International Society for the Psychological treatments of Schizophrenia and other Psychoses (ISPS), the Meriden Programme and other institutions. Our presentation (Burbach & Stanbridge, 2004) at an Institute of Psychiatry conference chaired by Julian Leff led to our inclusion in a Journal of Family Therapy special edition (**submitted paper 7**). In the editorial Leff commented:

“Burbach and Stanbridge are convinced and convincing proselytizers for family interventions. They have achieved remarkable success in winning over the minds and purse strings of an entire NHS Trust in Somerset, UK. As a result, numerous mental health professionals have not only received the necessary training but are actively employing it in their daily practice. The lessons to be learned are so important that the detailed account given by these authors should be required reading for any professional trying to establish a family intervention service, and for all mental health managers.” (Leff, 2006: 2)

Other highlights were two-day events in Leeds and Birmingham. The Leeds Systemic Therapy course invited us to present alongside Jaakko Seikkula so that the Somerset and Open Dialogue approaches could be compared and contrasted (December 2007) and John Burnham, after reading our 2009 paper (**submitted paper 14**), invited us to be key presenters at the 2-day conference “Working with families in the context of inpatient

settings". This was the first time this conference had included adult focused work alongside work with children and led to article in Context (Stanbridge & Burbach, 2010).

Postgraduate university courses in Psychosocial Interventions (e.g. Sunderland, Surrey) now include teaching about the Somerset FI approach and an Integrated FI skills assessment tool has been developed (Brizolara, 2012). This assessment tool is being used on the University of Sunderland MSc in CBT & Recovery in Psychosis programme and has been presented at national conferences (the 2012 AFT and BABCP conferences).

We have implemented major workforce training initiatives in partnership with colleagues in Cornwall, outer London - Oxleas NHS Trust - and Cumbria (FIRST course, Family Inclusive Practice course, and a combination of both courses, respectively). We have also consulted to South London & Maudsley NHS Foundation Trust and University College London regarding Family Intervention and Systemic Therapy training courses and service development (28/06/06).

Somerset has also been selected as one of the services to be researched in detail as an example of a 'whole family approach' that contributes to the 'reablement' of people with mental health difficulties. This national research study being conducted by University of Birmingham (Tew et al., 2012) is based on the Cabinet Office's 'Think Family' reports (2007, 2008).

As a result of our presentations and publications our services have been commended as "exemplary practice" by the Healthcare Commission in 2005, we have received awards (e.g. 2004 Health & Social Care Awards, South) and our work has been recognised in national publications (see Table 7). A recent Care Quality Commission report highlighted our development of family inclusive services:

"Involvement of families and carers

Involving families and carers is important too. One example of good practice is Somerset Partnership NHS Foundation Trust, which has for some years adopted a strategy to enhance working partnerships with families and carers. This involves staff training, and a family liaison project designed to increase the number of face-to-face meetings between staff, families and carers on inpatient wards, and to hold such a family meeting within seven days of a patient's admission.

The project appears to have worked well. These meetings are now a routine part of the admission process and there has been very positive feedback from families, carers and patients. This is an excellent way to ensure that aftercare planning is started from the point of admission. This, in turn, could help to avoid future re-admissions. We commend this project as a model for other services.”

Care Quality Commission (2010: 58)

Managers and educators find it helpful to adopt aspects of our training and service-development approach, while clinicians introduced to our ideas find that ‘cognitive- interactional’ formulations are more clinically helpful than the oversimplified ideas based on the earlier EE research. Clinicians also report that they enable conversations that are non-blaming and therefore more therapeutic.

Table 7: National reports in which our work developing services for families in Somerset has been acknowledged

Association for Family Therapy and Systemic Practice in the UK. (2007) **Current practice, future possibilities** www.aft.org.uk

Simpson,A. and Benn.I. (2007) **Scoping exercise to inform the development of a National Mental Health Carer Support Curriculum**. City University, London/ DOH.
<http://www.citypsych.com/docs/Carersfinal.pdf>

Social Exclusion Task Force (2008) **Think Family: a literature review of whole family approaches**. London. Cabinet Office.<http://www.cabinet-office.gov.uk/>

Association for Family Therapy and Systemic Practice in the UK. (2009) **Family Friendly UK: Making it happen** www.aft.org.uk

National Patient Safety Agency (2009) **Preventing suicide: A toolkit for mental health services**. <http://www.nrls.npsa.nhs.uk>

National Mental Health Development Unit & Princess Royal Trust for Carers (2010) **The Triangle of Care: Carers included: a guide to best practice in acute mental health care**. www.acutecareprogramme.org.uk

Care Quality Commission (2010) **Monitoring the use of the Mental Health Act in 2009/10**. CQC, London.

The training, consultancy and service development role of Clinical Psychologists

The training of Clinical Psychologists is multi-faceted and as a result we embrace the sometimes seemingly contradictory roles of scientist-practitioner and reflective-practitioner; clinician and leader/ manager; and work at many different levels, e.g. individual, organisational, or social network. This multiplicity of roles has recently been

emphasised in the New Ways of Working (BPS, 2007), but our rigorous training in the discipline of Psychology as well as evidence-based practice, has for many years enabled many Clinical Psychologists to take on clinical leadership and service development roles (DCP, 2010).

In Somerset we realised 23 years ago that our small department could not possibly directly meet the psychological needs of all of our mental health service clients and we began to focus on training our nursing and other colleagues. Our initial project was to train rehabilitation unit staff in behavioural principles in order to then provide a more effective consultation service. We have continued to develop our 'whole-team training and consultation' model (Quarry & Burbach, 1998)² to meet the needs of various services and teams. Training new (part-time) teams in order to develop Family Intervention services was a variation on this theme. However, we would not have sustained our service, nor have influenced other parts of the UK or further afield, if we had not rigorously audited and improved our service in keeping with the scientist practitioner role.

GENERAL DISCUSSION

The future development of family based services

In Somerset we began to develop our Family Interventions (FI) for psychosis service in the mid 1990s in the context of a recognised body of evidence (cf. Cochrane review, Mari & Streiner, 1996²) and NHS service guidance (Health of the Nation, Key Area Handbook: Mental Illness, 1993¹³). Our services were developed after surveying the literature (**submitted paper 1**) and comparing the views and practices of clinicians from both sides of the family therapy and family management divide (Burbach, 1995²). They were also a response to personal accounts regarding the low rates of implementation of FI following other training initiatives (these were subsequently published- eg. Fadden, 1997⁵- see Tables 2&3). Our services therefore preceded the emphasis on family work in the National Service Framework - Crisis Intervention, Assertive Outreach and Early Intervention specialist services all emphasised the importance of engaging families, partnership working and family intervention. In Somerset we were able to use our existing FI service as the initial stage of our development of Early Intervention in Psychosis services (see **submitted paper 12** for more details). This coincided with our

increased focus on encouraging family inclusive practice throughout the trust. Whilst we were explicit that this 3-day training was not to develop family therapy practitioners, we wished to encourage frontline staff to engage with families and equip them with some skills and the confidence to do so. To encourage ward staff to hold more family meetings as part of the assessment process we developed the 'family liaison service' (**submitted paper 17**; Stanbridge, 2012; Carter, 2011; Gore & Stanbridge, 2012; Leftwich et al., 2011).

We designed the FI and FIP training initiatives to be complementary (see **submitted paper 11**) to meet the needs of a range of families. However, our 3-day Family Inclusive Practice training could also be considered to be a first stage of a family therapy skills training (see Table 8) and was influential in the development of the AFT Family Friendly UK proposals for 6 levels of training:

“For the UK to become truly family friendly, better able to safeguard vulnerable children and adults and to develop preventative working in universal and specialist services, it is essential that an effective, widespread and accredited model of training in family-sensitive working is introduced and cascaded throughout key UK services...

It is based on the “Somerset Model” of training in adult mental health. This model, already applied successfully in Somerset and some other areas including Oxleas Foundation Mental Health Trust in South East London, demonstrates how trainings in family sensitive working can be cascaded throughout all service tiers, supported by specialist services and clinically qualified Family and Systemic Psychotherapists able to deliver staff training, supervision and consultation and work with families experiencing particularly complex and serious difficulties. The involvement of families and carers in service design has ensured a good fit between provision and need...

This workforce training is based on a robust and tested pyramid structure, with all staff trained to level 1 and increasingly smaller groups trained to higher, more specialist levels. All levels are necessary to support families, services and staff effectively. “ (AFT, 2009: 6-7)

Table 8: Level 1 training (AFT, 2009:7-8)

Aims

To develop staff understanding of the importance of family sensitive and family inclusive approaches in a particular field of work; to identify its particular issues and constraints; to develop skills in communication with families and family members.

Length and format of training

2 days plus 1 follow-up day a month later to review and reinforce practice development

Target Group

All staff in public and third sector services who meet with children, young people and adults in 'helping' and/or 'caring' capacities, including teachers, mental health nurses, doctors, police officers, GPs, general nurses, health and social care key workers.

Curriculum

- The importance of the family and other contexts to individual well being in the particular area of work
- The impact on the family of stressful family and external events relevant to particular area of work
- Ethics (including confidentiality)
- Development of some concepts and language to describe family and family interactions
- Basic awareness of the importance of family beliefs, culture, structure, expectations, life cycle experiences etc
- Basic listening and communications skills with more than one person in the room

Basic skills in convening, listening and talking with family groups

Competencies to be achieved.

(all will relate to a particular area of work)

- Basic awareness of the individual in the family context
- Basic awareness of family members' and carers' needs, experiences, wishes and resources
- Basic understanding of the impact of the problem on the family and the family on the problem
- Basic sensitivity to diverse family forms and beliefs
- Ability to communicate more effectively with family members

It is interesting to note that the 4 or 5 day Behavioural Family Therapy training provided by the Meriden Programme, whilst leading to relatively low rates of formal family intervention provision without considerable emphasis on enabling subsequent practice (e.g. establishing robust supervision structures), has the positive effect of generally stimulating more family inclusive practice (Fadden 2006¹⁵, Fadden & Birchwood, 2002). A range of training initiatives have thus been developed with different objectives, but the hoped for outcomes include a range of family based services from routine partnership working to formal family interventions. In Somerset we have explicitly targeted both routine partnership working and formal family interventions. Nonetheless the distinction between the different types of family meetings remains difficult, especially if routine partnership working is provided by a trained family worker, and we have therefore developed the Somerset guidelines (see Table 9 for the most recent version) which were published in the comprehensive UK Early Intervention practice guide edited by Paul French and colleagues (see **submitted paper 15**). I have also contributed to the development of the revised Early Intervention Guidelines (IRIS, 2012) in which a clear

distinction is drawn between routine family involvement and formal FI (see Tables 10 & 11). Another new development is the suggestion that, in order to meet the range of family needs, stepped care may be an effective framework in which to conceptualise different family based services.

Table 9: Somerset Guidelines: The distinction between formal and routine family work

<p>ROUTINE FAMILY WORK (One aspect of Individual EI Worker's Role)</p>
<ul style="list-style-type: none"> • Exploration of distress and provision of emotional support • Assessment of family context for client's symptoms/problems • Initial Carers Assessment (and signposting on to carers services) • Provision of information about psychosis, coping strategies and services • Involvement in care planning and reviews
<p>FORMAL FAMILY INTERVENTIONS (Family needs-led sessions convened by FI trained co-therapists)</p>
<ul style="list-style-type: none"> • Constructing a safe, secure base for families to reflect and experiment • Reducing stress/burden and encouraging realistic expectations • Reducing negative arousal and distressing affect • Enhancing family members' skills for coping with psychotic symptoms • Enhancing the ability to anticipate and solve problems • Helping the family to communicate more clearly • Identifying early warning signs of relapse and agreeing a plan of action • Liaison and advocacy with mental health and other services • Enabling change in the family interaction system • Helping the family to be reflective, explore options, reach a shared understanding, deal with strong feelings (eg anger, guilt) and encourage a sense of personal agency <p><i>It is recognised that in less complex presentations the first 8 of the above can also be met within Routine Family Work</i></p>

Table 10: IRIS Early Intervention Guidelines (2012) - Family Engagement

IRIS GUIDELINES UPDATE 21 March 2012

What should an EIP service be able to offer?		
Family engagement		
Key Components	Key Elements	Comments
<p>All EIP services should be family orientated, supporting the family as part of the care team.</p> <p>Engaging families is a core service aim irrespective of how well engaged their relative is with the service.</p> <p>Engaging and supporting families & carers features in the WHO Early Psychosis Declaration (Bertolote & McGorry 2005).</p>	<p>EIP services should work in partnership with service users and families to:</p> <ul style="list-style-type: none"> Engage carers/family early. Provide information, support and guidance to maintain hope and optimize coping. Involve family/carers in treatment planning, reviews and monitoring of mental health. Ensure family/carers know whom to contact in crisis. Provide information on self-help support groups. Offer Carer's Assessment. <p>Provide early engagement with families as routine part of the assessment process to enable</p> <ul style="list-style-type: none"> Gathering of invaluable information about the young person who has developed their FEP Low-key assessment and consideration of family members' physical, social and mental health needs, particularly the welfare of dependent children, siblings and vulnerable adults. <p>Collaborative engagement of families requires sensitive ongoing negotiation about the extent of information-sharing with the person with psychosis.</p>	<p>Involving families in a collaborative partnership of <i>Triangle of Care</i> (Worthington & Rooney 2010) from the beginning can create a very different long-term relationship with services and facilitates the development of an environment that promotes recovery.</p> <p>Most young people with a FEP are in close contact with their families. Relatives commonly initiate contact with services, and provide much of the practical care and support. However families have traditionally struggled to initiate help and have felt excluded from their relative's care.</p> <p>When the lives of young people with psychosis are chaotic and poorly engaged with services, working with family members is sometimes the best way to maintain therapeutic input.</p> <p>Relatively straightforward information, support and guidance can encourage medication concordance, enable family coping strategies, prevent formation of unhelpful attitudes / interactional patterns.</p>

Table 11: IRIS Early Intervention Guidelines (2012) - Family Interventions

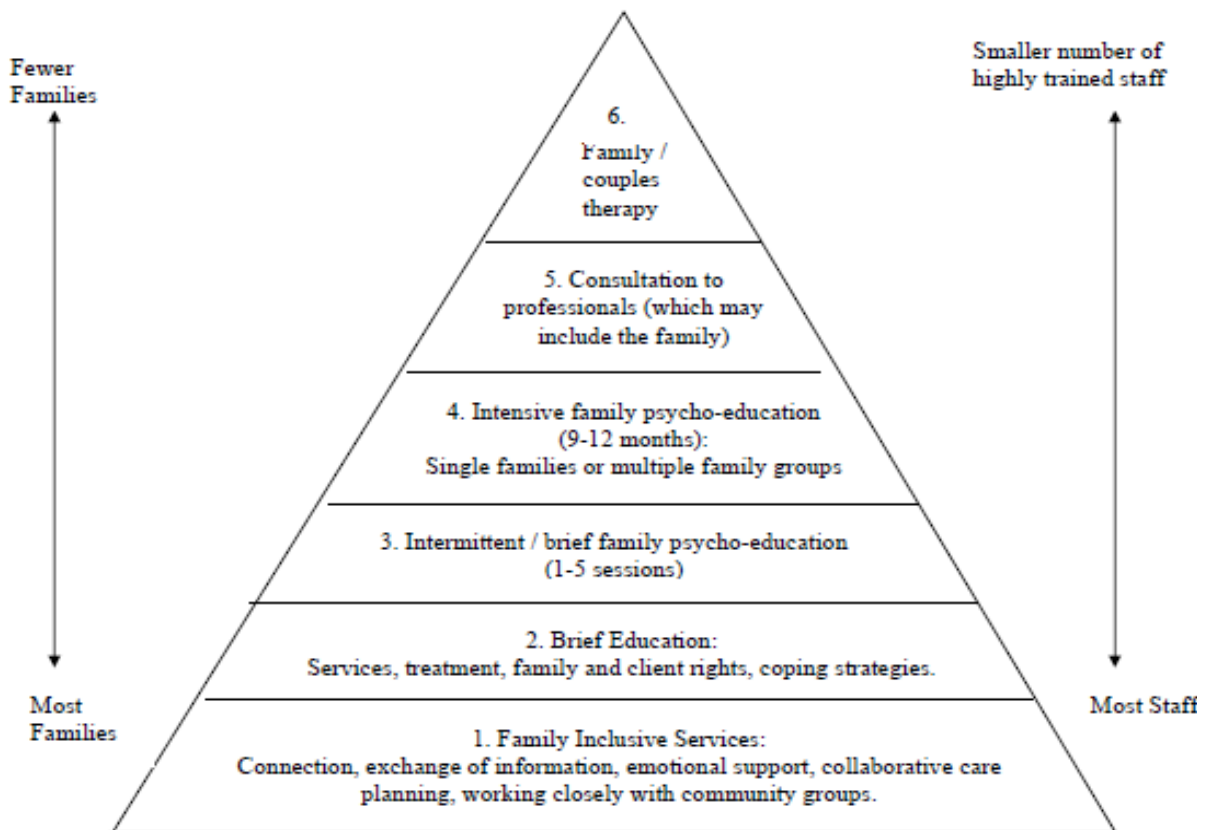
What should an EIP service be able to offer?		
Family interventions		
Key Components	Key Elements	Comments
<p>Providing care for families is a core EIP service requirement.</p> <p>NICE recommends that family intervention (FI) should be provided for a minimum of 6 months (NICE CG 82 2009).</p> <p>Family Interventions (FI) sessions should be tailored to meet the needs of family members and offered irrespective of how well engaged their relative is with the service.</p>	<p>All EIP services should offer single family interventions (e.g. psycho-education, family therapy) and multi-family group interventions.</p> <p>Formal structured goal oriented FI sessions can: Help improve partnership with families as part of routine care</p> <ul style="list-style-type: none"> • Validate and normalise the family's emotional reactions • Provide tailored information about psychosis, stress and vulnerability, treatment etc • Explore appraisals to reach a more helpful shared understanding about what has happened • Goal set and encourage realistic steps towards recovery • Practice clear, direct, positive communication • Identify and help change unhelpful interactions • Problem-solve about everyday issues • Identify early warning signs of relapse and agree an intervention plan • Promote stress management and encourage all family members to look after their own needs, referring to mental health/ carer support services when required. <p>Families identify very diverse difficulties, requiring different types of intervention. Ideally services offer a menu of ways to support families e.g. Systemic and Behavioural family therapy, Care Support Groups and other modes of multi-family working.</p> <ul style="list-style-type: none"> • Structured FI should be offered where there is family tension or over-involvement. • Not all families require formal, structured FI and the approach should always be tailored to each family. • A small number of families may require more in-depth psychotherapeutic input to address complex and entrenched negative interactions and conflicts; or to address significant pre-existing or recently developed risk factors (e.g. abuse or violence). 	<p>FI reduces relapse and hospital admission rates in FEP (Bird et al 2010). Social functioning and 'family burden' are improved and overall treatment costs are reduced (Onwumere et al 2011).</p> <p>FI approaches are based on the stress-vulnerability model, helping families develop problem-solving skills, communication skills and ways to achieve low stress environments. Families are encouraged to support goals tailored to the family member's stage of recovery. These psychoeducational cognitive-behavioural approaches may be augmented by a focus on systemic issues where families have become trapped by unhelpful patterns of belief and behaviour, or in exploring socio-cultural and intergenerational beliefs, roles, and family life-cycle issues.</p> <p>Stepped-care models enable the most highly trained staff to respond to those families with the most complex needs; contrasting with families with simpler needs who may only require basic levels of engagement, information and support (Cohen et al 2008; Mottaghipour & Bickerton 2005).</p>
<p>A number of useful treatment guides are available which provide examples of services for families of young people with a FEP (Addington & Burnett 2004; Birchwood et al 2002; Burbach et al 2010; Crisp & Gleeson 2009; Fadden & Smith 2009; Gleeson et al 1999). A useful guidebook for implementing family work (Froggatt et al 2007) is also available.</p>		

Matching family needs, family services and staff training

A number of service models (e.g. Mottaghypour & Bickerton, 2005¹⁴; Shankar & Menon, 1993; Breitborde & Srihari, 2012) have been developed to match family needs to different types of family interventions. These are based on the increasing recognition that it is not necessary (or feasible) to offer in-depth interventions to all families. Such 'stepped care' models reflect the 'sufficiency principle' (Cohen et al, 2008) – by providing a range of family based services the needs of clients and family members can be met with the least intensive intervention. A group of American experts (Cohen et al, 2008) recommended a number of steps consisting of very brief (educational) interventions prior to offering intensive family psycho-education, whereas the model developed in Sydney, Australia (Mottaghypour & Bickerton, 2005¹⁴) proposed that all families be offered a minimum level of care before being assessed and referred to consultation and family therapy.

In more developed mental health services, the 'pyramid of care' service model is an effective way of matching family needs with intensity of service provision and staff skill mix. The basic needs of most families can be met by existing mental health service staff with minimal additional training, but some highly trained staff are required to meet the needs of a smaller number of families with complex needs. Based on the American and Australian models I have proposed a composite stepped care model (Burbach, 2012; see figure 5). Please note that a collaborative therapeutic relationship and the provision of emotional support are integral to the care provided at each of the 'steps'.

Figure 5: An aggregated stepped-care family interventions model.

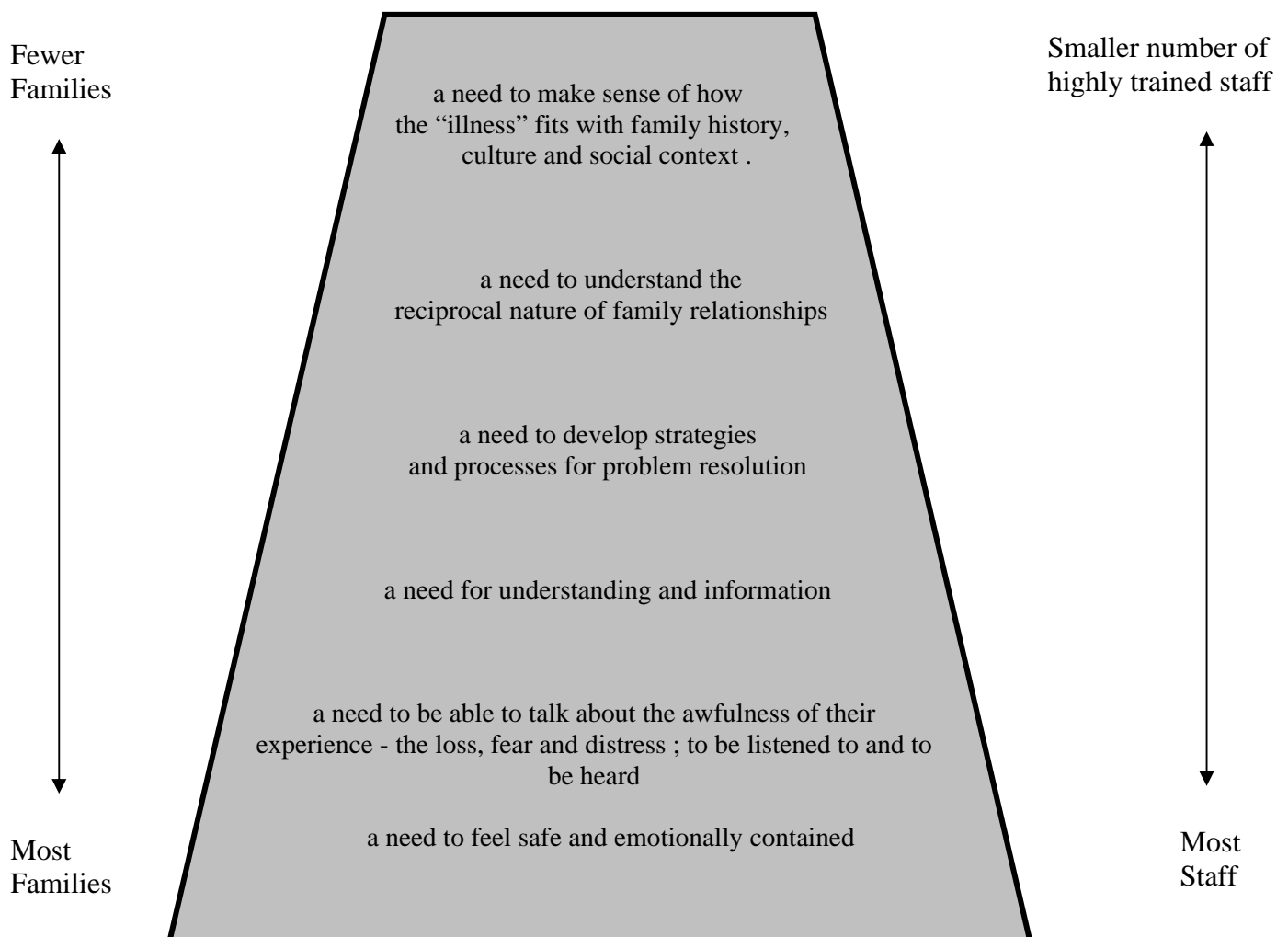


Although the American and Australian models emphasise assessment at each stage to determine whether the family should progress to the next level of intervention, a service able to offer this range of interventions could also be organized on the basis of assessed needs. A thorough initial assessment as part of the minimum level of family engagement could trigger immediate referral to the most appropriate level of intervention rather than requiring the family to progress through the steps. One way of achieving this is to initially involve a more highly trained member of staff in the lower level family intervention with particular families (eg. those with longstanding, complex presentations or high risk issues) so that the family can seamlessly be offered a more intensive intervention. In an ideal mental health service, the principles of ‘assessed care’ as well as ‘stepped care’ would be implemented on a flexible, case-by-case basis.

In our experience, some families engage more with psychoeducational interventions, while others are more interested in reflecting on family relationships and interactions in the context of family history and cultural issues. It is not just a tiny minority of families

that are interested in having more multi-faceted family discussions and thus our Family Needs diagram (Pearson, Burbach & Stanbridge, 2007¹⁵ and Figure 6 below) has a trapezoid rather than pyramidal shape. This conceptualization of family needs also differs from service related models in that families referred to in the top sections of the diagram are not viewed as more challenging or needing greater input. In services where staff have more extensive training in working with families (eg. Somerset, **submitted paper 5**, or Turkku in Finland (the Open Dialogue Approach) it is often possible to have family sessions in which multi-faceted, systemic issues are addressed in a relatively brief but comprehensive manner. It remains to be shown whether such approaches confer additional benefit over the psychoeducational interventions in terms of outcome for the person with psychosis or the other family members, but the evidence is encouraging (Seikkula et al., 2006)¹⁵.

Figure 6: A hierarchy of family needs.



Future theoretical developments

It is only relatively recently that we have begun to investigate how the individual with psychosis and the family members experience the service provided in Somerset, with the aim of identifying key mechanisms for change. Our original satisfaction study (15 of the first 22 referrals to our service agreed to take part in semi-structured interviews) **(submitted paper 4)** highlighted that people appreciated the positive therapeutic qualities/ skills of the therapists (e.g. empathic, non-judgmental approach; mutually agreed goals), and valued the opportunity for open discussion, developing new perspectives and problem solving. They also valued the closer working relationship with the professionals in the service. This study emphasised how the therapeutic relationship was an essential platform for the other aspects of the approach which families identified as being helpful such as help with specific problems and symptoms, via exploration of interaction patterns and the development of problem solving and coping skills. However, it did not explore the importance of affect or the nature of the therapeutic relationship in detail.

More recently, Jo Allen **(submitted paper 16)** interviewed seven service users in depth about their experiences of the Somerset FI service and its significance to recovery. Interpretative Phenomenological Analysis (IPA) revealed three central themes: 1. They welcomed the shared experience with their families and feeling contained and valued by the therapists. 2. They felt the sessions contributed to changed patterns of relating within the family and the creation of new meaning through the validation of multiple perspectives. 3. They described how the family sessions supported a new positioning in the world, feeling empowered with their own sense of personal responsibility, greater self-acceptance, an increased ability to manage emotions and hope for the future.

Estelle Rapsey has just completed another study using IPA where she interviewed 10 participants from 5 families. She explored how family members' experience of family interventions helped them to think differently about attachment, attributions and the maintenance of difficulties. This is the first study where we have specifically considered attachment. Participants valued the 'containing therapeutic space' which 'facilitated difficult discussions'; and highlighted the importance of the therapeutic relationship and the therapist being 'normalising, validating and comforting', as helpful mechanisms for therapy. Understanding relationships with significant others also emerged as a super-

ordinate theme (see Table 12) but attachment issues were not explicitly identified by the participants.

Table 12: One of the super-ordinate themes identified by Estelle Rapsey, 2012.

Superordinate theme	Sub-theme	Theme
Understanding relationships with significant others	<ul style="list-style-type: none"> • How I understand my experience of being a parent, husband/wife, son/daughter, sibling. 	<ul style="list-style-type: none"> -Developing understanding, insight - Parenting role – protecting, learning when to stand back, let go -Burden of caring -Increasing empathy -Perception of self in relation to family
	<ul style="list-style-type: none"> • How I make sense of my own experiences of being parented • 	<ul style="list-style-type: none"> - Reflecting upon and making links with past experiences -Relevance to current situation -Own mental health difficulties -Mental health difficulties of relatives -Changing perspectives -Influence of own attachment experiences (implicit)
	<ul style="list-style-type: none"> • Developing a sense of cohesion 	<ul style="list-style-type: none"> -Being held in mind (by family members) and being mindful of others -Uniting the family
	<ul style="list-style-type: none"> • Family traits 	<ul style="list-style-type: none"> -Similarities and differences in personalities

We hope to use some of the data from this study to begin to develop a more nuanced approach, acknowledging the role of attachment and attachment narratives in our work. Reviews (e.g. Liotti & Gumley, 2008) indicate an increased recognition of the role of attachment issues with regard to psychosis. For example, Mickelson et al (1997) and Dozier (1990) found high levels of insecure and avoidant attachment styles in psychosis samples. Individuals with an insecure attachment are typically characterised by a negative self-image, an overly demanding interpersonal style and a fear of rejection. Avoidant attachment is associated with a negative image of others, interpersonal hostility and social withdrawal (Mikulincer et al, 2003). Given these predictions of interpersonal functioning and the fact that the quality of relationships with family

members is influential in recovery and relapse (Penn et al, 2004), these issues have a clear relevance for people with psychosis and the processes involved in family work. We would hope to be able to make a contribution in this area in the future, possibly drawing on more recent theorising in the systemic therapy literature about attachment narratives (e.g. Dallos, 2006; Dallos & Vetere, 2009). It is interesting to note that psychoeducational practitioners have also begun to recognise the importance of emotion and attachment for FI. For example, Elizabeth Kuipers (2006) proposed a primarily emotional rather than a cognitive mechanism of change and Berry, Barrowclough & Wearden (2009) found associations between previous interpersonal experiences and adult attachment and proposed the inclusion of measures of attachment in future studies testing cognitive models of psychosis.

A related issue that we would like to investigate further is the benefits associated with working in pairs and our robust supervision structure (**submitted paper 13**). We believe that the direct and indirect support that co-therapy and supervision provide, respectively, enables clinicians to create a safe containing therapeutic space in which reflection and problem solving can occur.

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Family based interventions in psychosis - An overview of, and comparison between, family therapy and family management approaches*

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Abstract

This paper aims to be of assistance to those who wish to work with families which include a person exhibiting psychotic symptoms. The literature is dauntingly large, often highly complex and is divided into two opposing camps which are often critical of one another. The paper summarises the distinctive contributions made within the field and notes the historical context for the split between the 'family therapy' and 'family management' approaches. The two approaches are compared in terms of their understanding of the issues of causation, lineality and circularity, acceptance of the concept of schizophrenia, and their emphasis on research or theory. It is suggested that future theoretical innovation is unlikely to be based on the unitary conceptualisation of the expressed emotion measure but is more likely to draw on systemic theories.

Family therapy is now widely recognised as a particularly useful approach for a large number of mental health problems. However, family interventions with the more severely disturbed (psychotic) clients are less widely accepted within mental health services and medication appears to be the treatment of choice. There is also a great deal of confusion and dissent among practitioners who are working with families which include a psychotic person (e.g. see Berkowitz, 1988). It appears to be particularly difficult to carry out family based interventions with these clients in mental health services. Family members are often difficult to engage in family work - this may be because they are

sensitive to any implications that they are to blame for their relative's "madness" or, perhaps more fundamentally, they may not accept the rationale for family work because their relative is regarded as ill. In order to deal with such difficulties practitioners of family interventions have adopted a wide variety of theoretical models and intervention strategies. Broadly speaking, however, these may be divided into two camps: 'family therapy' and 'family management'. Each is critical of the other because of the (negative) implications that they perceive to be inherent in one another's approach (Berkowitz, 1988).

It is the aim of this paper to be of assistance to those who wish to work with this client

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group and their families by providing an overview of the theoretical debate. It is also hoped that by providing an overview of both approaches and illustrating how the more recent family management practitioners have proposed models not dissimilar to those developed by earlier (family therapy) theorists the unnecessarily antagonistic debate will move into a more mature and productive phase.

Brief historical overview¹

It is well known that family therapy was 'born' almost forty years ago when innovative therapists began experimenting with seeing whole families instead of the 'identified patient' alone. Therapists looked to general systems theory, communication theory and cybernetics to provide the necessary theoretical framework to expand on theories they used when working with individuals (usually psychoanalysis, e.g. Nathan Ackerman). The early exponents of family therapy were particularly concerned with understanding and treating 'madness' or 'psychosis'. These approaches presented a powerful challenge to the dominant psychobiological approach which involved medical (drug) treatment of the 'mentally ill' patient.

There has long been a tension between biological explanations (disease processes, constitutional weaknesses, etc) and psychological models. Psychological models propose that the emergence of symptoms is understandable within a particular context (e.g. childhood experiences). Viewed from a medical model perspective these models may appear to carry an implication of blaming (e.g. of the parents). Freud saw 'neurosis' as being

rooted in the family - the family is the background against which the individual's (conscious and unconscious) personality develops. Psychoanalytic theorists have since put forward etiological theories for psychosis which are also based on childhood experiences - especially concentrating on nurturance in early infancy (e.g. Mahler's theory of symbiosis; Fromm-Reichman's 'schizophrenogenic mother'). This tension was exacerbated by the development of systemic theories of madness which sought to understand the development and maintenance of psychotic symptomatology in terms of the family's interactional processes/organisation.

Early systems theorists noted that many families of psychotic patients appeared to be unusual and that contact with their family often precipitated a relapse/exacerbation of symptomatology in the 'identified patient'. Bateson, Lidz, Wynne, Bowen and others proposed theories to explain the development of 'schizophrenia'² and other psychotic symptomatology. These theories further challenged the prevailing medical orthodoxy. There was an initial flurry of interest in these new approaches and they became widely known to the general public through the writings of R.D. Laing and others in the 1960s. However these concepts were opposed by most psychiatrists and others in the mental health field and, in the absence of sufficient evidence of their efficacy, by the 1970s systemic family therapy with schizophrenics had generally fallen out of favour.

However, at the time that the "theories of family causation"³ were being called into question and systemic work with schizophrenia was in decline, new approaches to working with the families of patients who have

¹ Readers interested in more thorough overviews are referred to Hoffman (1981), Wynne (1981) and Liem (1980).

² The acceptance of the concept of schizophrenia is an issue which often separates 'family therapy' and 'family management' adherents. It will be discussed in the final section of this paper.

³ The issues of causality and blame are also discussed in the final section of this paper.

schizophrenia were being developed (McFarlane, 1983a). The new “family management” approaches as developed by Leff, Anderson, Goldstein, Falloon, Liberman and others, were based on an acceptance of a medical (biological) basis for schizophrenia but proposed that working with the identified patient’s family could reduce stress and thereby improve the course of the illness. This body of work has been well researched and has become widely accepted within mental health services.

However, despite differences between the family therapy and family management approaches, commentators have noted that they have a great deal in common (e.g. Berkowitz, 1988). In addition, Johnstone (1993) has cogently argued that the overall implications of the family management research also provide support for family therapy models.

Approaches to family intervention

‘Family therapy’ approaches

The work of the early family therapists who contributed significantly to the development of the systemic approach to psychosis will be reviewed first. The most popular models currently used will be discussed thereafter.

The double-bind theory developed by Bateson and his colleagues at the Mental Research Institute (Bateson, Jackson, Haley & Weakland, 1956) is seminal in the development of family therapy as a whole and, although these concepts are also useful for understanding the development of others symptoms, was specifically developed to explain psychosis. Bateson and his colleagues recognised habitual contradictory communication sequences in families containing a schizophrenic member.

In their original formulation they proposed that a person (usually a child), confronted with these incongruent messages, reacts by

distorting and denying important aspects of themselves and their perceptions. Double-binding occurs when a child repeatedly receives a message (for example, forbidding certain behaviour) which is contradicted by another injunction conflicting with the first at a more abstract level, but also accompanied by covert prohibitions against commenting on the contradiction or escaping from the conflict. Although they emphasised that the double-binding occurs within a pathological relationship, the original formulation was justifiably criticised for apparently blaming the parents. However, Dell (1980) points out that in subsequent reformulations (e.g. 1963) they discussed double-binding in terms of sequences of interaction which ensnared both parties.

They argued that the behaviour of both parties can only be understood in the context of the existing relationship: everyone behaves as they do within a particular interaction pattern, which may be described as schizophrenic; one cannot describe the parents as causing schizophrenia in their offspring (Dell, 1980).

Lidz (1958,1963) noted the blurring of boundaries in families containing a psychotic member. He distinguished two family patterns which could result in schizophrenia in a child/young adult: ‘marital schism’ and ‘marital skew’. In the first pattern there is a conflictual marital relationship, separation is threatened, and each parent disqualifies the other and seeks an exclusive relationship with the children. In the second pattern, the parental relationship is distorted, with one parent excessively powerful and dominant in the family organisation due to his/her gross psychopathology (e.g. psychotic thinking).

More recently, Lidz (1972) has placed more emphasis on the role of language and communication but his position remains one which “blames” the parents for schizophrenia in

their offspring: "Lidz's position on schizophrenia is an elaboration of the ways in which neurotic, narcissistic parents sacrifice their children in the service of maintaining their own precarious adjustment" (Dell, 1980:323).

Wynne and co-workers (1958) proposed the concept of 'pseudo-mutuality' to describe families which contain a schizophrenic member. In these families there is a rigid adherence to a shared illusion that they all have the same expectations. The "subjective tension aroused by divergence or independence of expectation, including open affirmation of a sense of personal identity, is experienced as not merely disrupting that particular transaction but as possibly demolishing the entire relation." Therefore communications which "might lead to an articulation of divergent expectations, interests, or individuality are, instead, diffused, doubled, blurred or distorted" (1958:210).

In a series of meticulous research studies (Singer & Wynne, 1965b; Wynne *et al.*, 1977; Singer, Wynne & Toohy, 1978) it was found that 'communication deviance' (CD) was relatively unique to, and present in the majority of, families in which someone is diagnosed as having schizophrenia. However, in a careful British study (Hirsch & Leff, 1975) these results were only partially replicated. The British study failed to find the same degree of gross CD in their sample of parents of schizophrenic patients using a more acutely symptomatic sample meeting stricter criteria for the diagnosis of schizophrenia. (The American sample were generally more chronically disabled with fewer floridly psychotic symptoms). It should be noted that although Singer & Wynne's conclusions about the specificity of CD are open to question they did not ascribe a simple causal explanation to their findings and hypothesised that genetic factors as well as thinking/communication styles may be determinants

of schizophrenia. Their finding that "the degree of disturbance in family interactions is greater and qualitatively different from that found in the contributions of any individual member" (Wynne & Singer, 1963:194) led them to a theoretical position similar to the Bateson *et al.* reformulation. They do not regard schizophrenia as having been caused by certain types of parental communication but describe schizophrenia in terms of a *pattern* of communication (a *transactional* thought disorder)

"...once an offspring has grown up within a given kind of family his (sic) styles of behaving and experiencing will 'fit' into the particular family which, transactionally, has produced him (sic) and which he (sic) has helped produce" (Singer & Wynne, 1965a:190).

Reiss' (1967, 1971 abc) research examined the impact of family interaction on problem solving and found that families which contained a schizophrenic member maintained a close and uninterrupted agreement at all times. They did not tolerate any dissent and distorted or oversimplified the task in order to reach a speedy consensus. His concept of 'consensus-sensitivity' appears to have a great deal in common with the concept of pseudo-mutuality. A particularly important finding was that these families may collectively engage in very poor quality problem solving despite the fact that individual members could each do far better when alone (1971 abc). This seems to support the view that a simple causal explanation of schizophrenia is insufficient and that schizophrenic behaviour cannot be separated from the relationship context within which it is embedded.

Bowen (1978) proposed that schizophrenia reflected the submerging of the individual's identity within an extremely undifferentiated 'family ego mass'. He hospitalised, and made detailed studies of, families containing

a schizophrenic member. Bowen developed a three generational hypothesis which proposed that a lack of differentiation over three succeeding generations was required for schizophrenic symptoms to become evident.

Two approaches which are deserving of somewhat more detailed discussion as they are currently particularly influential are the work of Haley (1980) and the work of the original Milan Team (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). Selvini-Palazzoli and her co-workers' later contributions (Selvini-Palazzoli, 1986; Selvini-Palazzoli *et al.*, 1989) and the most recent formulations of this team (Selvini, 1992, 1993), the Brief Therapy model, as well as the work of Michael White (1987), Donald Langsley *et al.* (1968), and R D Scott and co-workers (Scott & Ashworth, 1967; Scott 1973ab, 1974; Scott & Starr, 1981) are also discussed below.

Family Therapists such as Haley (1980) and Minuchin (1974) understand the development of a wide variety of symptoms in a child as involving a rigid triad consisting of a parent-child (cross generational) coalition and a peripheral parent. The child develops symptoms in order to defuse the tension between his/her parents. Parents commonly define the child as the source of family problems and unite to deal with him/her, or alternatively fight about handling the child, thus avoiding dealing with the problems in the couple's relationship. However, Haley (1980) proposes that psychosis is the result of a more complex and severe form of rigid triad, which involves a "double bond", where both parents join the child and each demands that the child sides with them against the other. He suggests that the 'mad' behaviour of the young adult occurs when the child is facing the dilemma of having reached an age when he/she would be expected to leave home, but feels unable to do so, as this is likely to result

in increased conflict and instability in the family. The development of psychotic symptoms is a solution to this dilemma as it allows the young adult to stay at home (remain triangulated). The symptoms are thus seen as serving a protective function for the family.

In his book *Leaving Home*, Haley (1980) clearly sets out a deceptively simple approach which is applicable to nearly all troubled young adults, including those with psychotic symptoms (see also Madanes, 1983). The approach is a strategic one which aims to restore the family hierarchy so that the young person no longer dominates his/her parents by means of disturbed behaviour (e.g. aggressive behaviour, bizarre communications, extreme apathy). The model stresses the competencies in the family and the young adult is viewed as capable of normal functioning.

The Milan Team (Selvini-Palazzoli *et al.*, 1978) developed the concept of 'reciprocal self-disqualification' to explain the development of psychotic and other symptoms. Although not specific to schizophrenia, they termed the concept a "schizophrenic transaction" - every family member disqualifies both the statements of other family members as well as his/her own statements, and as a result no commitment to, or definition of, any relationship emerges; (cf the concept of pseudo-mutuality). Severely disturbed families are viewed as rigid, unchanging and brittle systems. It is assumed that the identified patient (IP) is remaining symptomatic as an extreme solution to a very complex family dilemma (e.g. the IP remains insane to prevent the emergence of catastrophic conflict in the extended family). This dilemma appears insoluble as any change to the status quo would threaten the continued existence of the family unit.

The Milan Team uses two main therapeutic techniques - positive connotation and the

paradoxical prescription of the status quo. Firstly the family members' motivation, values, judgement and perception of the situation need to be thoroughly understood. Then the "sacrifices and adaptations" that each family member has made to "preserve the psychological integrity of the other members and the relational balance of the whole family" (McFarlane, 1983b) is praised in a genuine, deeply empathic manner (Positive connotation). A paradoxical injunction follows naturally from the positive connotation, but is not necessarily made explicit. Although using a paradoxical injunction requires considerable subtlety and skill, it is basically a suggestion that all family members continue their present symptoms and interactional behaviour, in order to avoid more serious consequences.

Although there are few outcome data available for systemic family therapy for schizophrenia, a report (Jones, 1987) of approximately 90% success with 'acute' cases (first onset of psychotic symptoms/hospitalised on two or fewer occasions) and 30% success with 'chronic' cases (10-30 hospitalisations over many years) using a combination of the systemic (Selvini-Palazzoli et al., 1978) and strategic (Haley, 1980) approaches indicates that comprehensive outcome studies would be worthwhile. Jones' (1987) criteria for 'success' were that the patient should be symptom free, not readmitted to hospital or engaged in other forms of therapy during the four year follow-up period, and the "family relationships should have changed and eased to permit family members to get on with the ordinary business of living in a way that seemed satisfactory to them and to us" (p3).

An impressive study conducted in Heidelberg, Germany with another group of psychotic patients provides further support for the efficacy of a systemic family therapy approach. Retzer *et al.* (1991) report the

results of an average of seven sessions of family therapy over a period of 15 months with a sample of 30 families (20 diagnosed bipolar affective disorder and 10 schizo-affective disorder). Family therapy took place an average of six years after the onset of symptoms. They compared the relapse rate (average number of hospitalisations per annum) before family therapy with that in the three years after the conclusion of therapy. Statistically significant differences were found between the mean relapse rates before and after family therapy. There was a 68% reduction in the relapse rate in the 'manic depressive psychosis' sub-group and a 90% reduction in the 'schizo-affective psychosis' sub-group (total sample = 78%). Retzer *et al.* (1991) point out that their results (relapse rate changes in the three years after termination of therapy) are more powerful indicators of the efficacy of the intervention than the 9 and 24 month follow-up statistics reported in family management studies, especially as some of the family management studies include significant amounts of intervention in the "follow-up" period. However, they also report the number of relapses (hospitalisations) in the first nine months following the termination of family therapy (17%) to facilitate comparison with data from family management of schizophrenia studies.

The Heidelberg team have also made significant theoretical contributions in their description of the therapeutic process with this group of families (see also Stierlin *et al.*, 1986; Weber *et al.*, 1988). They note that a successful outcome was attained when they were able to relax family members' "rigid, objectified illness concept" (Retzer *et al.*, 1991: 146) and to help the patient to be regarded as less of a victim. It should be noted that the family therapy team operated independently of the usual psychiatric treatment of the patient. Retzer *et al.* (1991)

report that whereas all patients were on medication before family therapy commenced this had reduced to two thirds after therapy. They also noted a reduction in the use of multiple drugs.

Following a split in the original Milan Team in 1980, Selvini-Palazzoli and Prata deemphasised systemic hypotheses in the here and now, abandoned a basic tenet of the original approach (therapeutic neutrality) and adopted a powerful therapeutic technique which could perhaps best be described as a technique which aims to change the structure of the family. The “invariant prescription” (Selvini-Palazzoli & Prata, 1983) involves a direct instruction to the patient’s parents that they declare that the therapist requires them to keep a secret and subsequently to leave the house for increasing lengths of time. The formation of this secret alliance has a powerful effect on the (nuclear and extended) family’s interaction patterns (the ‘game’ metaphor is used), with the result that the parents’ hitherto secret ‘game’ is revealed and the identified patient’s psychotic behaviour is no longer required.

The technique does not appear to offer widespread applicability as it requires the therapist to be in a very influential position in relation to the family. In addition, after using the technique for seven years, the team realized that despite “yielding remarkable therapeutic effects in a considerable number of cases” it “might be harmful to others” and stopped using it in every case (Selvini, 1992 : 86). However, the importance of this work appears to lie in its contribution to developing an understanding of the etiology of psychotic symptoms. Selvini-Palazzoli and co-workers (Selvini-Palazzoli, 1986; Selvini-Palazzoli *et al.*, 1989) proposed that a child’s psychotic behaviour is the culmination of a six stage process. The process begins with a specific interaction between the couple

(“stalemate”) in which the child, who will become psychotic, actively interferes in an attempt to change the situation. The failure of the child’s attempts coincides, at the sixth stage, with his/her resorting to psychotic behaviour.

The child who becomes psychotic is “embroiled” in a relationship with the parent who is passive, the apparent “loser” in the couple’s “stalemate”. Although this relationship appears to be a coalition, there is in fact little to bind them except a “passionate, common interest” in the apparently dominant parent (the apparent “winner” in the couple’s game). The “imbroglio” is “characterised by reciprocal, seductive behaviour: verbalisations are absent or are poor and confusing” (p348).

A historical perspective (diachronic model) continues to be emphasised by Selvini-Palazzoli’s (new) team. However their latest theoretical position now emphasises the evolution of the ‘family game’ over successive generations and considers the developments of psychotic symptoms to be the “endmost link in an unconscious and self-defensive chain of inter-generational suffering” (Selvini, 1993). Families which have a pervasive tendency to distort reality are hypothesised to produce, in the third generation, someone who will deny any relational suffering at all - the psychotic person (Selvini, 1992). Realising the potential danger in using a method invariantly, in 1987/88 the team started to move away from the use of short-term strategic approaches such as forming a privileged therapeutic alliance with the parents (invariant prescription technique) and strove to form a long-term supportive therapeutic alliance primarily with the ‘patient’ but also with the other family members (Selvini, 1992; 1993).

The team’s theorising makes use of attachment theory (Bowlby, 1980) and object relations theory. The classic psychodynamic concept of idealisation is reformulated from

a relational perspective (cf Miller, 1981) as a distortion of reality. A focus for therapy is the way in which reality is distorted at five (overlapping) levels: parents' view of their families of origin; the parents' view of themselves; how the patient and his/her siblings see their parents; how the patient sees him/herself and the parents' view of the patient (Selvini, 1993). The parents of psychotic patients idealise their family of origin and themselves (denying any suffering) and conceal the pathology that affects the relationship between themselves and their son/daughter (the patient). They convey the myth to their off-spring that they are perfect parents and "conceal the very real trauma unintentionally and unwittingly inflicted ... on the offspring who will later need psychiatric treatment" (Selvini, 1993). It is the concealment of the abuse (eg. unconscious denial of the anger they direct toward these children or the denial of their neglect of their children's emotional needs) which sows the seeds for the later development of psychotic symptoms. The "formidable task" of therapy is to help the family members (the patient and his/her siblings as well as the parents) to stop idealising their families of origin and their own current relationships and to become more aware of past and present suffering - to "undermine the myths" (Selvini, 1992).

White (1987) emphasises the socially constructed nature of schizophrenia's course, concentrating on the circuits of feedback that ensure the survival of the "in-the-corner" life-style, rather than such issues such as 'etiology' or 'cure' (although he accepts that psychotic behaviour can be understood by means of a variety of etiological models). His particular contribution is his questioning technique which *externalises* the problem so that the family no longer sees the psychotic person as the problem, but rather sees the problem ("in-the-corner") lifestyle as the prob-

lem. In this way he challenges the notions of chronicity, incurability and deterioration inherent in the classification of the person as schizophrenic, and so he unites and empowers family members to find new solutions.

The Brief Therapy approach (Watzlawick, 1983) overlaps with that of the other systemic and strategic approaches (e.g. Milan school, Haley) but appears to offer a particularly useful therapeutic framework. Within this approach, problems (including those which become labelled as "schizophrenia") are understood as the result of failed attempted solutions. A mere coincidence or a practical difficulty becomes an insoluble problem as a result of the attempted solutions. In addition, the way crises are dealt with by mental health services is often counterproductive and "deviation amplifying". The model is optimistic in that it regards the only difference between acute and chronic problems to be the length of time these problems have been mishandled.

The brief therapist focuses on the current problem and attempts to change the pattern of interaction maintaining it. An example of this is how a parent, distressed by a child's bizarre behaviour may be 'over polite' and try to gently induce him/her to voluntarily change his/her behaviour. The son/daughter is likely to react to the indirect approach with an indirect or bizarre response ("I'm not really telling you what I want you to do"; "OK, I'm not really refusing either"). This, in turn, convinces the parents of the offspring's fragility and thus escalates the perceived need for indirectness in subsequent transactions (Fisch, Weakland & Segal, 1982:153-4). The aim of the brief therapist is "adequate functioning - a term that embraces a wide gamut of more or less successful adaptations to the ups and downs of life" (Watzlawick, 1983: 222) - it focuses on attainable goals rather than on any notion of cure.

Watzlawick (1983) cites the research of Langsley and his colleagues (1968) in Denver, USA, as being compatible with, and testing the ideas of, a brief therapy approach. Langsley *et al.* published the results of a controlled trial which illustrated that family crisis therapy with people requesting hospitalisation for psychosis was effective at preventing admission during the crisis and reduced the recidivism rate over the following six months: none of the family therapy group (N= 75) was hospitalised; all of the control group (N = 75) were hospitalised for an average length of stay of 26 days; percentage of control and family crisis therapy groups (re) admitted at one and six months = 17% vs 7%; and 21% vs 19%, respectively. The duration of family crisis therapy was approximately three weeks and consisted of an average of five sessions, a home visit and a few telephone calls. The goals of the therapy were to “aid in the resolution of the crisis, to assist the patient to re-compensate and to return to functioning at the previous level of adaptation”. All family members and significant others were seen immediately following the initial request for hospitalisation. “The history of events leading up to the crisis is obtained and the interactional aspects of the crisis are stressed. Efforts to avoid the family crisis by scapegoating one member and labelling him a ‘mental patient’ are blocked” (Langsley *et al.*, 1968:147). They employ a directive and supportive approach - reassurance and specific advice is given, tasks are assigned, and drugs are used for symptom relief in any member of the family. They argue that family crisis therapy has the effect of lowering the tension level in the family system and that this results in previously paralysed problem solving capacities being freed up. Conflicts can then be negotiated and symptomatic relief occurs in hours or days. From the beginning the family is told

about the short term nature of the treatment and that the team will continue to be available for any subsequent crises. Referral for longer term therapy of an individual or group within the family may also be made where indicated.

Also worth mentioning is the family therapy based approach developed in the London Borough of Barnett by R.D. Scott and co-workers (Scott & Ashworth, 1967; Scott, 1973ab, 1974; Scott & Starr, 1981). This well established service appears to have much in common with the family crisis therapy of Langsley *et al.* (see above). They have also made significant theoretical contributions with their description of the process of ‘closure’ and the introduction of the concept of the ‘treatment barrier’.

Scott and co-workers found that the hurt, despair, stress and conflict between the patient and his/her family during the period preceding the crisis which precipitates admission results in “some degree of dehumanisation of their bonds of relatedness” (Scott & Starr, 1981: 181). This shutting off from (unbearable) feelings and severance of the links between the patient and his/her family they termed ‘closure’.

Scott (1973 a,b) reports that in approximately 20% of individuals admitted to a psychiatric hospital the treatment of the relationship between the patient and his/her significant others is essential since these relationships form a severe obstacle to leaving hospital. In these cases the cultural view of mental illness prevailing in Western society forms a severe barrier to effective treatment as it enables the patients and their relatives to deny that they have any agency in their situation (“these unfortunate people are suffering from a disease; therefore they lack responsibility for themselves and psychiatric staff are obligated to treat them”). Scott and his colleagues cogently argue that the entry into the mental health system, and particu-

larly psychiatric diagnosis and admission, creates a (further) rift between the patient and his/her family because the frame of 'mental illness' makes it even more difficult to access the relationships which existed prior to the process of closure. Thus if the origins of the psychiatric symptoms lie within these relationships they cannot be explored and resolved. Thus, entry into the "field governed by political laws, social attitudes and cultural values ... creates a barrier to treatment, the effect of which is to establish chronicity, to maintain illness" (Scott & Starr, 1981: 179).

As a result of these insights Scott and his colleagues developed a new therapeutic approach which attempted to resolve the crisis without resorting to admission, in order to prevent the severance of relationships and to challenge the passive 'mental patient' role which many people adopt after admission (eg. they ask the patient what he/she wants from being in hospital - and insist on a reply). They noted that 90% of psychiatric admissions occurred following a crisis and that many patients were not seeking treatment but rather sought to escape from an intolerable situation.

This approach has been extremely effective in reducing admissions and chronicity: from the introduction of the service in 1970 admission rates were halved from 38.2 per 10,000 to 19.3 in 1974; and stays in hospital of a year or longer were reduced from 3.5 to 1.75 per 10,000 per annum (Scott & Starr, 1981). The work of the Scott group has also shown that the part played by the patient in the relationship between them and their parents is a key factor in outcome. (They have studied outcome in terms of crisis, social and work functioning, and relapse - although the relapse figures have not been published to date (Scott, Fagin & Winter, 1993)). They have shown that when patients perceive their parents as "ill", this tends to threaten the self-

concept of often vulnerable parents and leads to the rejection of the patient. It is this group of patients who become chronically hospitalised (Scott, 1974; Scott & Alwyn, 1978).

'Family management' approaches

These approaches developed in reaction to the earlier family therapy models which appeared to imply that there was an identifiable type of family uniquely and ubiquitously associated with schizophrenia. Many (e.g. Terkelsen, 1983; Anderson, Reiss & Hogarty, 1986; Falloon, Pederson & Al-Khayyal, 1986) criticised the family therapy approaches for suggesting (implicitly if not explicitly) that families cause schizophrenia, thereby causing families to feel pain, guilt and anxiety.

The family management (FM) approaches, although largely empirical in nature, are based on the stress-vulnerability model of schizophrenia (Zubin & Spring, 1977). In essence this model proposes that psychotic symptoms arise as a consequence of environmental stress interacting with an individual's (genetic) predisposition to develop schizophrenia. An individual with a substantial predisposition would manifest psychotic symptoms when exposed to relatively little environmental stress, whereas someone with relatively little predisposition would require a substantial amount of environmental stress to be pushed over the threshold into schizophrenia (see Figure 1).

Although stress-vulnerability models are accepted by most family intervention practitioners, McFarlane & Beels (1983a) identified two "opposing ideologies" which tend to dominate the treatment programmes of workers within the FM and FT camps. FM workers tend to accept a disease/medical formulation of psychosis whereas family therapists base their work on communication/interactional models of psychosis. McFarlane & Beels (1983a) roughly summarised the

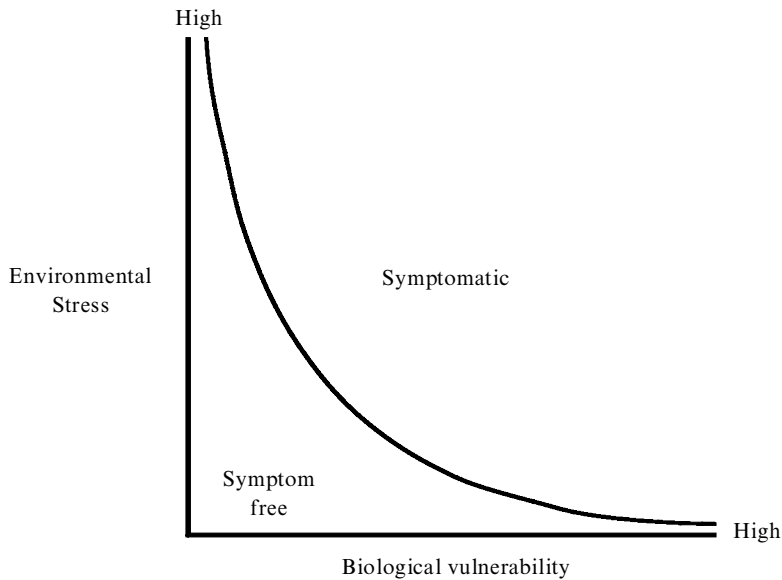


Figure 1: The stress-vulnerability model of schizophrenia (Zubin & Spring, 1977) which proposes the relationship between biological vulnerability and environmental stress.

difference between the two models as follows:

“...The medical model sees schizophrenia as a collection of psychiatric syndromes occurring in constitutionally vulnerable people. It regards diagnosis as important, and medication and hospitalisation as helpful in the acute phase. The communications model lumps schizophrenia together with many other severe problems of youth, such as addiction or anorexia; calls them all problems of differentiation within the family system; and avoids diagnosis, medication, and hospitalisation as all tending to victimise and/or institutionalise the patient in the sick role.” (p321).

The contributions of Brown, Leff, Falloon, Anderson, TARRIER, Goldstein, and others will be discussed. A factor that distinguishes these contributions is their research orientation; the results of their outcome studies are summarised below.

Brown and his colleagues (1962, 1972) have been very influential in that their initial findings and their research measure of ‘expressed emotion’ (EE) precipitated most of the family management research. In their studies a number of family interactional and emotional phenomena have been consistently linked with the schizophrenic patient’s tendency to relapse, apparent need for medication and vulnerability to ‘life events’. Expressed emotion is a composite measure of relatives’ reported attitudes and behaviour toward the patient derived from an analysis of an audio tape of a semi-structured interview. During the development of the measure the relatives’ emotional responses were rated on various subscales (critical comments, hostility, emotional over-involvement (EOI), dissatisfaction, warmth, and positive comments) but only the first three are now used to rate EE as these were the most powerful predictors of relapse. As the originators of the measure acknowledged, “‘ Expressed

emotion', therefore, has a mainly negative connotation" (Brown *et al.*, 1972: 253). EE is a dichotomous measure, and relatives are rated high or low on the basis of scores above specified cut-offs on any one of the indices of criticism, EOI or hostility (cf Leff & Vaughn, 1985). Vaughn & Leff (1981) have refined the concept of EE by specifying the following associated behavioural characteristics: intrusiveness; anger and/or acute distress and anxiety; overt blame of the patient; marked intolerance of symptoms and long term impairment.

The EE measure is not specific to schizophrenia (High EE has been shown to be related to relapse in a number of mental health difficulties/illnesses - e.g. depression) and any suggestion that it is involved in the initial breakdown is de-emphasised in family work based on the concept.

Vaughn & Leff's (1976) study reported that schizophrenic patients returning to low EE homes have a much lower relapse rate at nine months (13%) than have those who return to high EE homes (51%). They found that for those patients returning to high EE families the amount of contact (less than 35 hours contact: 28% relapse; greater than 35 hours: 69%), as well as neuroleptic medication, significantly affected relapse rates. The treatment principles which have been derived from this research involve enlisting the family's help to ensure compliance with neuroleptic medication, and working with the family to reduce their criticism of, and over-involvement with, the patient.

Leff and his team conducted controlled trials (Leff *et al.*, 1982, 1985, 1989, 1990) of interventions aimed at reducing EE. The interventions consisted of education about schizophrenia (given to families without the

IP present), a relatives' group (patient not present) and family sessions which included the patient. The family sessions focused on management problems, using structural and behavioural techniques, as well as homework tasks (Berkowitz, 1988). There was no statistically significant difference between the education plus family therapy and the education plus relatives' group interventions, but the combined results of the experimental groups clearly indicate the efficacy of the interventions (relapse rates at nine months: 9% experimental group vs 50% control group; two years: 40% vs 78% - sample size = 24).⁴

Falloon and his colleagues (1982, 1985) conducted a number of controlled trials of their family-based management approach for schizophrenia. Relapse rates at nine months (6% of patients in family management group relapsed vs 44% of patients in the individual therapy group) and two years (17% of family management group relapsed vs 83% of the individual therapy group - sample size = 36), clearly indicate that the approach is effective at preventing further escalation or exacerbation of schizophrenic symptoms.

Falloon hypothesised that "schizophrenic symptoms become manifest when a person is overwhelmed by situational challenges that he or she does not have the interpersonal coping skills to handle. Thus, relapse of schizophrenia may be determined by the balance between life stress and problem solving behaviour" (Falloon & Liberman, 1983: 126).

Their 'behavioural family intervention' or 'problem solving approach' is based on this model. The family therapy sessions are conducted in the home with the whole family present. They consist of three main components - education, communication training and problem solving training. The family is

⁴These figures, as well as those given for the studies of Falloon *et al.*; Anderson, Hogarty *et al.*; and Tarrier *et al.*, are taken from the review by Lam, 1991. (The original papers do not necessarily report their findings in precisely comparable ways).

trained to employ a structured problem solving method and trained in the use of a range of specific behavioural strategies (e.g. social skills training, token economy programmes, contingency contracting for parental discord). Problem solving methods require competent communication skills and thus these are taught if necessary (e.g. active listening skills, directly expressing feelings, making requests).

Anderson, Reiss & Hogarty's (1986) psychoeducational programme for families of patients with schizophrenia is based on the assumption that these patients appear to have a 'core psychological deficit' which appears to increase their vulnerability to internal and external stimuli. Patient vulnerability to stimulation and family anxieties/disturbed communication patterns are thought to interact to a patient's disadvantage in a spiralling manner.

Their programme "attempts to decrease a patient's vulnerability to stimulation through the administration of psychotropic medication, and to decrease the amount of stimulation provided by the patient's family, the primary context within which the patient functions". The programme adopts a directive approach that provides families with "support, information, structure, and specific coping mechanisms for use in dealing effectively with psychotic family members". (Anderson, 1983:100-101)

The programme of family intervention has four phases:

- I. Formation of an alliance between the family and the therapist soon after inpatient admission;
- II. A group of families attend a one day 'survival skills workshop' which provides them with information about schizophrenia and its management (emphasising limit setting, decreasing expectations and developing support networks);

III. Highly structured, low key individual family (including patient) sessions are held every two-three weeks for a year or more. The aim of the sessions is to strengthen interpersonal and inter-generational boundaries within the family, diminish the boundary between the family and the community, and gradually encourage the patient to assume more responsibility for his or her life and functioning;

IV. Once the goals for effective functioning have been attained the family is offered 'traditional family therapy' (to resolve long term family conflicts/unresolved issues), or periodic supportive sessions of gradually decreasing frequency.

Research into this approach (Anderson *et al.*, 1986; Hogarty *et al.*, 1986, 1987) compared a variety of treatment conditions and found that the family programme and social skills training were both effective at reducing relapse, while a combination of the two was even more effective (relapse rates for family programme, social skills programme, family plus social skills, and medication control group at one year were: 23%, 39%, 9%, 49%; and at two years: 34%, 42%, 25%, 67% - sample size = 103).

Tarrier and his co-workers (1988, 1989) adopt a detailed behavioural analysis approach. Families are taught to identify goals and establish procedures to achieve them. (Such goals may include effective communication). Relatives are also explicitly taught relaxation and other cognitive-behavioural techniques to control their anxiety.

Their research clearly indicated that behavioural family treatment (plus medication) is superior to education (plus medication) or routine medical treatment (relapse rate for high EE patients in the above groups at nine months were: 13%, 43% and 53% respectively; and at two years: 33% behaviour treat-

ment group vs 59% control). Tarrier (1989) hypothesised that schizophrenic patients had deficits in information processing and arousal regulation mechanisms. Complex, vague or emotionally charged environments (e.g. a high EE family) thus resulted in information overload and the reappearance of positive symptoms (e.g. hallucinations, delusions).

The crisis-oriented family therapy approach of Goldstein and colleagues (Goldstein *et al.*, 1978; Kopeikin, Marshall & Goldstein, 1983), although similar to the other approaches described above, involves significant differences. It does not involve an educational component (about schizophrenia) and is therefore applicable to most forms of acute psychosis (McFarlane & Beels, 1983b). Their crisis oriented family therapy is provided in six weekly sessions following discharge from inpatient treatment. Neuroleptic medication is prescribed in all cases. The initial focus in the sessions is on developing realistic recovery expectations (the family are told that recovery often takes six to twelve months), exploring the psychosis (helping the patient and family to accept the fact that he/she has had a psychosis; identifying some of the probable precipitating stresses), and explaining the need for stress control. The therapy sessions have the following sequence of objectives:

- I. Identifying the two or three current stresses to which the patient and his/her family are most vulnerable;
- II. Developing strategies to prevent stress and cope with it;
- III. Implementation of these strategies by the family, evaluation and refinements of the strategies;
- IV. Planning how to minimise or avoid anticipated future stresses.

They report that although they spent an average of 1.5 sessions on each objective, this was not sufficient for some families.

Underlying their treatment appears to be the belief that helping the patient and significant other to accept and use the events of the psychosis, rather than “sealing it over and deflecting the attention away from the psychotic episode” (Goldstein *et al.*, 1978:1170), in combination with medication, will result in a decreased risk of relapse and help to reduce the risk of repeated periods of hospitalisation. They recognise that the crisis oriented family therapy has a circumscribed focus and, while effective in the short term, further interventions (e.g. improving family relationships; promoting vocational rehabilitation) are indicated.

Their results are encouraging - in six weeks none of the high medication dose plus family therapy group had relapsed, 24% of the low dose + no therapy group relapsed, while there was no significant difference between the high dose + no therapy group (10% relapse) and low dose + therapy group (9%) - sample size = 96. Although the results of the six month and three year relapse rates are unreliable (Barrowclough & Tarrier, 1984) it is worth noting that the trends found at six weeks appear to have been maintained initially, but not over a longer period.

Comparison between the two approaches

Causation and blame

The debate between the F.T. and F.M. approaches arose out of an unsophisticated lineal understanding of causality. The association between schizophrenia and impairment in the family led to the postulation of theories which implied, or appeared to imply, that certain families ‘caused’ schizophrenia. Understandably, families felt blamed by family therapists who held such views. The F.M. approach was an attempt to develop a “non blaming” alternative formulation. As a re-

sult, an overly simplistic dichotomy arose - F.M. adherents proposed that where there was impairment in family functioning this was 'caused' by the schizophrenic individual, contrasting this with the perceived F.T. position that impaired families 'caused' schizophrenia in their offspring. These simplistic causal models explain how people within the F.M. and F.T. traditions came to concentrate on different aspects of research and theory - research into the family characteristics related to relapse in schizophrenia, and research into the family characteristics precipitating schizophrenia, respectively.

It is now generally accepted that the EE and communication deviance (CD) studies, which were discussed earlier, offer clear evidence that relapse in schizophrenia (re-emergence or exacerbation of symptoms) is related to family (especially parental) characteristics. It is perhaps less well known that rigorous research investigating the family factors prevalent prior to the onset of overt schizophrenic symptomatology has also been carried out.

A prospective longitudinal study by Doane *et al.* (1981) provided evidence that family attributes measured during adolescence are associated with the subsequent presence of schizophrenia or schizophrenia-related disorders in the young adult; (65 non psychotically disturbed adolescents were followed up for five years). They found that the children of parents who exhibited both high CD and negative affective style (AS), a measure somewhat similar to EE, manifested schizophrenia spectrum disorders on follow up.

They emphasise that these parental characteristics were measured at least five years prior to the onset of schizophrenic symptomatology and are "therefore clearly not reactive to the presence of psychosis in offspring", but warn that "one cannot assume

from these results that they play an etiological role in the development of schizophrenia" (Goldstein, 1983:9). On the basis of studies of EE, AS and CD, Goldstein (1983) is able to conclude that "families in which significant others, usually parents, express strongly critical and/or emotional overinvolved (intrusive) attitudes are at higher risk for onset of and relapse for schizophrenia" (Goldstein, 1983:17).

McFarlane & Beels (1983) argue that "the correlation of any one factor or dimension to schizophrenia says very little about the direction of causality, or even whether the concept of causation is relevant" (p321-2). They argue that the 'medical model' and the 'communications model' are not mutually exclusive, and that most thoughtful practitioners use aspects of both. It appears, therefore, that the difference between the two approaches in terms of the direction of causation is largely a matter of emphasising different aspects of a circular process. McFarlane & Beels (1983a) propose a circular multi-variate model of schizophrenia to integrate the various family factors associated with schizophrenia.

Acceptance of the concept 'Schizophrenia'

An often heated debate regarding the validity of the diagnostic label of schizophrenia frequently accompanies and confounds the debate between the F.T. and F.M. approaches. Family therapists tend to agree with writers such as Bentall, Jackson & Pilgrim (1988) that schizophrenia is not a valid scientific construct. In addition, many family therapists (eg. White, 1987) are concerned about the potentially harmful effects of using psychiatric diagnoses such as schizophrenia because of the stigma associated with the term and the negative connotations it has in terms of severity, chronicity and the need for life-long medication. Family therapists thus tend

to use the term schizophrenia in quotation marks. Unfortunately the use of quotation marks tends to antagonise some of the more medically-orientated family management adherents (eg. Leff & Vaughn, 1994). Other F.M. workers, however, acknowledge the difficulties inherent in the concept of schizophrenia but argue that it should be retained for practical, heuristic reasons (eg. Barrowclough & TARRIER, 1992; Birchwood & Shepherd, 1992). The debate concerning the validity of the syndrome of signs and symptoms that is called schizophrenia will no doubt continue. However, it should not detract from the importance of contributions made by both F.T. and F.M. researchers to the development of family based interventions where one person is experiencing psychotic symptoms.

Research vs Theory

A major difference between the F.T. and F.M. approaches is their emphasis on empiricism vs theoreticism. Johnstone (1993) has recognised that the achievements of the two approaches are complementary but argues that family management researchers cannot afford to acknowledge the similarities between them because it would threaten the professional position of psychiatrists. It is nevertheless hoped that, despite ideological differences, a move toward integration of the two approaches will take place.

A strength of the family management approach is its empirical research basis, which has proved extremely effective in convincing mental health professionals of the value of family-based (psychosocial) interventions in schizophrenia. Thorough research has proved the efficacy (in terms of reducing stress within the family and thus delaying relapse and/or ameliorating symptoms) of family management - although its effectiveness has not yet been proved on a widespread, routine clinical

basis (Kuipers, Birchwood & McCreadie, 1992).

However, the empirical, atheoretical nature of these approaches also constitutes a weakness. Birchwood points out (in Kuipers *et al.*, 1992) that such approaches do not necessarily advance the efficacy of treatment and calls for theoretical innovation. "It is... the absence of models of the family interior underlying EE (other than the general stress - vulnerability model) that is responsible for the apparent diversity of interventions" (p273). Lam (1991) points out that "despite nearly thirty years of research, EE remains an empirical concept, the origin of which is not understood" (p437).

Issues of lineality and circularity

It is proposed that Lam's (1991) lament is largely the result of EE's unidirectional nature - it is an index of relatives' behaviour (critical comments, hostility, emotional over involvement) towards schizophrenic patients. In addition, its subsequent extensive use in F.M. research, which has established that relatives' EE status is related to patient relapse, has reinforced a lineal conceptualisation of EE. The lineal thinking has predominated for almost two decades despite the fact that the originators of the EE measure recognised that a "circular effect" between the patient's disturbed behaviour and the relatives' expressed emotion "seems much more probable" than a model "in which the degree of expressed emotion is held to be primary" (Brown *et al.*, 1972: 255).

The unidirectional nature of the EE measure and its subsequent use in research studies has resulted in criticism from systemic thinkers such as family therapists (eg. White, 1987). Family therapists regard the emotional climate within a family system as reflecting the interactional processes within it. The systemic analysis employed by family therapists

involves a completely different understanding of causality - 'reciprocal' or 'circular' causality is the concept used to describe how the elements in a (family) system continuously influence one another. Such a view appears to be potentially more fruitful than adhering to unidirectional models, which implies that schizophrenia's origins can only be sought in terms of genetic or biological factors.

The concepts developed by the family management approach are understandable within a historical context of an initial desire to distance the approach from early family therapists' theorising, but it appears to have prevented advances in the understanding of the nature and development of high or low EE families, and their treatment. However, rigorous research more recently conducted in the USA (Miklowitz *et al.*, 1989; Strachan *et al.*, 1989, Hahlweg *et al.*, 1989) suggests that EE does indeed measure a transactional process. Strachan *et al.* (1989) proposed that EE reflects "transactional patterns between relatives and patients that are reciprocal in nature, rather than linear and unidirectional, as was the original EE concept" (p180). This research appears to have great clinical significance. For example, the finding that high EE critical families showed a stronger pattern of negative escalation (Hahlweg *et al.*, 1989) indicates the need for family system intervention. The reviews by Tarrier (1991), Birchwood (1992) and Kavanagh (1992) indicate that the transactional models of EE are beginning to supersede the earlier (unidirectional) models. Based on studies by the research group which contains Goldstein, Miklowitz, Strachan, Nuechterlein and others (Miklowitz *et al.*, 1989; Strachan *et al.*, 1989) Tarrier concluded:

"These results ... argue against a trait model of EE and support a conceptualization of EE as representing coping and response styles

that develop over time and interact with the patient's behaviour" (p321).

Birchwood (1992) similarly concluded that: "The concept of a developmental dimension to EE and the transactional processes that take place between patient characteristics and family behaviour is taking an increasingly central position in theorising" (p297).

Kavanagh (1992) also concluded that:

"... the evidence appears to be pointing to a model that incorporates reciprocal influences between symptoms and the reactions of other people" (p611).

He proposes an "interactive model of EE and relapse" which is a variant of the stress-vulnerability models of schizophrenia. (Such models have been developed since Zubin & Spring's (1977) seminal paper). Kavanagh's (1992) model, which takes account of "patients' biological vulnerability, cognitive processes and skills, and describes the interaction between these factors and their social context" (p611), is illustrated in Figure 2. He suggests that patients' symptoms and other problem behaviour elicit a variety of responses in significant others, commonly including frustration, distress and concern. In attempting to cope with the patients' behaviour relatives sometimes interact in a way that patients perceive as critical or intrusive. Patients are then likely to react in a negative way. In this way the patient's sensitivity to negative emotions is heightened, symptoms are exacerbated and they are less able to function effectively. Kavanagh points out that such destructive feedback loops do not only occur through an increase in psychotic symptoms, but can be created by negative responses by either of the parties involved. If such interactions occur frequently "social perceptions are coloured by expectations and coping strategies may be automatised with the result that cycles of interpersonal distress

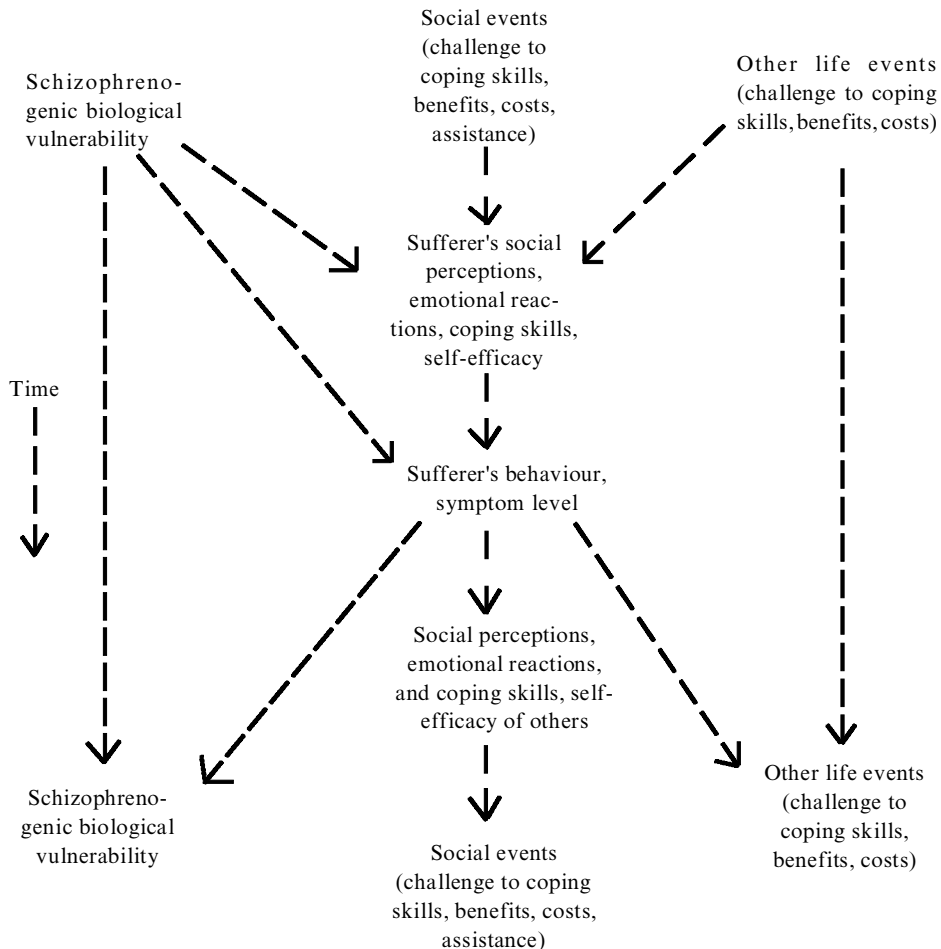


Figure 2: An interactional model of the course of schizophrenia, describing the reciprocal dererminism of risk factors through time (Kavanagh, 1992)

and symptom development are unwittingly repeated” (p612).

Kavanagh’s model appears to provide a potentially useful framework in that it integrates the more sophisticated systemic formulations with the impressive findings of the research using the EE measure. Researching the hypothesised links between various aspects of the model will no doubt present enormous challenges as the model reflects a complex interplay of factors and biological vulnerability is not measurable at present.

Nonetheless Kavanagh’s contribution is a valuable one and should act as a spur to further research and theoretical development.

Should EE form the basis of further research and theorising?

EE measures have enabled research into family interventions which “may prove to be the most significant treatment breakthrough in schizophrenia since the discovery of neuroleptic medication” (Kavanagh, 1992: 616). It has, however, widely come to be

regarded as a unitary concept - clinicians and theorists describe families as displaying "high or low EE" - despite the fact that this is a classification which may be obtained through various behavioural ratings. It is suggested that due to the confusion surrounding EE it may have outlived its usefulness.

Goldstein (1983) reported the results of a re-analysis of Falloon's data by Miklowitz (1981) and suggested that EE should be broken down into sub-styles. Miklowitz found that patients from families where the mothers displayed emotionally-over-involved attitudes had a significantly poorer pre-morbid adjustment than patients whose mothers were highly critical or low EE. Patients from environments defined as high EE solely on the basis of emotional-over-involvement were significantly more symptomatic at discharge than were those coming from families defined as high EE on the basis of critical comments.

Concepts such as affective style (AS), communication deviance (CD) or other family therapy concepts such as "enmeshment" are likely to provide greater impetus for the development of more sophisticated theories. It has been suggested, for example, that the concept of affective style (AS), which is derived from directly observed family interactions, may be more theoretically useful than the concept of EE (Goldstein, 1983). AS index components such as criticism, guilt inducement and intrusiveness can be construed as interpersonal analogues of certain dimensions of the EE measure.

Similarly, the concept of communication deviance (CD), which is measured by an individual projective test administered to the parents, has also been found to have interactional correlates. CD is related to "family units generally lacking in effective paternal participation, which are poorly organised to deal with emotional material, and

which show signs of marked interpersonal tension between parent and teenager" (Goldstein, 1983:12).

McFarlane & Beels (1983a) suggest that EE measures aspects of interactional process which create and/or maintain enmeshed or disengaged relationships. Minuchin's (1974) concept of 'enmeshment', in turn, appears to draw on "earlier ideas such as Bowen's 'undifferentiated ego mass', Bateson's 'double bind' hypothesis (specifically the inability to leave the interactive field) and Boszormenyi-Nagy's 'family loyalty', ...shares with EE an emphasis on over-closeness, poorly-defined intra-family boundaries, and high emotional reactivity and intensity" (McFarlane and Beels, 1983a:313). They argue that both constructs imply communication problems, inadequate problem solving and poor conflict resolution and that "while the overlap is not complete, clinical experience strongly suggests that the two constructs describe a common set of characteristics in many disturbed families" (p313). They point out that the advantage of the concept of enmeshment, as opposed to EE, is that it is more systemic (everyone in the family is affected by it) and it is less blaming (everyone is equally entrapped in the process - no one is at fault). McFarlane & Beels (1983a) noted that Wing (1978) proposed using the concepts of 'disattention' or 'disengagement' (the opposite of enmeshment) to understand the negative symptoms of schizophrenia (withdrawal and apathy).

With growing maturity in research and theory in the field of family interaction and schizophrenia, it is increasingly likely that models which integrate the family management and family therapy approaches will be developed. One example is the model proposed by McFarlane & Beels (1983a). They describe a multivariate circular model of positive feedback processes (Figure 3).

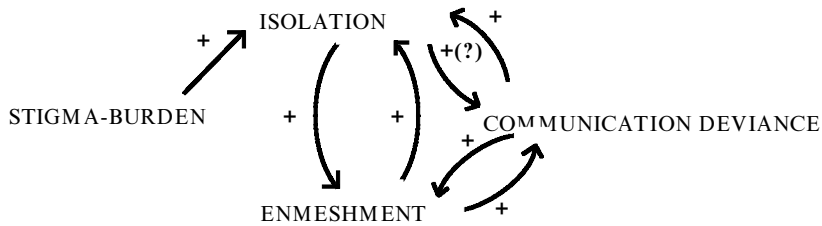


Figure 3: A multivariate circular model of positive feedback processes (McFarlane & Beels, 1983a)

They summarise the complex, and in some cases speculative, relationship of each of these factors to a presumed constitutional vulnerability as follows:

- “1. Enmeshment (EE) is a coincidental factor, completely nonspecific, yet has a powerful effect on course of illness.
2. Isolation may pre-date the initial episode, thus perhaps contributing in a minor way to the onset of the illness, while it is clearly exacerbated by the social processes that follow from it.
3. CD, in the presence of enmeshment, may be a contributing factor to onset, while it has been speculated that it is at least partially an effect of an underlying heritable disorder.
4. Stigma and burden have to be considered an effect of the patient’s illness, yet highly specific to it.” (p319).

They point out that “the convergence of all four (factors) would be likely to occur in association with schizophrenia” but that “schizophrenia will not necessarily be associated with any one factor, or even with all four together” (p320).

It is surprising that McFarlane & Beels’ model has not been more fully evaluated in the decade since it was proposed. The model is largely testable although, of course, constitutional vulnerability is not yet measurable and enmeshment needs to be defined in a more clear, testable manner. Minuchin’s (1974) description of enmeshment poten-

tially provides the basis of a research instrument - eg. “capacity for independence”, “feelings of loyalty and belonging”, “capacity for interdependence and for requesting support when needed” (p55), problem solving style, and the sensitivity of family members to any one individual members’ actions. The author hopes that researchers in the field will take up the challenge.

Conclusions

On reviewing the family therapy and family management literature it appears that there are now many similarities in the models of theory and therapy despite the historical antagonism. Now that the family management research projects have established the value of family interventions in schizophrenia, it is hoped that greater theoretical sophistication can occur. Kavanagh’s (1992) and McFarlane & Beels’ (1983a) models deserve further investigation. Both appear to provide hope for the further construction of theoretical models which develop and extend the stress-vulnerability model and systemic/transactional (FT) theories. It is suggested that an understanding of the epistemological issues underlying theory and research about schizophrenia and the family (cf. Dell, 1980) will aid in this endeavour.

Having established that family management interventions in psychosis can be of considerable benefit, the author now chal-

lenges researchers to examine the efficacy of family therapy approaches more clearly. Although it would be a considerable improvement on traditional medical approaches if F.M. was to be widely adopted, it is hoped that the concentration of research effort on F.M. will not preclude further research into approaches which might hold out the possibility of even better outcomes, and that the wider professional and political issues (cf. Johnstone, 1993) will not prove to be insurmountable obstacles.

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A family intervention in psychosis service integrating the systemic and family management approaches

Frank R. Burbach^a and Roger I. Stanbridge^b

A project to establish new family intervention services to support people with psychotic symptoms and their families is described. The new services are developed by training a whole team in each main population centre. The multidisciplinary training course and the family intervention service are described, and the way in which we integrate the 'family management' and 'family therapy' approaches is discussed.

Introduction

It is widely recognized that care in the community is based on a partnership existing between statutory services and carers/families/relatives. There is currently a great deal of concern being expressed by user groups and mental health organizations (Mind/Sane/NSF) about the fact that families feel unsupported, carry too great a burden of care, and that communication between services and families is often poor. Research has also shown that the home environment can have a significant positive or negative impact on relapse rates for severe mental health problems (Brown *et al.*, 1962, 1972). Despite a large number of impressive controlled studies demonstrating the efficacy of family interventions in severe mental health problems (cf. reviews by Burbach, 1996; Dixon and Lehman, 1995; Goldstein and Miklowitz, 1995; Lam, 1991; Mari and Streiner, 1996), there have been relatively few initiatives with families in routine clinical settings (Kuipers *et al.*, 1992).

In Somerset, as in other areas of the UK, large Victorian hospitals have been closed and replaced by smaller, more locally accessible units. Services continue to evolve, but supporting the needs of families in cases where a member has severe mental health problems is

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acknowledged as a priority. Fortunately, we have a tradition in Somerset of working with families with a wide range of mental health problems, including psychosis (cf. Brennan and Challenger, 1996; Procter, 1985, 1986; Procter and Pieczora, 1992; Procter and Stephens, 1984). It is in this context that a new accessible, flexible family support service is being developed.

The Family Support Service

Over the next five years we plan to establish a specialist service, supporting families where a member experiences psychotic symptoms,¹ in each of the four major population centres in Somerset (Yeovil, Taunton, Bridgwater and Wells). The Family Support Service will complement the existing local services (acute inpatient ward; community mental health team(s); rehabilitation day centre; residential units) in each area. The aim of the service is to support families in specific ways, according to the individual needs of each family. This is done in a collaborative manner with the sufferer and his or her family, following an assessment process where needs and goals are agreed. One of the main aims of the service is to help families identify helpful ways of dealing with the specific problems they encounter, including strategies for coping with psychosis. The other main aim is to help family members look after their own, as well as each others' needs. All families are given an information leaflet about the service, which offers a range of ways in which the service might be of assistance (see Table 1).

The objective of the service is to intervene as early as possible but it also works with well-established cases. This means that we often see the sufferer with his or her parents and siblings, but we also see sufferers and their partners. We include children as appropriate. Attendance at sessions is negotiated with each family and varies according to their specific needs/wishes. Early intervention is likely to lead to a better long-term outcome for psychotic disorders (Birchwood *et al.*, 1997) and many who work with families would agree that early intervention is preferable (Burbach, 1995). Entry into the Family Support Service is therefore determined by the presence of psychotic symptoms rather than the confirmation of a particular diagnosis.

¹ The service has already been established in the Wells/Burnham-on-Sea service area.

TABLE 1 *Extract from the Family Support Service leaflet*

What sort of help can the service provide?

- To build on family strengths and resources.
 - To identify helpful strategies for dealing with specific problems.
 - To help the sufferer and family members to understand the symptoms.
 - To provide information about psychosis and stress.
 - To help families reduce levels of stress while also providing appropriate stimulation.
 - To identify particular strategies for coping with psychotic symptoms.
 - To help in maintaining and improving relationships and communication within the family.
 - To help family members balance the burden of caring with attention to their own needs.
 - To support family members and to encourage them to maintain hope.
 - To help families plan for the future.
 - To help families to access appropriate services.
 - To help maintain clear communication between the family and the mental health services.
-

Two members of the Family Support Service are allocated to each family. Families are seen in a variety of settings including inpatient units, community units and people's homes. Meetings are by arrangement, according to need. A co-therapy model is used and all members of the service meet monthly for supervision and to deal with administrative matters.

The service is provided by existing staff drawn from the range of units. This multidisciplinary group will, in addition to their particular professional training, also receive specific training in this area of work. It is to this end that we have established the Family Interventions (Research, Skills, Theory) in Psychosis Course.

Family Interventions: Research, Skills, Theory (FIRST) in Psychosis Course

The course has two main aims. First, to teach basic family intervention theories, skills/techniques and research findings to multidisciplinary groups of staff.² Second, to train a team that will deliver the local Family Support Service. The course philosophy is based on an

² The first two groups have included staff nurses, community psychiatric nurses, social workers, a clinical psychologist and a clinical medical officer.

integration of the family therapy and family management approaches to severe mental health problems (cf. Burbach, 1996).

The course consists of three twelve-week modules spaced over one year. Students attend nine half-days and three whole days per module, and further home study is required. Each module is assessed by means of a written assignment and key learning/skills ratings. The course is accredited by the Institute of Health Studies, Plymouth University, at degree and diploma level, the English National Board for Nursing (ENB A28), and the Association for Family Therapy (foundation level).

The first module covers basic theories of family functioning (for example, systems theory; family life cycle; family structure and beliefs) and basic skills training (for example, engaging families; interviewing skills; goal setting). The second module presents research findings in relation to family interventions in psychosis, evaluates the contributions of the family therapy and family management approaches, and introduces their core techniques. It also includes consideration of issues such as user empowerment, self-help groups, hospitalization, medication, education and a review of government reports into mental health services. The third module focuses on the application of family intervention theories and techniques in mental health settings. Basic cognitive-behavioural techniques for working with hallucinations and delusions are introduced, together with further consideration of therapeutic techniques such as task setting, genograms, reframing and active techniques. Issues that are common to all three modules include gender, cultural and sociopolitical perspectives.

Students begin supervised work with families midway through the second module. Where possible, this is done using a team approach involving one-way screen, earpiece and video. Although the Family Support Service itself does not revolve around the traditional family therapy clinic format, we have found it particularly useful for training purposes. The team's identity begins to form as the new clinical service is launched within the context of the training course. This aspect is significantly different to most other courses, which tend to provide education and training to individuals in a manner that is difficult to generalize to their work setting. The advantage of our training approach is that trainees are able to practise and develop their new-found skills, because they receive ongoing supervision and have the support of a team of colleagues

who have had the same basic training. (For further consideration of these issues see Quarry and Burbach, 1997.)

The other significant feature of the FIRST course is in the integration of the family therapy and family management approaches. To the best of our knowledge, other courses teaching family intervention with this client group have used family management approaches exclusively. Whereas it is acknowledged that the manualized treatment approaches are more easily taught, it appears that they are not sufficiently flexible to respond to the range of needs presented by families. This has led us to develop our own integrated approach to family interventions in psychosis.

The Family Support Service approach

Individualized

Research (Fadden, 1997; Kavanagh *et al.*, 1993) has shown that therapists trained in family interventions have difficulties in putting the new skills into practice. This seems to be related to service issues such as the lack of like-minded trained colleagues and the absence of a supportive structure in the workplace but, in addition, appears to reflect deficits in the training process itself. Fadden's survey of eighty-six therapists who had undergone behavioural family therapy (Falloon *et al.*, 1984) training in Buckingham found that the main difficulty encountered by therapists in putting family interventions into practice was a 'lack of availability of "suitable" or appropriate families'. She urges that the issues surrounding therapists' criteria for 'suitable families' and the process of engaging families be addressed in training.

Informal discussion with colleagues who have been on family management courses has revealed that many therapists believe their new skills/knowledge do not equip them to work with the range of families they encounter. This is not surprising, given that families where a member experiences psychotic symptoms are often severely traumatized and, by the time they are in contact with mental health services, are often functioning poorly (Terkelsen, 1987). Indeed, Hatfield (1990) and Marsh (1992) have described the development of severe mental illness as a 'catastrophic event' for families. In considering a respectful approach to families, treatment protocols that were originally developed for research purposes and which are taught on many family intervention

courses appear insufficiently responsive to the needs of individuals within the range of families.

On the FIRST course in psychosis, trainees are taught basic family therapy theories and skills in order to enable them to form therapeutic relationships with a wide range of families, and to agree an intervention plan with the family which will meet their particular needs. In some cases this has included exploration of the nature and origin of the psychotic experience, developing strategies for coping with these symptoms, clarifying communication to avoid misinterpretation, helping family members express their feelings of loss following psychotic symptoms, helping parents implement solutions to problems which they have identified, and enabling families to negotiate family life-cycle stages such as 'children leaving home'. This individualized approach with families both enables and requires a close collaborative relationship between therapist and family.

Collaborative

Most of the recent family intervention approaches have been tailored to those clearly diagnosed as having schizophrenia and have included sessions aimed at helping family members to better understand, and adjust to, this disorder. In addition to such educational sessions, some approaches (e.g. Falloon *et al.*, 1984) teach family members how to communicate clearly and solve problems. Barrowclough and Tarrier (1992) advise that education sessions need to be conducted in a sensitive manner, taking into account the family members' views and not overloading them with information. We are concerned, however, that the inexperienced or rigid use of educational materials, or an insensitive coaching style with regard to communication or problem-solving skills, could place the family in the dependent position of asking questions of a therapist who is deemed to have the answers. This may create a hierarchical, 'teacher-pupil' relationship with the family. While acknowledging that we have specialist knowledge regarding symptoms and family processes which we would want to share with the family, we assume that family members are the most knowledgeable about their own situation. We see the therapist's role as that of an enabler, who has joined the family in order to facilitate fresh perspectives and to aid in evolving solutions. In contrast to a fixed hierarchical therapeutic relationship, a collaborative approach involves ongoing negotiation between therapist and family to agree goals and methods of therapy.

Similarly, Marsh (1994) advocates a therapeutic relationship which is based on collaboration, as this enables and empowers families and thereby enhances their competencies in coping. She identifies these and other benefits with a shift in professional practice from a 'pathology paradigm' to a 'competence paradigm'. Reviews of 'consumer studies' of family therapy (cf. Reimers and Treacher, 1995) appear to provide support for the adoption of a collaborative approach in that the therapeutic alliance is identified as the crucial factor relating to users' satisfaction and positive outcome.

Informative

Some form of family education regarding the prevalence, nature and treatment of schizophrenia is common to most recent family intervention approaches (Haddock and Lewis, 1996). This has had the aim of improving psychiatric care, by consolidating the treatment alliance with the sufferer and his or her family, monitoring mental state over the course of the disorder and improving medication compliance.

Education is designed to correct misconceptions regarding the nature, severity and chronicity of the disorder which are prevalent in society. However, others (e.g. White, 1987) have argued that the use of the term 'schizophrenia' is synonymous with chronicity, incurability and deterioration, which results in a reinforcement of the sick role and objectifies the person so classified (i.e. schizophrenia constitutes their total identity; for example, 'he or she is a schizophrenic' as opposed to being a person suffering from schizophrenia). Due to diminished expectations, sufferers may not achieve their full potential.

Research has indicated that while education does not have significant long-term effects on relatives' perceptions of the patients' difficulties, or on their knowledge about schizophrenia (Lam, 1991), it leads to increased optimism concerning the family's role in treatment and reductions in relatives' stress (Birchwood *et al.*, 1992). It is for these reasons that many clinicians continue to use educational approaches, arguing that education sessions are a useful way of developing a therapeutic alliance (e.g. Hughes *et al.*, 1996).

In our service we do not routinely schedule formal education sessions as, in addition to being ineffective at changing attitudes and beliefs, education about schizophrenia is often not relevant, in that the diagnosis of schizophrenia is usually premature during a

first episode of psychosis, and may remain contentious in many cases. McFarlane and Beels (1983) argue that the risks and indications of different family interventions should be considered according to individual cases, and that 'giving the patient and family full information about schizophrenia only seems justifiable if that is, in fact, what the patient has' (p. 331). This would suggest that in a routine clinical setting, for a service such as ours which seeks to engage families as early as possible, formal education about schizophrenia would not be appropriate. Our concern would be that routine use of educational material regarding schizophrenia may precipitate premature diagnosis, with the concomitant risks associated with labelling.

Although the Family Support Service approach does not rely on educational material about schizophrenia, an important part of our role includes the provision of information. The information provided varies in each case as it is tailored to fit the family members' construal of their situation. We try to provide information which, while acknowledging the severity of the sufferer's distress, helps to de-catastrophize the situation and engenders cautious optimism. In common with most family management approaches, we find that the widely applicable stress-vulnerability model (Zubin and Spring, 1977) is often useful in this regard. This often leads to discussion regarding appropriate levels of stress and stimulation, and we often emphasize a gradual, incremental process of recovery. We do not avoid discussing issues regarding diagnosis and often provide information about the current scientific status of diagnostic labels and discuss issues of course and prognosis, and various treatment options. We provide information about coping strategies in addition to encouraging the sufferer to discuss careful titration of neuroleptic medication with their psychiatrist in order to maximize its effectiveness. One of our aims is to promote supportive family involvement regarding medication and other treatment issues. We also provide information about the availability of useful services and users' rights.

As we do not rely on educational sessions to engage families, the FIRST course trains staff to use established family therapy techniques (for example, brief therapy first interview) to engage with families in a therapeutic alliance. Our initial assessment not only establishes therapeutic goals but also explores the psychotic symptoms in detail (cf. Chadwick *et al.*, 1996) and considers these in the context of family beliefs.

Systemic

Underpinning our work is the systemic perspective which locates the individual's difficulties in their family, cultural and sociopolitical context. Seemingly meaningless behaviour often becomes more understandable when considered in context. Although we would consider multiple levels of meaning (Cronen and Pearce, 1985), of particular relevance are the interpersonal interactions which maintain problems. For example, where parents identify their symptomatic offspring's withdrawal as a problem, their attempts at involvement are often perceived as intrusive and critical, and prompt further withdrawal. In this situation others might attempt a linear, behavioural approach (for example, teaching problem-solving techniques), with the inherent danger that this might intensify the polarization between them. Although our approach would sometimes be to connote the behaviours positively and to paradoxically prescribe the status quo (Selvini-Palazzoli *et al.*, 1978), more commonly we would seek to positively connote behaviour and explore the nature of the interactions (in this example a cycle of pursuit and withdrawal) in a collaborative manner with the family. In this way we would be able to acknowledge in a non-blaming manner the distressing interactions in which they had all become stuck. We find that families welcome the systemic perspective in situations which are inherently laden with feelings of guilt and blame.

Although some family management practitioners have acknowledged the importance of an interactional perspective (cf. Burbach, 1996) there are other aspects of a family therapy approach which we find valuable. In particular, we find it useful to locate a family's difficulties in the context of transitions in the family life cycle (Carter and McGoldrick, 1989) and to consider the family structure in terms of boundaries, roles and power distribution (Minuchin, 1974). For example, symptoms often occur at a time when a young person is emerging into adulthood and establishing a separate identity. It is important to consider the family life cycle, as, for example, symptoms may occur in the last offspring to leave home in the context of fears regarding the parents' well-being. Similarly, it is important to consider family structure, as the symptoms may be connected with issues such as disempowerment, closeness or distance between family members, and the family's relationship with the outside world.

We find it useful to be aware of theories developed by family therapists regarding the interactional processes associated with psychosis (cf. Burbach, 1996). Symptoms may be related to processes such as scapegoating (for example, anger related to marital conflict directed towards another family member) or disqualification (for example, family members negating a young person's view of themselves/beliefs/actions/speech), and knowledge of the various family dynamics provides a therapist with a wider range of therapeutic options. Obviously this does not imply a belief that there is a single and all-embracing family dynamic associated with psychotic symptoms, and our use of these theories is consistent with the stress-vulnerability model.

We consider the systemic perspective to be essential in our work with families, as although we might first adopt a more direct, problem-oriented approach, we often find that with this complex client group the ability to formulate systemically is required as problems are often maintained through interactional processes. In addition, we adopt a cognitive behavioural, constructivist position which sees the inter-relatedness of cognitions, affect and behaviour: i.e. beliefs shape behaviour and behaviour reflects beliefs.

Incorporating solution-focused and cognitive behavioural approaches

The content of most Family Support Service sessions is informed by the therapeutic goals which are agreed with the family during the assessment phase or subsequently. Family members' goals are often specific (for example, carrying out household chores, developing a social network) and lend themselves to a problem-solving approach; however, on other occasions a more explorative approach is required (for example, family grief). In the latter situations we would aim to have 'therapeutic conversations', assessing efficacy not in terms of goal achievement but in terms of 'usefulness' to the family.

With a solution-focused, cognitive behavioural perspective we feel able to work with families at various levels.

- (1) Some families present with readily accessible problems which are amenable to a relatively straightforward behavioural problem-solving approach. In these situations we would use the six-stage approach but in a less formal and more collaborative manner than that proposed by Falloon and colleagues (Falloon

et al., 1984). Families in therapy often present a wish to eradicate problem behaviour. We seek to translate this into a constructive goal (for example, a wish that somebody would spend less time in bed could be restated in terms of what the family would like that person to be doing more of). As Barrowclough and Tarrier (1992) point out, this technique allows family members to begin to generate constructive solutions to problems.

- (2) While acknowledging the often extremely distressing nature of the symptoms, in general we would take a normalizing stance, encouraging open discussion and locating the psychotic experience at one end of a continuum of psychological processes. This is explicit from our first contacts with the family as it is outlined in our information leaflet (see Table 2). We are aware that in many cases medication is only partially successful in eliminating psychotic symptoms (cf. Johnstone *et al.*, 1984; Shepherd *et al.*, 1989), and the goal of the intervention is often to help people to manage their symptoms in a way which minimizes their effect on quality of life. We find Hearing Voices Network (Romme and Escher, 1993) and Coping Strategy Enhancement (Tarrier *et al.*, 1990) ideas useful in this regard. We believe it is an advantage to work 'individually' in the presence of family members, as they can be both a useful resource within the session and also reinforce coping strategies between sessions.
- (3) In many cases we find it necessary to adopt a more cognitive approach as the goals are predominately concerned with attitudinal change. In addition, behavioural change often requires a shift in ways of construing. Like Tarrier and his colleagues (Barrowclough and Tarrier, 1992), we often invite families to keep written records of problem situations to elicit unhelpful 'automatic thoughts'. These techniques can be used for either self-monitoring and/or monitoring by other family members.
- (4) In other cases people find it more difficult to adopt alternative perspectives because they conflict with core beliefs/constructs. These may be individual, family or cultural beliefs and it is often useful to explore transmission of beliefs or 'myths' through the generations. It is also important to be aware of the way in which families construct shared systems of beliefs which shape each individual's thoughts and actions (the 'Family Construct System': see Procter, 1996). The therapy can enable the family's exploration of family beliefs through verbal means

TABLE 2 *Extract from the Family Support Service leaflet***What do we mean by 'psychosis'?**

People are predisposed to react to stress in different ways. These have been viewed as being arranged along a line with the two ends called 'neurosis' and 'psychosis'.

'Neurosis' ————— 'Psychosis'

At the neurotic end people experience a disturbance of emotions and thinking (e.g. clinical depression), while psychosis involves a disturbed sense of reality. Common symptoms of psychosis may include hearing imaginary voices (hallucinations), jumbled thoughts, feeling watched or controlled, believing that thoughts are being put into your mind, believing that people are against you or that you have special powers (delusions), and losing emotional feeling.

When the sufferer loses touch with reality his or her behaviour will be affected; for example, he or she may stay in bed or talk back to the voices. Often the sufferer will feel afraid or angry. Of course this is also very hard for the family to cope with. As everyone gets more and more stressed the original problems tend to get worse. People often value some help to break such cycles and the Family Support Service can also assist with this.

such as interventive circular interviewing (Selvini-Palazzoli *et al.*, 1980; Tomm, 1987) as well as through more active techniques such as constructing a genogram with the family (McGoldrick and Gerson, 1985) and art techniques (Stanbridge, 1995).

Conclusion

In this paper we have described a project to establish Family Support Services in Somerset, and the philosophy of our approach. We intend to formally evaluate the project once we have established Family Support Services in each of the four planned sites and are routinely gathering data to this end. We are currently in the process of establishing our second service. Feedback from families, clinicians and managers has been positive. Families have welcomed the service, which is reflected in high attendance rates. Clinicians and managers have noted the benefits for individual families, an increase in consideration of the person and their network on the inpatient unit, and have commented on the way in which the service has fostered closer working relationships between units

within the service and between mental health and social services. We have received active support from managers and senior clinicians in establishing the new service and interest from other parts of the South-west region in using this model.

We believe that our approach offers distinct advantages. In particular, we have sought to integrate the systemic and family management approaches, and have set about establishing the new service by creating a programme which trains whole teams. Training staff to take a flexible and integrated approach, and providing ongoing supervision, should enable the establishment and maintenance of high quality services throughout Somerset.

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Service Development through Multi-Disciplinary and Multi-Agency Partnerships

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Abstract

In order to establish a new Family Interventions in Psychosis service in Somerset we have developed an approach which integrates individual skills-based training with team and service development. Our approach has necessitated the development of new multi-disciplinary and multi-agency partnerships to transcend existing training structures. We propose that the new Workforce Development Confederations (formerly Education Purchasing Consortia) and universities adopt similar in-situ multi-disciplinary team training approaches in order to meet clinical service development needs identified in the National Service Framework (Department of Health, 1999).

Introduction

The National Service Framework for Mental Health sets a challenging service development agenda for specialist service providers and commissioners to ensure that effective and timely interventions are available for individuals whose mental health problems cannot be managed in primary care. This is to be achieved by recognising that change needs to be systematic and sustainable, and by developing ambitious standards and realistic local delivery systems. The National Service Framework accepts that change cannot be implemented in a matter of months; additional facilities, extra staff and more training will be required to achieve some of the standards. While there is a need for extra investment in the mental health infra-structure, the primary focus for change and development will be in the staff, multi-disciplinary and multi-agency teams, and in the systems of care delivery.

To support this development the National Service Framework's aim for workforce planning, education and training is: 'to enable mental health services to ensure that their workforce is sufficient and skilled, well-led and supported to deliver high quality mental health care'. There is an acceptance that 'not all mental health staff, even those trained relatively recently, have the skills and competencies to deliver modern mental health services' (page 108), and recommends a 'fast track ... of focused education and training to address the critical skills gaps, including competencies for ... psychosocial interventions' (page 111).

Current Approaches to Training

The development of staff skills and competencies has generally been part of individual development plans, connected to the overall strategies of the mental health provider. Training is either delivered in-house or by contracting with Education Purchasing Consortia to provide places on existing courses. New courses are developed to meet anticipated needs. However, there are a number of difficulties with existing approaches to training. First, most training courses do not meet the needs identified within the National Service Framework (Gournay, 1999), although there are exceptions to this, such as the Thorn/COPE training in psychosocial interventions. In addition, even where the content of training is appropriate, it often does not lead to changes in individuals' clinical practice (Fadden, 1997). Furthermore, individual-based training tends not to have any immediate impact on the practices of the team, nor lead in itself to service development.

At present training consortia and those they commission to provide training appear to have invested significant resources in an individual-based training model, and have largely ignored the opportunities to develop a direct linkage between the training input and service development. This appears to be a consequence of emphasising qualifications or creditable experiences, and assuming that the cumulative impact of individual training will somehow enable service to be developed.

Service Culture

We would argue that in order to deliver the significant improvement in the quality of services required by the National Service Framework training will need to address the service culture as well as individuals' skills.

While team training is increasingly being recognised as a valuable means of complementing individual training; particularly in addressing issues of team identity, culture, attitude and processes, it does not lead to the development of new specialist services.

A New Approach

What we propose is a training approach that combines elements of traditional specialist clinical skills training and team development (Quarry and Burbach, 1998). We have found that it is effective to train natural groups of staff in-situ rather than training individuals in educational settings. Intensive, accredited training programmes in the workplace can be an effective method of creating new services. This enables trainees to integrate their learning with local clinical practice and transmit new ideas to colleagues, thereby influencing the local culture. In addition, training can be tailored to the specific needs of each locality.

Case Example: Establishing a Family Interventions Service

This innovative training model was used in the Somerset Partnership NHS and Social Care Trust to develop a new and effective Family Interventions Service readily available to the people of Somerset. We have completed a training and service development programme which involved the training of multi-disciplinary and multi-agency teams in each of the four localities in the Trust. Our one-year Family Interventions training course has been accredited by the University of Plymouth (60 credits at degree or diploma level), the English National Board (A28) and the Association of Family Therapy (foundation level). The training, grounded in the evidence-base for family work with psychosis, aims to provide an understanding of the main theoretical approaches as well as a range of clinical skills. Team

members acquire a broader range of interviewing and engagement skills in addition to individual – and family – cognitive behaviour therapy skills (Burbach and Stanbridge, 1998). Evaluation of our service (Stanbridge et al, 2001; Bailey & Burbach, 2001) has confirmed that this approach to training enables the delivery of a service which is effective and well liked by users.

The course has been provided in each of the main population centres in rotation as part of a trustwide service development strategy. Students are selected in collaboration with course tutors, locality managers and respective line managers on the basis of their ability to provide the service when the course finishes. Our aim is to create a team which includes representatives from the various services (in-patient, CMHT, day services) and the range of professions. To date this has included, social workers, nurses, psychiatrists, psychologists, art therapists, occupational therapists and support workers.

In this way the eight course members develop a team identity during the year and, as the clinical work begins part way through this year, the new clinical service is in place by the end of the course. Training a whole team also ensures that on completion of the training team members can provide one another with mutual support and supervision. On-going clinical peer supervision by means of co-therapy and a monthly supervision group, which includes team members who have clinical experience and training at an advanced level as well as on-going regular consultation and supervision by the course trainers, ensures that we can maintain a high quality service. The approach has also been successful in fostering the sharing of skills, effective multi-disciplinary working and good communication between the different parts of the service. Although our model has proved successful in terms of both individual and service development, the difficulties we encountered with the university system would need to be addressed by the Workforce Development Confederations if our model were to be more widely used.

Difficulties Experienced

The language and processes of the university are often overly bureaucratic, not readily understandable by clinical staff, and support and maintain the individual as the focus of educational achievement. Within tertiary education settings there is little emphasis on education improving outcomes for patients.

The difference in ethos could be demonstrated in a number of ways. There was a fundamental lack of understanding of the purpose of team-based training, exemplified by the Education Purchasing Consortium seeking to place individuals from other Trusts within the team-based family intervention service development programme running within the Somerset Partnership Trust. We also experienced difficulties in scheduling the course to link with service needs, as service development does not always fit into the academic year.

Another fundamental difficulty related to university cost structures and the need to maximise student numbers. Clinical skills training in general, and we would argue mental health skills training in particular, requires a high ratio of trainers to trainees. The course involves techniques such as role play, observation and live supervision of work with families. In order to provide sufficient supervised clinical experience to each trainee there are two trainers and the number of course participants is limited to eight, resulting in a relatively expensive trainee to trainer ratio of four to one.

Although this project has largely relied on clinicians' drive and determination to overcome difficulties in order to establish the new service, it would not have succeeded without striking a number of partnerships.

Partnerships

This service development initiative originated with the desire of clinicians and managers in a mental health trust to develop an effective family interventions in psychosis service. It was recognised that such a service could best be delivered by a mutually supportive multi-disciplinary and multi-agency team. Social services managers agreed to release approved social workers to attend our one-year training course, places on which were provided free with mental health trust management's agreement. (Such good inter-agency working relationships pre-dated the development of the Somerset Partnership NHS Trust – the first health and social services trust in England with a single management structure).

Once we had decided to develop an extensive training course in order to establish the new service the then chief executive of the trust suggested a formal link with the newly established Institute of Health Studies (IHS) at the University of Plymouth. Although fully multi-disciplinary, it was always recognised that the majority of course participants would be nurses and as the IHS trains mental health nurses throughout the South West and wished to develop post-basic nursing training, exploratory discussions between the two organisations commenced. This led to the signing of the first formal partnership agreement between the University of Plymouth and a mental health trust whereby the IHS ensured the academic standards of the course and awarded students 60 credits (degree/diploma level). Our additional accreditation of the course with the Association for Family Therapy (foundation level) provided course participants with further reward for their efforts. Subsequently, the IHS has established many further partnership agreements which has enabled the development of clinically relevant courses with local delivery to health service staff.

Conclusion

In the light of our experiences we would argue that a new approach to workforce education and training is required. The Workforce Development Confederations should have as their primary aim the facilitation of service development and the improvement of patient outcomes. To date, unfortunately, the Consortia/ Confederation structures have not been able to overcome the long-standing lack of strategic co-ordination between trusts who are attempting to implement government health policy and educational institutions. This may improve as a result of recent initiatives to involve NHS workforce planners, educational institutions and trust training departments in new multi-disciplinary Workforce Development Confederations. Although optimistic that the development of Confederations will result in the establishment of more training opportunities in skills relevant in today's mental health services (training in psychosocial interventions, for example), we are still concerned that the nature of such training courses will be insufficiently tailored to the needs of clinical services. A balance is required between individual training, team training and service-led training of natural staff groups. In Somerset we have found that training multi-disciplinary teams in-situ is a particularly effective way of developing new services, and we would commend this method for the development of the new mental health services identified in the National Service Framework.

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A study of families' satisfaction with a family interventions in psychosis service in Somerset

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Although research has shown the efficacy of family interventions in psychosis, there has been little research into families' own experience of services in routine clinical settings. Fifteen of the first twenty-two referrals to a Somerset Family Interventions Service agreed to take part in semi-structured interviews regarding family satisfaction and clinical outcome. High levels of engagement and satisfaction with the service were reported in spite of initial apprehension regarding family sessions. Family members thought that the sessions had helped them deal more effectively with problems and relatives' symptoms. They valued the opportunity for open discussion, developing new perspectives and problem-solving, as well as liaison/closer working with mental health services. Positive therapeutic qualities/skills (e.g. empathic, non-judgemental approach; mutually agreed goals) were highlighted. This study also indicated that successful engagement in family work requires referral at an early stage. The findings of this study, particularly those relating to the therapeutic relationship, are discussed, including their relevance for future research.

Introduction

The National Service Framework for Mental Health (NSF: Department of Health, 1999) emphasizes the need to work in partnership with service users and carers to provide both effective and acceptable care. This is against a background of users' and carers' dissatisfaction with the implementation of community care and an increasing awareness of the burden of caring for someone with a severe mental

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illness. The influence of the family and other carers in relation to outcome is well documented and this has led to the development of 'family intervention' approaches. The efficacy of interventions with individual families has been the subject of a number of recent reviews (e.g. Dixon *et al.*, 2000; Bustillo *et al.*, 2001; Pitschel-Walz *et al.*, 2001; Pharoah *et al.*, 2002; Pilling *et al.*, 2002). Although Family Interventions (FI) have been shown to be effective (rated Type-I evidence in the NSF) problems have been identified in implementing FI in routine clinical practice. While this may suggest the need for research into the acceptability of FI, the literature reveals no specific studies of user/carer satisfaction with contemporary FI services.

Research into carer/family's views on mental health services

Studies generally identify an under-provision of services for those with severe mental illness (Patmore and Weaver, 1992; Shepherd *et al.*, 1994; Dixon *et al.*, 1999). In addition, carers/families express dissatisfaction because they feel insufficiently acknowledged by services either as the main carers and/or as potential partners in care. They request improved communication with professionals and more information about diagnosis and the management of their relative (see also Hatfield, 1983; Spaniol and Zippel, 1988; Hanson and Rapp, 1992; Solomon, 1994; Leavey *et al.*, 1997). Hatfield (1983) reported that even when family sessions do take place there can be a marked discrepancy between what families seek from therapy and the focus adopted by professionals.

Research into family/carer burden

Carers' dissatisfaction with services is also understandable in the light of research into family/carer burden. Studies have documented the pervasive effect of mental illness on other family members and carers with adverse objective and subjective consequences (i.e. effects on work, social and leisure activities or psychosocial and physical health; and the extent to which carers feel they carry a burden, respectively) (Fadden *et al.*, 1987; McCarthy *et al.*, 1989; Birchwood and Cochrane, 1990; Maurin and Boyd, 1990; Schene, 1990; Raj *et al.*, 1991; Johnson, 1994; Schene *et al.*, 1994). It is interesting to note that studies by Kuipers and Raune (2000) and Tennakoon *et al.* (2000) found that family burden is not only associated with long-term symptoms but is present at first episode psychosis.

Family Intervention outcome studies which have incorporated measures of burden indicate varied findings but a recent meta-analysis of sixteen studies (Cuijpers, 1999: 275) concluded that 'family interventions can have considerable effects on relatives' burden, psychological distress, the relationship between patient and relative and family functioning'. One of the mechanisms by which family sessions may reduce burden is by affecting family members' construal of their situation. This is supported by Scazufca and Kuipers' (1996) study which showed that the measures of expressed emotion (EE) and burden of care are related, and concluded that both measured aspects of the relationship between relatives and patients. They suggested that EE and burden are more dependent on relatives' appraisal of the patient's condition than on their actual deficits.

Research into families' views on family intervention/therapy

Although extensive literature searches have not uncovered research into users' satisfaction with family intervention in psychosis services, there is a study by Budd and Hughes (1997) into the therapeutic impact of FI, and some research into families' experiences of systems-based family therapy which is of note.

Reimers and White, described in Reimers and Treacher (1995), found that many families attending a family therapy clinic felt uninformed about what to expect in therapy and that many families attended expecting advice, only to find that the therapist's emphasis was on exploring relationships. This sense of mismatch between a family's expectations of therapy and those of the therapist has also been documented in other research (Burck, 1978; Lishman, 1978; Hunt, 1985).

The need for treatment to match family expectations is highlighted by Crane *et al.* (1986), who found that 'fit of treatment' was the only variable to reliably predict users' ratings of treatment outcome. They describe the need for therapy to match expectations of families, i.e. a common agenda, agreed pacing and therapist concern for a positive relationship based on collaboration. Bennun's (1989) research also emphasizes the crucial importance of the therapeutic alliance, and he points out that an over-emphasis on technical aspects of therapy can lead to family dissatisfaction. For a more extensive review of this research see Reimers and Treacher (1995).

An interesting study of a routine family interventions service in South Wales (Budd and Hughes, 1997) also found that families

highlighted the importance of the therapeutic relationship. This psychotherapy process research study explored what twenty carers found helpful and unhelpful about the various aspects of the family interventions programme. They found that 'the relatively non specific positive impacts of emotional support, backup, and reassurance were more commonly reported as helpful by relatives than were the more specific impacts concerning behaviour change and skills acquisition' (Budd and Hughes, 1997: 344). It is interesting to note that despite the psychoeducational and skills training focus of their behavioural FI model, Budd and Hughes (1997) report similar findings to the systemic family therapy satisfaction/process research reviewed above.

Research into difficulties in applying FI in routine clinical settings

Research into the implementation of evidence-based family interventions in routine clinical settings also points to the significance of the therapeutic relationship. Studies by Fadden (1997), Brennan and Gamble (1997) and Kavanagh *et al.* (1993) have highlighted a number of reasons why people have had difficulty in delivering family interventions following FI training programmes. While many difficulties related to unsupportive service environments, others related to the skills taught on training programmes. Fadden (1997) found that therapists experienced the most difficulty with engagement skills, and significant numbers of therapists did not feel confident in the applicability of the programme to the needs of people with psychotic symptoms or their families.

The Somerset Partnership NHS Trust 'Family Support Service'

The Somerset FI service was developed following a review of FI research (Burbach, 1996) and services (Burbach, 1995). In order to work with a range of families, and in particular those with first episode psychosis, an approach integrating individual- and family-cognitive behaviour therapy and a systemic perspective was developed (see Burbach and Stanbridge, 1998). Integral to this approach is a collaborative therapeutic stance derived from contemporary family therapy practice (Burbach and Stanbridge, 2001). The service is provided by a multi-disciplinary team trained in FI. Individual families are seen by two team members at their homes or in mental health settings. The therapeutic contract between individual families

and clinicians is negotiated collaboratively to meet family members' needs.

In 1995, with Trust Board support, Frank Burbach and Roger Stanbridge developed the one-year Family Interventions (Research, Skills, Theory) in Psychosis course which utilizes an *in-situ* whole team training approach (Quarry and Burbach, 1998) to develop locality-based FI services.

Methodology

Aims of research

This study sought to gain direct feedback from families who had experienced the service in the first of the four localities in which FI services were established.¹

The aim of the research was to evaluate the Family Support Service in the Wells/Burnham-on-Sea areas in terms of:

- 1 Satisfaction with the Family Support Service.
- 2 Which aspects of the Family Support Service families found helpful/unhelpful.
- 3 Clinical outcome.
- 4 Other factors possibly linked with satisfaction/outcome (e.g. gender of therapists, whether the person with psychotic symptoms was involved in sessions, brief versus longer term involvement with service, whether or not the family was still being seen).

This was carried out during the summer of 1999 by conducting a semi-structured interview with families who had experienced the service.

Sample group

The sample group included all families who had been referred to the Wells/Burnham-on-Sea Family Support Service, which at the time of starting the research (January 1999) stood at twenty-two families.

The group therefore included newly referred families, families who had been involved with the service for some while, and families who were no longer being seen. The majority (86 per cent) of the referrals had been made by the two locality consultant psychiatrists.

¹ FI services have been established using the FIRST course to train teams in Wells in 1997; Yeovil in 1998; Bridgwater in 1999; and Taunton in 2001.

The criterion for referral to this service is the presence of psychotic symptoms in a family member.

The catchment area has a population of approximately 95,000. It is a semi-rural, semi-urban area which includes the cathedral city of Wells and the holiday resort of Burnham-on-Sea. It is served by two community mental health teams, and has an acute inpatient unit, two continuing care units, and a rehabilitation day hospital. It has a predominantly white population with a low racial mix.

The families approached

Three families had declined contact with the Family Support Service and were not approached for this study. The other nineteen families were contacted by letter. All family members who attended sessions were invited to participate. This included specifically the person experiencing psychosis, but where other family members (e.g. younger siblings) had attended only an occasional session it was left to the regular family attenders to decide whether or not that person should be included. Members of fifteen families agreed to take part in the research. This included twenty-one relatives (eleven mothers, six fathers, two wives, one sibling, one aunt) and four male clients.² This included ten families who were no longer being seen where attendance averaged 6.5 sessions (range 1–18) over 40.4 weeks (range 2–116). Attendance of the five families currently being seen averaged 16.4 sessions (range 5–25) over eighty-six weeks (range 60–120).

Procedure

Ethics Committee approval was sought successfully for the research proposal. Consultant Psychiatrists and Family Support Service therapists were also consulted to ask if any families should not be approached due to clinical considerations.

Of the fifteen families interviewed nine were interviewed by the first author, a white male, in order to meet the requirements of an MSc. in Family Therapy. Two colleagues, one white female (KC) and one white male (AL), interviewed three families each. All interviewers

² Due to our concern regarding the effects of labelling we have struggled to find an acceptable short term for the person referred to mental health services. Where the longer phrase 'person experiencing psychotic symptoms' seemed too cumbersome we have decided to use the term 'client'.

had experience of meeting with families where a member experiences psychosis, but had not had any prior therapeutic contact with these families.

All family members taking part in the research opted to be interviewed together rather than separately. Ten families chose to be interviewed at home and five families on trust premises. All gave prior written consent to taking part in the research and for audio-taped recording of the interviews. Interviews took between one and one-and-a-half hours.

In two family interviews the interview schedule was discontinued part-way through the meeting. In both cases the meetings were with mothers who had sons in their twenties who had required hospital admissions. Both had attended only one or two sessions respectively, had poor recollection of these meetings and felt that they had been referred to the Family Support Service 'too late'. They did not feel that they required the service at the time of referral which was on their son's discharge from hospital, when the situation had improved. The study therefore reports on results of thirteen completed family interviews (twenty-three individuals).

The interview schedule was compiled specifically for this research.³ It was circulated for comments to the local National Schizophrenia Fellowship group and to Family Support Service therapists, and piloted by each of the interviewers with one family prior to adopting the final version. It consisted of various sections including initial preconceptions, the therapeutic alliance, satisfaction and outcome, and families' comments on the research process.

Method of analysis

Where questions have involved a rating scale a quantitative analysis was conducted and summary statistics are calculated in terms of the number of families and individuals interviewed. Qualitative data were subjected initially to a thematic content analysis by the first author. A year later the data and its analysis were reviewed by the first and second authors. There was a high level of agreement regarding the main categories but some amendments were made in the final categorization during this review. The material presented here represents a consensus view of both authors.

³ Copies are available from the first named author.

Results

1 Initial preconceptions

When asked about their preconceptions about being referred to the Family Support Service, family members in ten of the thirteen families reported feeling apprehension or worry on referral:

'I was hesitant as to how I would be treated. A sense of trepidation as to whether or not we would be treated sensitively. Whether therapists would be trained and could be trusted with sensitive issues.'

(Father)

'Somewhat negative. That basically it would be a wishy-washy social work affair. A lot of polite simpering but not a lot of structure. We thought it might have been a painful experience.'

(Aunt)

Six families feared sessions might not be successful or lead to things becoming worse:

'I was concerned that it wouldn't do us any good and that we wouldn't achieve the objectives we were there for.'

(Father)

'An intellectual fear that things would unravel and not be able to be put back together again. We were relieved someone was picking it up but not sure where it would all end.'

(Client and wife)

'Nervous for James [son]⁴ due to his fearfulness and worry about going. Worry that James would feel worse after coming.'

(Mother)

Four families described previous bad experiences of mental health services:

'I had a lack of confidence in the process. I was also prejudiced against the service generally because of our first contacts.'

(Father)

2 Overall satisfaction with the Family Support Service

Although one would anticipate that bad experiences and negative preconceptions might lead families to have poor involvement with the service, this was not the case. In fact, when asked to rate their satisfaction/dissatisfaction with the Family Support Service on a four-

⁴ All names have been changed to ensure confidentiality.

TABLE 1 *Overall satisfaction*

In an overall, general sense how satisfied are you with the service you received from the Family Support Service?

Very dissatisfied		Partially dissatisfied				Partially satisfied				Very satisfied					
Families		Indi- viduals		Families		Indi- viduals		Families		Indi- viduals		Families		Indi- viduals	
N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
0	0	0	0	0	0	0	0	3	23	6	26	10	77	17	74

point rating scale, no one expressed dissatisfaction. Ten families rated themselves as ‘very satisfied’ (seventeen individuals) and three families as ‘partially satisfied’ (six individuals)⁵ (see Table 1).

‘Surprised and satisfied. The most important thing was that they listened and responded to the family’s needs, not followed their agenda, and that happened.’

(Aunt)

‘Very satisfied, I wish it was available seven years ago when his illness started.’

(Mother)

Of the four families who described previous bad experiences of mental health services, all replied that they were ‘very satisfied’ with the service. All described a collaborative relationship with their therapists in which they felt understood and worked on aims which were mutually agreed. In addition, all described sessions as being helpful both in dealing more effectively with identified problems and in coping more effectively with the patient’s symptoms.

3 Likes and dislikes about the service

When asked, there was very little that families did not like about the service and there were many interesting responses to the question: ‘The thing that you have liked best about your experience of the service is...?’ The following themes emerged:

⁵ Where there are differing ratings within the same family we have ‘averaged’ the individual ratings to derive the family rating (e.g. one family member ‘partially satisfied’ (+1) and another ‘very satisfied’ (+2) = a family rating of 1.5 (‘very satisfied’); similarly, ‘same’ (0) and ‘worse’ (-1) = -0.5 (‘worse’).

- Openness of discussion with sessions

‘Open discussions in a safe and supportive environment.’ (Mother and son)
 ‘The non-judgemental nature of the service has helped most, but not in a wishy-washy way.’

(Father)

- Therapist’s qualities

‘Talking to someone about Jack who knows and understands him and is sympathetic.’

(Mother)

‘A feeling of concern and warmth.’

(Mother)

- Support offered

‘Knowing someone is there to talk to, to explain or answer a problem in sessions or on the phone.’

(Mother)

‘We liked the flexibility in the timing of appointments which vary depending on what is happening and how much help we need. You only need to pick up the phone to arrange a session.’

(Mother and father)

- Managing the burden of care

‘An easing of the pressure, burden at the time. Especially after the meetings. We didn’t feel so much on our own.’

(Mother and father)

- Access to the mental health services

‘Another point of contact with the system.’

(Mother and father)

4 Therapeutic alliance

Family members were asked a number of questions about the qualities of the relationship between themselves and their therapists. When asked whether they felt understood by their therapist (‘no’; ‘partly’; ‘yes’) ten families (eighteen individuals) replied ‘yes’ and two families ‘partly’ (four individuals). One person replied ‘no’ (see Table 2).

Feeling understood by their therapist was often described as a powerful experience:

‘I felt very much understood. That was very overwhelming in a way, having come from a place where we weren’t understanding each other at home, to have two people who were empathic there for me and for our son Jack.’

(Wife)

TABLE 2 *Therapeutic alliance*

	Q1 Did you feel understood by your therapist?											
	Q2 Were you able to let your therapist know if the sessions were useful or not?											
	No				Sometimes				Yes			
	Families		Individuals		Families		Individuals		Families		Individuals	
	N	%	N	%	N	%	N	%	N	%	N	%
Question 1	1	8	1	4	2	15	4	17	10	77	18	78
Question 2	0	0	0	0	2	15	3	13	11	85	20	87

TABLE 3 *Therapeutic alliance*

How were the aims of the meeting arrived at?															
Family decided				Therapist decided				Mutually agreed				Other			
Families		Individuals		Families		Individuals		Families		Individuals		Families		Individuals	
N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
2	15	4	17	0.5	4	1	4	10.5	81	18	78	0	0	0	0

The one person who did not feel understood was a man with a long-term delusional framework who said that he had not felt understood by anyone during his many years of contact as a user of the mental health services.

When asked whether they were able to let their therapist know if the sessions were useful or not ('no'; 'sometimes'; 'yes'), eleven families (twenty individuals) replied 'yes' and two families (three individuals) 'sometimes'. When asked how they did so, twelve families said that they were able to speak to their therapists directly in the sessions, with eight families specifically remembering being asked this regularly by their therapists (see Table 2).

When asked how the aims of the meetings were arrived at ('family decided'; 'therapist decided'; 'mutually agreed'; 'other') ten families said that aims were 'mutually agreed' (eighteen individuals) and two families said that they decided (four individuals). One family, where the client's sister and mother were interviewed,

replied ‘mutually agreed’ and ‘therapist decided’, respectively (see Table 3).

5 Helpful therapist qualities

All thirteen families identified positive qualities in their therapists. These included:

- The ability of the therapist to listen

This was referred to explicitly by seven families and implicit in many families’ reference to other qualities.

‘The therapists didn’t take sides or become judgmental, but listened to the problems we had as a family.’

(Mother)

- Non-judgemental

This was referred to by five families:

‘Parents are concerned about being judged. This didn’t happen. We were not made to feel responsible or judged or put in a box in any way.’

(Mother and father)

- Therapist answered questions and shared views

This was referred to by five families:

‘It was possible to ask questions and discuss things. They would give frank answers.’

(Mother and father)

‘They were very open, sympathetic and shared their views.’

(Mother and father)

- The therapists worked well together

This was referred to by five families:

‘They had two very clear roles and confidently interacted with us and each other.’

(Mother and Father)

- Helpfulness of therapist

This was referred to by four families:

‘It’s helped us to cope with the situations that do arise with Alex from time to time when his psychosis flares up.’

(Father)

- Interest of therapist

This was referred to by three families:

‘They were very interested in the problems we were having as well as Philip’s [son]. That was the first time that had happened, they knew that we were having problems, we were worried and we were suffering from stress. They realized that.’

(Mother and father)

- They created a calm and quiet atmosphere

This was referred to by three families:

‘The therapists were pleasant, calm, helpful and patient. You didn’t feel oppressed in any way.’

(Mother)

6 Most common problems

The most commonly identified problems for which families sought help related to the impact of the sufferer’s behaviour on family relationships. Themes identified included:

- Managing specific behaviours (e.g. domestic chores, irregular sleep patterns, aggressive behaviour, suicidal ideas)

‘Conflicts with my mum over household chores was a specific problem and stress.’

(Client)

James’ suicidal ideas were high on the agenda.’

(Mother and father)

- Difficulties created in close relationships

‘We were concerned that we might be giving mixed messages to James, you saying one thing and me saying another, and the impact of different approaches.’

(Mother and father)

- Making sense of the experience

‘How best to manage it and how best to understand what had happened and what it meant to my wife and I.’

(Client)

- Support for family members’/carers’ own needs

‘It was for us, to carry on trying to live a normal life with Alex the way he was.’

(Mother and father)

TABLE 4 *Problems and symptoms*

Q1 Are the problems/stresses the same, better or worse?
 Q2 In terms of X's symptoms, compared with when you first came to the Family Support Service, are they the same, better or worse?
 Q3 Has the Family Support Service helped you deal more effectively with your problems?
 Q4 Has the Family Support Service helped you cope more effectively with X's symptoms?

	Much worse				Worse				Same				Better				Much better			
	Families		Individuals		Families		Individuals		Families		Individuals		Families		Individuals		Families		Individuals	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Question 1	0	0	0	0	2	15	2	9	0	0	2	9	5	38	8	35	6	46	11	48
Question 2	0	0	0	0	1	8	1	4	4	31	6	26	2	15	6	26	6	46	10	43
Question 3	0	0	0	0	1	8	1	4	0	0	0	0	5	38	9	39	7	54	13	57
Question 4	0	0	0	0	0	0	0	0	2	15	3	13	5	38	11	48	6	46	9	39

7 Problems and symptom change

Interviewees were asked to rate changes in their problems and the client's symptoms compared with when they first came to the Family Support Service on a five-point scale (See Table 4). Six families rated both as 'much better' (eleven and twenty individuals, respectively). Five families rated their problems as 'better' (eight individuals) and two families rated their relative's symptoms as 'better' (six individuals). Symptoms were rated the 'same' by four families (six individuals). Two families rated their problems 'worse' (two individuals) and one family rated symptoms as 'worse' (one individual). One of the families categorized as 'worse' for problems was a man who had attended sessions in an attempt to improve his marriage but had since separated and who for research purposes was interviewed individually. In another family where the client's sister and mother were interviewed the former rated problems and symptoms as 'the same', whereas the latter rated both as 'worse'. The mother answered both questions in relation to the deterioration in her daughter's mental state following her withdrawal from family sessions.

8 Coping with problems and symptoms

Interviewees were also asked whether the Family Support Service had helped them to 'deal more effectively' with their problems and with their own or relatives' symptoms (see Table 4).

Seven families (thirteen individuals) felt that the Family Support Service had helped them a 'great deal' in managing their problems effectively, with five families saying it helped 'somewhat' (nine individuals). The individual referred to above, whose marriage had subsequently ended, responded negatively to this question.

Six families (nine individuals) reported that the service helped them to cope 'much better' with their relatives' symptoms, five families (eleven individuals) responded 'better', and two families (three individuals) said that it 'made no difference'.

A number of themes emerged when people were asked what had helped with their problems or symptoms:

- Developing improved coping strategies

Jenny has been able to use her relapse strategy and has not had a full-blown episode.'

(Relative)

- Improved communication

‘Changing our communication between ourselves, improving that. Avoiding certain triggers.’

(Client and wife)

- Increased understanding of mental health problems

‘Helping us understand mental illness. I learnt a lot about it I didn’t know.’

(Father)

- Availability of support

‘They were clearly communicating well as a network. Everyone seemed to know what was going on elsewhere in the service and what they were doing and we admire that, because it’s not common.’

(Mother and father)

- Reduced contact with relatives

‘His leaving home, space to get away from us, otherwise I think he would be in hospital again.’

(Mother)

Four families also referred to the passage of time having made a difference and two families highlighted the importance of their respective sons abstaining from illegal drugs. Four families included medication as making a difference with one family also including hospital admission. A wife described the realization of the importance of family relationships as having made a difference to her husband.

9 Other factors

A number of other factors possibly related to satisfaction with the service were analysed:

- Gender of therapists

This did not appear to be associated with satisfaction. When asked for comments about the gender mix of the co-therapists the majority of families (nine) expressed satisfaction. In this group, four families had met with two female therapists, three families with a male and female therapist and two families with two male therapists. Two of these families who both met with two female therapists said they felt that personal qualities were more important than gender. One of these families felt it would have been acceptable to meet with a man and a woman therapist but not with two male therapists. Three families did not make any comment at all. In addition, one husband

who had been seen with his wife by two male therapists felt that it might have been helpful to his wife had one of the therapists been a woman. It was not possible however to ask his wife as she did not take part in the research.

- Families currently/no longer being seen

Although it was hypothesized that families currently engaged with the service might give different answers to those who were no longer being seen, no association was found between whether or not families were currently being seen and their level of satisfaction.

- Involvement of the person experiencing psychotic symptoms

Only four people who experienced psychotic symptoms agreed to take part in the research interviews. However, this does not reflect the involvement of psychosis sufferers with the service, where in 90 per cent of families this person attended sessions. We interviewed two families where the person who experienced psychotic symptoms was not seen in the service – one family was ‘very satisfied’ and the other dissatisfied, having been referred ‘too late’. In four cases where the person experiencing psychotic symptoms was seen for only one or two sessions and declined to attend other sessions, this was not associated with lower levels of satisfaction in the study; although two sets of parents felt that had their sons been willing to attend, this would have been beneficial.

- Brief vs. longer term involvement

Because longer term involvement is generally regarded as beneficial (Fadden, 1998; Scottish Intercollegiate Guidelines Network, 1998) two groups of families were compared on the basis of whether brief or longer term interventions were associated with levels of satisfaction. Six families seen for seven sessions or under (range one to seven sessions, mean 3.7) were compared with seven families seen for eleven sessions or more (range eleven to twenty-five sessions, mean 16.3). No association was found between length of treatment and satisfaction with the service.

10 Views on participation in the research

All who took part in this research were asked whether they had any comments to make about the way in which they were contacted or the interview itself.

All those interviewed felt positive about taking part in the research. This included the two families, who made up the subset described above, who felt they had been referred too late. One said:

‘The reason I agreed to it is because as a carer I think it is a must to have a service like this ... there must be support services for families.’
(Mother)

The sense of passion both about carers’ needs and about valuing the service they had received, together with wanting to see it continue, was not uncommon. Eight families specifically took the opportunity of this question to express this, often in extremely powerful ways. They saw participating in the research as a tangible way of helping others:

‘We’re pleased to be of help and will do anything in the future, for all that’s been done for us ... without the help I don’t think we’d have been in business. I don’t think we’d have been able to carry on normally ... it was a 24-hour constant worry.’
(Mother and father)

In commenting about the research itself two people drew attention to it being difficult to remember details of their contact when it was between one and two years ago. Two other families felt that the process of being asked about their experiences had been helpful in making sense of their experiences:

‘Very interesting to review, very cathartic. I’m glad we did it because it’s quite cathartic, quite useful to remember what it was like, just at a personal level. I’m very grateful for the work, it made a big difference.’
(Client)

Discussion

The findings of this study indicate that families were highly satisfied with the Family Support Service. This is also supported by audit data which indicate high levels of engagement with the service. The fifteen families attended 147 sessions, cancelled twelve sessions, and three families did not attend on one occasion. This represents a cancellation rate of 7.4 per cent and a DNA rate of 1.9 per cent. These results contrast with the difficulties in engaging families experienced by some other family interventions services (Fadden, 1997).

This level of satisfaction is interesting given the high level of negative preconceptions experienced by family members on referral to the Family Support Service. These preconceptions may be explained partly by the fact that some families have had specific bad experiences with mental health services, but may also reflect a more general feeling of being judged and excluded from services which has been highlighted by previous research with carers (Shepherd *et al.*, 1994). It is in this context that the families' highlighting of the qualities of the therapeutic relationship is significant. Therapists paying attention to family members' expectations and needs, combined with mutually agreeing therapeutic aims, appears to be crucial in ensuring initial engagement. Other aspects of the therapeutic relationship also commented on were the benefits of open discussions with therapists who listened, did not follow their own agenda, and were non-judgemental, empathic and genuine. This is consistent with wider psychotherapy research (eg. Patterson, 1984) which emphasizes the primacy of the therapeutic relationship. However, we would argue that in family interventions a good therapeutic relationship, while being necessary, is not sufficient for a good outcome. An effective therapeutic alliance is likely to depend on the therapist's 'personal qualities'/'interpersonal skills', combined with their competency in relation to specific interventions, ranging from exploration of a psychotic experience and family interaction patterns to the development of problem-solving and coping skills. This is supported by findings in this study where families identified the management of specific behaviours (e.g. domestic chores, sleep, aggressive behaviours and suicidal ideas), difficulties in close relationships, the need for a greater understanding of their situation, and support in helping them to cope as their main needs. Although most families reported significant improvement in problems and symptoms the ratings for the extent to which the Family Support Service had helped them to cope with these problems and symptoms (see Table 4) were even greater. This appears to indicate that a good outcome is related not only to problem/symptom change but also to family members' construal of their situation (cf. family burden research, above). This supports the importance of an interactional perspective in that change in the way family members construe each other can have a positive effect on family interactions and therefore lead to an emotional climate more conducive to recovery.

The high levels of satisfaction reported in this study may also be linked with other factors. Our audit data highlight that in the majority

of cases (90 per cent) the person experiencing psychotic symptoms was involved in the sessions. The involvement of the person experiencing psychotic symptoms has been linked with improved outcome in family interventions (Fadden, 1998).

This study has also confirmed the importance of early referral of families for successful engagement. This is consistent with the crisis intervention literature which describes how families are most strongly motivated to seek help during times of crisis. It is also during these times that relational issues are most accessible (Scott and Ashworth, 1967; Scott, 1973; Scott and Starr, 1981; Weisman, 1989). There is also a growing recognition that early intervention in psychosis is linked with improved outcomes (McGorry and Jackson, 1999; Birchwood *et al.*, 2000; IRIS, 2001).

Locally, this research has led to valuable feedback to Family Support Service clinicians, our colleagues in the mental health services and to users of our service. The high levels of satisfaction both with our approach and the outcomes attained appear to indicate that we are achieving our aims of collaboratively meeting the range of family needs. This type of exploratory qualitative research may also be helpful in identifying issues which can lead to improved outcome. Family satisfaction is probably linked to clinical outcome, in that improved communication with services and reduction in family burden may reduce family stress, with a beneficial effect on symptoms and relapse rates. We would hope that some of these issues identified in our small-scale research project would be able to inform larger, perhaps multi-centre, audit/research projects.

In addition, we would suggest that research into the identification of 'key ingredients' of family interventions, as well as into the difficulties in implementing these approaches in routine clinical settings, should pay particular attention to factors relating to the therapeutic relationship and further investigate the particular issues raised in this exploratory study.

Conclusions

This study is a contribution to the relatively under-researched area of families' views of family interventions services. Unlike the majority of research studies focusing on clinical outcome and treatment fidelity, this study's qualitative exploration of issues which contribute to satisfaction has highlighted some of the ingredients which may be associated with successful outcome. Satisfaction was related to

families' needs being met (e.g. coping with problems and symptoms, improved communication in the family and better liaison with the services) as well as feeling listened to in the context of a supportive therapeutic relationship. A number of factors emphasized specifically in the Somerset Family Support Service appeared to contribute to the establishment of a positive therapeutic relationship and be particularly valued by families, namely mutually agreed therapeutic aims and regular evaluation of the usefulness of sessions. These factors reflect the service's broad, flexible therapeutic approach which enables clinicians to offer a range of interventions suited to different families' specific needs. However, the generalizability of these findings is unclear and further research in other clinical settings is indicated.

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The ability of staff trained in family interventions to implement the approach in routine clinical practice

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Abstract

Background: Despite the proliferation of training programmes for Family Interventions (FI) in psychosis, there are many reported difficulties in the implementation of these approaches in routine clinical settings.

Aim: To examine the effectiveness of a team-based multi-professional training programme in FI for psychosis.

Method: Fifteen therapists who had completed a 1-year Family Intervention training course (FIRST) designed to establish local FI services completed questionnaires used in previous studies and participated in focus groups.

Results: All FIRST trained staff continued to work with families following completion of training and most (80%) reported little difficulty in implementing the approach. Organisational issues such as availability of time and integration with caseload or other responsibilities at work were identified as the main cause of difficulty in working with families, whilst the key enabling factors were related to the structure of the FI service – co-working, supervision, multi-disciplinary teams and its flexible approach.

Conclusions: FIRST trained staff experienced fewer difficulties in implementing FI in routine clinical practice than has been reported in previous studies.

Keywords: Family Interventions, Psychosis, Staff training effectiveness, Routine clinical settings implementation

Declaration of interest: This study was conducted by Rachel Bailey, under the supervision of Susan Lee. Frank Burbach is employed by the Somerset Partnership NHS & Social Care Trust and developed the FI training programme.

Introduction

Inclusion of Family Interventions (FI) in the National Service Framework (1999) reflects its increased recognition as an effective intervention. This is a result of some 20 years

of sustained high quality research into working with families where a member experiences severe mental health problems, particularly psychosis (Goldstein & Miklowitz, 1995). Numerous studies have indicated that family intervention may prevent relapse, re-

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duce hospitalisation and increase compliance with medication (cf. reviews by Bustillo *et al.*, 2001; Dixon *et al.*, 2000; Mari & Streiner, 1996; Pharoah *et al.*, 2002; Pilling *et al.*, 2002; Pitschel-Walz *et al.*, 2001).

FI is also known to be beneficial for the relatives caring for the individual with mental illness. Improvements in areas such as decreased burden, psychological distress and minor psychiatric morbidity have been reported (Brooker *et al.*, 1994; Cuijpers, 1999). In addition, families have reported that FI significantly enhanced their ability to cope with problems and their relatives' psychotic symptoms (Stanbridge *et al.*, 2003).

Despite the acknowledgement of the benefits of working with families where one member experiences a severe mental health problem, there are many reports that these families find it difficult, or are unable, to access this help (Brooker *et al.*, 1994) with estimates as low as only 30% of families with a member with a diagnosis of schizophrenia being provided with information, advice or support from the mental health services (Dixon *et al.*, 1999).

Relatively few FI services have been established in routine clinical settings. Unfortunately, many mental health services, which have recognised the importance of family work and have trained staff in FI, have subsequently reported problems with the implementation of the approach. A study by Kavanagh *et al.* (1993) documented the difficulties experienced by 45 staff trained in cognitive behavioural family work in Sydney, Australia. Six months to 3 years after training 22% of the respondents reported that it was extremely difficult or impossible to implement the approach, 48% rated it as moderately or very difficult. The area causing most difficulty was integrating family work with other responsibilities and interests, because of the time required for family

work, the requirement for out of hours working, illness and holidays. The researchers were concerned to find that staff had worked with an average of only 1.4 families since completing the training 6 months to 3 years earlier; only 18% had worked with three or more families.

Fadden (1997) also identified numerous difficulties experienced by staff in a study of 86 staff members trained in Behavioural Family Therapy in Buckingham. When asked to rate the difficulty experienced in implementing the approach, 11% reported that it was either extremely difficult or impossible, and 45% reported that it was moderately or very difficult. Four main issues were identified by staff as affecting their ability to work with families: the inability to find 'suitable' families to work with; the time needed for family work; the requirement to work out-of-hours; problems with engaging families and a lack of motivation or co-operation from the family.

In Fadden's (1997) study, the location in which the therapist worked and the number of therapists trained in the service area were identified as being the two significant factors affecting the number of families seen. Significantly more families were seen by therapists working in community settings and when larger numbers of therapists (eight or more) were trained in the service area. Fadden also found that women were significantly more likely to co-work, which helped therapists to put into practice what they had learned. In this study, staff had worked with an average of 1.7 families in the 9 months to 3.5 years since completion of the training course, a figure not dissimilar to that found by Kavanagh *et al.* (1993).

A further study by Brennan & Gamble (1997) identified the problems experienced by 38 staff trained in FI at the Institute of Psychiatry, London. The main difficulties

recognised were the ability to use assessment methods, collaboration with co-workers and keeping family sessions on track. Organisational issues were highlighted as the area of most difficulty, with 55% of staff experiencing extreme difficulty and 67% slight difficulty with integrating family work with their case load and/or other work responsibilities.

Given the importance of providing services to families with a member with severe mental health problems, in particular psychosis, and with the above difficulties in mind, a multi-professional training programme in FI commenced in Somerset in 1996 with the aim of establishing local 'Family Support Services'. An *in situ*, whole team training approach (Quarry & Burbach, 1998) was adopted and a new 1-year accredited course – the Family Interventions: Research, Skills, and Theory (FIRST) in Psychosis Course (Burbach & Stanbridge, 1998) – was developed to train multi-disciplinary teams in each of the four localities in Somerset.

The 'Family Support Service' is distinct from other FI services in that it integrates individual and family cognitive behaviour therapy with a systemic perspective, in order to provide staff with the skills to work successfully with a range of families where a member has psychotic symptoms (Burbach & Stanbridge, 1998).

The main aim of this study is to compare the experiences of staff trained in Somerset with the experiences of the staff in Buckingham in the original and most detailed UK study (Fadden, 1997). In addition, where possible, comparisons will also be made with the studies by Brennan & Gamble (1997) and Kavanagh *et al.* (1993). Specifically, the study aims to: compare the levels of difficulty experienced by staff in implementing the approach; identify factors that most affect the ability of Family Support Service staff to work with families; and examine the extent to

which previously noted difficulties in implementing family work remain a problem to those trained on the FIRST course.

Method

The study employed the complementary methods of quantitative and qualitative data collection and analysis (Tashakkori & Teddlie, 1998) in order to maximise the informative value of data gathered. Consequently, the study comprised two stages: a postal questionnaire, which informed focus group discussions.

Participants

At the time of this research three of the four localities in Somerset had received FIRST training. Consequently, all therapists who had completed their training on the FIRST course ($n=18$) in the Somerset area were invited to participate in the study.

Fifteen agreed to participate. Of the three who declined to participate, one was on maternity leave at the time while the remaining two did not provide a reason. Eight of the participants were female and seven were male. Five participants were community psychiatric nurses, four were nursing staff based on acute in-patient units, two were social workers, one was a psychiatrist, one was a clinical psychologist, one was an art therapist and one was a staff nurse based in a rehabilitation day resource centre. At the time of study, staff from Area A ($n=6$) had been trained for 2 years and 11 months, staff from Area B ($n=8$) had been trained for 1 year and 8 months and staff from Area C ($n=7$) had been trained 3 months previously.

Materials

A questionnaire was adapted from that used by Fadden (1997) in her study of family intervention training (which had been based

on Kavanagh *et al.*'s (1993) original study). This comprised 12 closed questions addressing details such as number of families seen and number of cases currently open. Participants were then required to rate the amount of difficulty experienced in using the approach on a five-point scale, as well as rating the amount of difficulty experienced with regard to 35 specified areas. Ten open questions were also included, focusing on factors such as difficulties encountered, factors that aided work with families and ability to attend supervision. The questionnaire took approximately 30 minutes to complete.

A semi-structured interview schedule was developed which was informed by, but not exclusively based upon, the questionnaire results in order to expand upon them. It addressed seven key areas: timing of referrals to the service, the experience of co-working, the ability to engage families, skills acquired from the training, any change in attitude experienced as a result of training, factors that could make family work more successful, and the effects of location of work and number of other therapists trained in the service area.

Procedure

Each of the 18 therapists trained in the Family Support Service in Somerset was sent the questionnaire regarding their experiences of implementing family intervention. A covering letter outlined the aim of the research and assured participants that their responses would be treated in confidence, that their anonymity would be guaranteed and of their right to withdraw from the study. A postage paid envelope was included in order to facilitate the return of completed questionnaires. As noted, 15 questionnaires were returned (a response rate of 83%).

Ten of the participants volunteered to take part in the second stage of the study. Two

focus groups (in areas B and C) were conducted, each comprising five trained staff. Both focus groups took place after a monthly Family Support Service supervision session for the convenience of the participants. The focus groups were audio-taped with the permission of the participants and lasted approximately an hour each.

The audio-tapes were transcribed verbatim and the data were analysed using thematic content analysis (Boyatzis, 1998).

Results

The findings of each stage of the study are reported separately for clarity of understanding.

Stage 1: Findings from the questionnaire

All 15 participants reported taking on families using the Family Support Service approach since completing the FIRST course. The average number of families seen per therapist in the period since completion of training (an average of 26 months) was 3.5. This figure is higher than the figures reported in both Fadden (1997) and Kavanagh *et al.*'s (1993) studies, where the mean number of families seen post training was 1.7 (9–42 months post-training) and 1.4 (6–36 months post training) respectively.

Unlike in Fadden's (1997) study where staff in community settings saw significantly more families than in-patient staff, there was no significant difference ($t=0.482$, $df=13$, $p>0.05$) between the mean number of families seen by staff based in community settings and staff based in in-patient settings in this study.

Fadden (1997) suggests that a minimum of eight people should be trained in any one location as she had found that significantly more families were seen in areas serviced by eight or more trained staff than in those with

fewer than eight. However no significant difference in number of families seen between the service with eight staff (A) and the other two services with less than eight staff was found ($t=2.011$, $df=13$, $p>0.05$).

The majority (71%) of families seen by the service had members who were experiencing schizophreniform psychotic symptoms.

Difficulty in implementing the approach

Staff were required to rate how difficult they had found the use of the Family Support Service approach in their work on a 5-point scale ranging from 0 (not at all difficult), to 5 (impossible). Eighty per cent of staff indicated that they had found it not at all or a little difficult to use the approach. Only 20% reported that they had found it moderately or very difficult and 0% reported that it was extremely difficult or impossible to use the approach. These findings are markedly different to those of Fadden (1997) and Kavanagh *et al.* (1993) as can be seen in Table 1. Overall, participants in this study reported experiencing far fewer difficulties than participants in these previous studies.

However, like Fadden (1997), participants working in in-patient settings reported significantly more difficulties (Mann-Whitney, $U=7$, $p<0.05$) in seeing families than those working in community settings. No significant differences in level of experienced difficulty was found between the three training groups (Kruskal-Wallis, $H=0.292$, $df=2$, $p>0.05$).

Participants were also asked to indicate the amount of difficulty experienced with regard to 35 different areas identified in Fadden's (1997) work as potentially affecting their ability to implement the Family Support Service approach. Amount of difficulty was rated on a scale from 0, indicating no difficulty, to 4, indicating extreme difficulty. The two main areas of difficulty were reported as allowance of time from the service to do the intervention, and integration with caseload or other responsibilities at work. Both factors, which were rated as less than 'moderately difficult' on average, can be seen as relating to organisational issues. Staff knowledge was highlighted as another area of some difficulty with knowledge and skills in family intervention, systemic-, cognitive- and behavioural-techniques all being reported as further areas of difficulty. Engagement of clients and families and availability of appropriate clients were also considered areas of difficulty. These results are compared to those of Fadden (1997) and Kavanagh *et al.* (1993) in Table 2 below, in which areas of difficulty are arranged in the order of decreasing levels of difficulty as reported in this study.

In addition, participants also reported numerous difficulties in response to an open question requesting them to comment on the main difficulties or challenges they had found in using the approach. The most commonly reported problem was co-working (33%). Other areas of difficulty noted were a lack of referrals (20%), the problem of engaging

Table 1: Overall level of difficulty implementing the family approach in three studies

Study	Difficulty rating		
	Not at all or a little difficult	Moderately or very difficult	Extremely difficult or impossible
Somerset, UK	80%	20%	0%
Buckingham, UK (Fadden, 1997)	44%	45%	11%
Sydney, Australia (Kavanagh <i>et al.</i> , 1993)	31%	48%	22%

Table 2: Areas of difficulty implementing the family approach in three studies

Area of difficulty	Somerset	Buckingham	Sydney
Allowance of time from the service to do intervention	1.60	1.56	2.3
Integration with caseload or other responsibilities at work	1.53	1.76	2.4
Knowledge and skills in family intervention	1.47	1.33	1.1
Knowledge and skills in systemic techniques	1.43	-	-
Knowledge and skills in cognitive techniques	1.43	-	-
Knowledge and skills in behavioural techniques	1.27	1.12	1.0
Engagement of clients or families	1.27	1.75	1.4
Availability of appropriate clients	1.20	2.18	1.9
Gaps in general clinical skills (or lack of confidence in them)	1.20	0.88	0.7
Keeping family discussion on track	1.20	1.30	1.4
Keeping to the concept that I was trying to teach	1.13	1.09	1.4
Lack of knowledge/ recognition by colleagues of value of family work	1.07	0.94	1.0
Lack of support by managers for the value of family work	1.07	0.53	1.1
Clashes of family sessions with crises with other clients	0.93	0.85	1.4
Availability of time in lieu or overtime for appointments	0.87	1.40	1.6
Ensuring that family sessions had a positive tone	0.87	0.74	1.1
Developing specific goals for sessions	0.87	0.91	1.1
Time needed before the results became apparent	0.86	0.91	-
The use of assessment measures	0.79	0.91	1.2
Clash with my preferred treatment approach	0.73	0.88	1.1
Integration with outside interests or responsibilities, e.g. family	0.73	1.00	1.8
Long-term commitment to a specific client and family	0.60	0.87	1.4
Lack of progress by clients or families	0.60	0.94	1.6
Illness or holidays (client or family)	0.53	0.77	(1.7)
Clash of FSS sessions and other clinical needs of the clients/families	0.47	1.09	-
Tailoring the programme to individual families and their needs	0.47	1.00	1.4
Travel to family sessions	0.40	0.45	0.9
Collaboration with my co-therapist	0.33	0.47	0.9
Non-applicability of programme to the needs of clients or families	0.31	1.36	1.4
Colleagues would not let me work with families they are involved in	0.29	0.54	-
Illness or holidays (mine)	0.29	0.30	(1.7)
Adequacy of the training given by the training sessions	0.20	0.65	1.1
Liaison with private practitioners	0.17	0.52	0.6
Access to consultation or supervision	0.07	0.82	1.4
The family intervention manual	-	0.80	0.8
Other	0.50	-	-

families (20%), the attitude of families (13%), case-load issues (7%) and time constraints (7%).

Impact of training on therapist's work

Seventy-three per cent of staff reported that the FIRST course had resulted in them seeing families more frequently than they did prior to attending the course. Eighty-seven per cent stated that they had used components of the Family Support Service approach with individuals, particularly the behavioural approach, goal setting, positive feedback, problem solving, psycho-education, hearing voices approach, genograms, stress-vulnerability model, systemic thinking and coping strategy enhancement. There were no specific elements of the approach that were more commonly reported as being utilised.

Overall, the impact of the FIRST course upon participants was positive in terms of the benefits they felt that it had for their work, in particular in actually working with families. Co-working, increased confidence when working with families and the role of supervision were the most frequently cited benefits of the training. With respect to supervision in particular, the majority of participants had no difficulty with attendance. Occasional problems, usually related to a crisis on the in-patient unit or with other work, sometimes prevented attendance for some participants.

Other benefits included a change in the participants' attitude, learning new approaches, re-thinking and confirming good practice, and significant improvements in the depth, quality and understanding of clinical work. Previous involvement with families or with people with psychosis was also reported as aiding the participants' ability to work with families.

Like Fadden (1997), no gender differences were found in areas such as the ability to use the approach, levels of difficulty experienced

in implementing the approach, and the number of families seen.

Stage 2: Findings from the focus groups

Thematic content analysis of the verbatim transcripts from the focus groups revealed two main themes, each with a number of smaller related sub-themes. The first theme relates to the organisation or structure of the wider service while the second involves the structure of the Family Support Service itself.

Wider organisational issues

Management of the locality mental health services, in particular the attitudes of management, emerged as an important factor influencing participants' work with families. However, contrasting views in relation to the influence of management were identified between the two service areas (B and C) participating in stage two of the research.

All staff in Area B reported that managers appeared to regard the time they spent on family work as being very much separate from their mainstream work. Indeed, it was revealed that managers had gone as far as voicing the opinion that mainstream work was more important than family work. This resulted in staff feeling that finding time for family work was difficult in itself, and their problem – as opposed to management's problem. This led to staff feeling frustrated because they believed that a greater investment in time could result in their work being more successful. Staff in area C reported no such difficulties. While they did feel that the work was time-consuming, the consensus among staff in area C was that their managers were aware of how much time would be required for this work from the outset.

Attitudes of other professionals in the service were also highlighted as an area of concern for staff in Area B, but not for staff in

Area C. In particular, area B staff reported that the attitudes of GP's was significant, in that they did not always refer clients to the Family Support Service as early as they might have. This caused problems for staff in area B in that there is increasing recognition that intervening early in psychosis is associated with better outcomes (Birchwood *et al.*, 2000; Department of Health, 1999).

Finally, some participants from both areas cited aspects of the structure of the organisation as being unhelpful to family work. For example, medically trained staff were only able to log the Identified Patient as having been seen and not the rest of the family. This tends to underestimate the time and effort involved with family work. By contrast, a social worker was able to log each person she visited in her statistics and therefore had no difficulty in this respect. This discrepancy between amount of work actually completed and apparent work completed, as measured by statistics, could be one reason why managers are unaware of the time-consuming nature and importance of family work.

The structure of the family support service

The flexibility of the Family Support Service in particular was seen as contributing to the success of the service in numerous areas of family work. These include engaging families, deciding which family members the service will work with, the location in which therapists will see families, and staff's willingness to work out of hours to fit in with the needs of the family. The service is also flexible in that although it is aimed at early intervention, it is applicable to rehabilitation clients as well as acute clients, both of which were being referred to the service.

The multidisciplinary nature of the Family Support Service teams was regarded as beneficial to the service because it allows staff to

learn new ways of thinking and to observe different points of view. In addition, participants felt that it is valuable to have Family Support Service (FSS) staff, and therefore the service, represented in nearly all of the local units. Such representation greatly assisted liaison between the FSS and the other mental health services, which not only enabled earlier referral to the FSS but also contributed to the delivery of a more consistent clinical approach. It also ensured that the FSS was perceived as a valued part of the mental health services.

A third aspect seen as contributing to the success of family work was co-working. Thus, although some participants from both areas had experienced occasional problems such as arranging family appointments if a colleague was working different shifts, the overwhelming majority felt that the benefits of co-working greatly outweighed the difficulties. Indeed, participants believed co-working resulted in greater success in the family sessions.

Monthly supervision sessions for Family Support Service staff were a further area of the service regarded as extremely beneficial. Staff reported that it made their work more successful in a number of ways including as a source of support and encouragement, and as an opportunity to refocus and solve problems.

Discussion

This study aimed to examine the effectiveness of a team-based multi-professional training programme in family intervention, which was designed to overcome identified difficulties in implementing family interventions subsequent to training. Both the questionnaire and focus groups data suggest that professionals in this study experienced fewer difficulties in working with families subse-

quent to training than has been reported in previous research (e.g. Fadden, 1997; Kavanagh *et al.*, 1993). Indeed, the questionnaire data revealed that 80% of staff experienced little or no difficulty in implementing the approach, as compared to only 44% in Fadden's (1997) study and 31% in Kavanagh *et al.*'s (1993) study. The design of the FIRST course and the Family Support Service approach generally appears to have helped overcome the difficulties previously experienced by professionals.

Compared with the Fadden (1997) and Kavanagh *et al.* (1993) studies, the staff in this study have been able to work with more families since completing their training. Indeed, the most valid comparisons to be made are between the two groups in Somerset who had completed their training between 1.5 and 3 years previously, and the four groups who were surveyed by Fadden (1997) between 1.5 and 3.5 years after completing training. Fadden reports that highest mean numbers of families seen per course participant (mean of 2.4 families) occurred in the group surveyed 18 months post-training, while the group surveyed 2.5 years post-training had the lowest mean number of families seen (mean of 2.0 families). In comparison, the Somerset groups had seen significantly more families overall, and length of time since training was correlated with increased numbers of families being seen (1.5 years: mean 4.3 families; 3 years: mean 5.3). This latter finding appears to indicate that the Family Service structure enables therapists to continue to deliver family intervention over time.

In common with previous studies (Fadden, 1997; Kavanagh *et al.*, 1993; Brennan & Gamble, 1997) organisational issues such as not having sufficient time from the service to implement the intervention, and integration of family intervention with caseload or other responsibilities at work, were identified as

resulting in the most difficulty in implementing the family intervention approach in routine clinical settings. Indeed, the time consuming nature of family work was identified as a difficulty in both the questionnaire survey and the focus group discussions. Further, local area differences suggested that time interacted with other factors. The differences between the areas may be attributable to the fact that the team more recently trained was therefore still at full strength, while the team in Area B had trained earlier and had recently lost some of its members. This finding suggests that maintaining the full complement of staff on a family intervention team is important to the delivery of that service.

While this study and those conducted previously have consistently reported most difficulty with organisational issues, previous research has also identified a range of other difficulties experienced by staff in attempting to implement a family intervention approach. These include the availability of suitable clients to work with, difficulty in engaging families, and families' low motivation or unwillingness to co-operate with the approach (Fadden, 1997). Further, Brennan & Gamble (1997) reported problems in the use of assessment methods, collaboration with co-workers, keeping family sessions on track and access to supervision. The fact that staff from the Family Support Service in this study did not consider any of the above to be areas of major difficulty may be due to aspects of the Somerset service designed to facilitate their ability to work with a wide range of families.

Fadden's (1997) research revealed that the location in which the therapists worked (i.e. community versus in-patient setting) and the number of therapists trained in the service area were central in this respect but no differences were found in the study. However, one participant, an in-patient nurse, reported dur-

ing the focus group discussion that she had occasional difficulties incorporating the family work with shift work and some of the community based workers felt that working in the community allowed them greater flexibility and probably made family work easier.

The second area identified by Fadden (1997) as influencing the number of families seen post training was the number of trained staff within an area. Although we did not replicate Fadden's findings the focus groups indicated that provision of an effective service is linked with having a critical mass of supportive FI colleagues.

In summary, there appear to be three main findings from this study. First, and in contrast to previous research, staff trained in this study experienced fewer difficulties implementing the FI approach and saw more families post training. Second, and in line with previous research, some difficulties relating to wider organisational issues were experienced. In particular, these were the allowance of sufficient time to implement the intervention and integration with caseload or other responsibilities at work. Third, a number of specific aspects of the service in Somerset appear to have facilitated successful work with families and may account for the lower difficulty ratings in implementing the approach found in this study. In particular, the following features of the service were highlighted as being beneficial: the flexible nature of the service, the multidisciplinary nature of the teams, the use of co-working and regular supervision. It is possible that these features may be the reason for staff experiencing less difficulty in areas previously identified as problematic, such as engaging families and the applicability of the approach to a wide range of families.

While these findings have important implications for practice, they need to be viewed with some caution due to the small sample size.

But despite this limitation, it is argued that the findings of this study may be of significance to others working in this area. Indeed, in the light of the relative success of the implementation of FI in this study as compared to those conducted previously, it appears that fruitful lessons may be learned. Ideally, studies of routine FI practice should employ both qualitative and quantitative methods in order to maximise the views obtained from staff involved in implementing the service. Finally, research is needed to compare different routine FI services in order to identify key factors that need to be incorporated to ensure effective FI. In this way, benefits to both the staff implementing the approach and families in need of such intervention may be maximised.

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Enhancing Working Partnerships with Carers and Families in Clinical Practice: A Strategy and Associated Staff Training Programme

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Introduction

Increased involvement of families and carers is central to all current national mental health policies. However, in most of the recent proposals for mental health services, enhanced working partnerships between professionals and carers/families¹ remains an aspiration rather than a reality. Research has highlighted the dissatisfaction of families, friends and relatives of people with mental health problems who often feel unheard and excluded from their relative's care (Leavey et al, 1997; Shepherd et al, 1994). This is in spite of the fact that they are frequently the first to become aware of difficulties (both at onset and relapse), often encourage the person to seek help and, in enduring cases of mental illness, provide much of the day-to-day support.

Routine involvement of carers/families, including formal family interventions, is an acknowledged component of effective and acceptable services for people with severe mental illness. The National Service Framework for Mental Health (Department of Health, 1999) clearly identifies the needs of carers and families both for support in looking after their relative with mental illness and also in looking after their own needs.

“Carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness. Providing help, advice and services to carers can be one of the best ways of helping people with mental health problems. While caring can be rewarding, the strains and responsibilities of caring can also have an impact on carers’ own mental and physical health. These needs must also be addressed by health and social services” (pp.69)

The focus of Standard Six of the National Service Framework (NSF) on carers’ and families’ rights to have their own needs assessed and to have a written care plan should not be viewed as a discrete additional task. A general reorientation of the existing mental health services and the availability of a wide range of interventions will be required if we are to meet the needs of carers and families. This is acknowledged in *Developing Services for Carers and Families of People with Mental Illness* which details the principles and service developments which mental health services should strive to meet (Department of Health, 2002a). These include a positive and inclusive approach by professionals, flexible and individualised services which are person centred, accessible and responsive services available at all times, and integrated and co-ordinated services with carers’ services embedded into mainstream services.

¹ These terms are used interchangeably throughout this paper to denote the social support network

This inclusive approach towards families/carers is fundamental to the modernisation of all mental health services as the quotations in Table One show:

Table One

<p><i>NSF for Older People</i> Department of Health, 2001a, p92.</p>	<p>“Carers of older people with mental health problems often need support. They may have physical and mental health needs of their own. They also need information, advice, and practical help to support them in caring for the older person.”</p>
<p><i>Valuing People: A new strategy for learning disability for the 21st Century</i> Department of Health, 2001b, p5.</p>	<p>“Caring for a family member with a learning disability is a lifelong commitment. Our objective is to increase the help and support carers receive from all local agencies in order to fulfil their family and caring roles effectively”.</p>
<p><i>Every Child Matters</i> Green Paper Department for Education and Science, 2003, p9.</p>	<p>“The Government intends to put supporting parents and carers at the heart of its approach to improving children’s lives, where support is needed or wanted”</p>
<p><i>Mental Health Policy Implementation Guide: Community Mental Health Teams</i> Department of Health, 2002, p13.</p>	<p>“families and carers should be involved in the Care Programme Approach as much as possible”</p>
<p><i>Mental Health Implementation Guide: National Minimum Standards for General Adult services in Psychiatric Intensive Care Units (P.I.C.U.) and low Secure Environments.</i> Department of Health, 2002, p19.</p>	<p>“Carers should be involved in every appropriate aspect of the patients care and the treatment in order to maximise positive experiences and reduce stigma. All PICUs/Low secure environments should respond to carers concerns regarding treatment in a secure environment”</p>
<p><i>NICE Clinical Guidelines for Schizophrenia</i> Department of Health, 2002b, p54.</p>	<p>“Family interventions to be offered to 100% of families of individuals with schizophrenia who have experienced a recent relapse, are considered to be at risk of relapsing, or who have persisting symptoms, and are living with or in close contact with their family”.</p>

The Research Base

There is considerable evidence demonstrating improved outcome where family interventions are included in routine treatment for a range of clinical conditions, particularly psychosis (for recent reviews see Bustillo et al, 2001; Dixon et al, 2000; Pharoah et al, 2002; Pilling et al, 2002, Pitschel-Walz et al, 2001). Caring for someone who is mentally ill can lead to high levels of stress and an increased vulnerability to mental health problems such as depression and anxiety (Birchwood & Cochrane, 1990; Fadden et al, 1987; Johnson, 1994; McCarthy et al, 1989) but there is evidence that the involvement of carers and families in treatment can reduce the burden (Cuijpers, 1999). The beneficial effects of working with the wider system are illustrated by an interesting study by Law and Crane (2000) which suggested that, in addition to the person referred, other family members also benefit from family therapy in terms of a subsequent reduction in health care use.

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Needs of Families and Carers

There has often been a discontinuity between the needs identified by clients and families, and the assessed needs identified by professionals (Pearson et al, 2003). This has led to mismatches between what families expect from services and what professionals choose to provide (Hatfield, 1983). Numerous research studies and carer initiatives, eg. West Midland Carers in Partnership(undated); (IRIS, 2001), have recommended ways in which mental health services can more effectively meet the needs of informal carers and families. What they would like from services includes:

- to be listened to and supported
- information about diagnosis, treatment and services, benefits etc.
- to be involved in planning their relative's care
- advice on ways to respond to the individual
- skills for coping.

This range of needs will not be met through a narrow focus on delivering the targets specified in Standard Six of the Mental Health National Service Framework but by comprehensively involving carers and families in all aspects of the mental health services.

A Strategy for Family/Carer Friendly Services

Services which are family/carers friendly would consider families and carers in all aspects of their functioning. This would represent a considerable cultural shift for many services where the focus has been on individual pathology and treatment. It would mean that aspects of services which might currently be regarded as best practice would become routine and mainstream.

A range of initiatives would be involved:

Family friendly facilities

This would include ensuring that mental health facilities are friendly to visit and that staff welcome relatives and carers. Providing appropriate facilities such as visiting rooms which offer privacy and are child friendly will provide a considerable challenge to many services, particularly acute in-patient units.

Involvement in Assessment

Staff would need to make contact with families and carers during the initial stage of engagement unless there was good reason not to do so, and may include the practice of involving significant others in the initial interview. This early contact would enable the identification of the social network of the person referred and facilitate treatment interventions which consider the client in the context of his or her relationships. Of course, even when it is not appropriate to meet directly with relatives it is both possible and desirable to include a family perspective when working with individuals.

This involvement of the family in the assessment process may also enable the early referral of all family members, when appropriate, for more specialist forms of therapy such as the provision of specialist carer/family interventions in psychosis and generic family therapy services.

Whole-system approach

The evolution of specialist services, whilst meeting the needs of the individual referred, has not always led to the needs of the whole family being met. A joined up approach which is family-focused would require close working between colleagues across specialities and agencies such as adult mental health services, child and adolescent mental health services, older adults' services, primary care, social services, non-statutory organisations and education in order to meet the needs of all family members. Included in this would be a greater consideration of the needs of children in families, for example, child protection issues and an acknowledgement of the impact of adult mental health problems on children and the needs of children who become carers themselves. Children in these situations will have their own needs for information, advice and support. There is also a need to provide greater consideration of the needs of adults who care for children with severe developmental or mental health problems.

Obstacles To Change

The obstacles to change would need to be specifically addressed if services are to achieve the vision. Even where staff have been specifically trained to work with families they have found it difficult to do so (Fadden, 1997; Brennan and Gamble, 1997; Kavanagh et al, 1993). The training is more likely to alter clinical practice if it is also accompanied by endorsement and encouragement by management at all levels, with a formal strategy and a 'champion' to take it forward. In addition, other workplace issues need to be addressed: for example, that team managers ensure that their staff have manageable workloads and appropriate supervision.

There is mounting evidence that the difficulties regarding implementation associated with training of individuals are reduced if training is team-based (Bailey et al, 2003; Corrigan & McCracken, 1998; Wilshaw & Bohannon, 2003). We have found that in-situ multi-professional team-based training with subsequent supervision (Quarry & Burbach, 1998) enables the required changes in culture and practice for service development (Burbach et al, 2002).

In order to take a carers and families strategy forward we propose that mental health services/trusts set up steering groups consisting of representatives of carers, users, professionals currently involved in family work and carer support, specialities, agencies, the training department and management. The function of this group would be to support and facilitate the implementation of the strategy and to ensure that it is embedded throughout organisational structures and policies. In addition, we propose that a clinical lead post with specialist family work skills is established in order to develop a staff-training programme and to provide clinical leadership for the strategy.

The Training Required

An understated aspect of implementing the National Service Framework is the need for targeted training to equip staff to make the transition to the new ways of working that are required. This represents a challenge to existing education and training purchasers, including the Workforce Development Confederations, who may have been organised around individual education based models rather than service led priorities. But, if the NSF is to deliver high quality provision as well as meet government targets, there is a need to provide specific training focused on establishing services (Burbach et al, 2002).

Most professionals' basic training does not include the specific skills for working with families. It is therefore proposed that comprehensive awareness/basic skills training packages are

developed to equip existing staff with the skills required to deliver the national agenda. The provision of a variety of training packages would enable a planned programme of workforce development. Staff could be encouraged to access a continuum of training from basic awareness/skills to more specialist skills according to their need and role in the service.

The aim would be to introduce a family/systemic perspective throughout the service including inpatient units, CMHTs, CAMHS, early interventions services, crisis resolution/home treatment, and assertive outreach teams in order that considering and working with families becomes a mainstream activity. We would recommend providing this training directly to whole teams to make sure that the training meets the needs of that particular team.

Attitude and Awareness

Focusing on staff attitude is central if we are to move to more family orientated services. Whilst many welcome this shift, it is still the case that some staff view family members either as a cause of the client's difficulties, or as interfering, and thus resist contact with families, while many others might not see a need to involve families in the clients' care. We recommend involving carers in the provision of the training in order to achieve the required shift in attitudes and to help staff to extend their commonly held client centred values and therapeutic skills to working with families.

Skills

The balance of attitude/theory and practice provided within these short courses would depend upon the needs of the particular part of the service. For some staff an awareness of issues facing families and carers, together with how to access further help and resources, may be sufficient; whereas for others with more direct contact, developing skills in conducting family meetings will be required. Relatively short packages of training would include a combination of theory and the evidence base for family work combined with case examples and skills training through role-play and a focus upon attitude and beliefs. Ideally, on-going supervision would enable staff to practise these skills and consolidate their learning.

This ambitious training strategy would include offering short training packages to all existing teams. Short training courses would also form an important part of the preparatory training of the proposed new crisis resolution/home treatment, assertive outreach, early intervention and primary care teams.

It is important to note that it is not the aim of such a strategy to train large numbers of staff to be family therapists, but rather to increase awareness of the needs of carers and families and to create more family sensitive mainstream services. At the specialist end of this continuum of services, however, is also the need to support the training of a smaller number of specialist level qualified therapists in both systemic family therapy and family interventions in psychosis in order to meet more specific needs (Pearson et al, 2004). This group will also be well placed to provide much of the training required by the strategy.

Conclusion

This paper describes the increased national focus on including families and carers in all aspects of mainstream mental health services. It proposes that the specific recommendations contained in the National Service Framework for Adult Mental Health be brought together in the form of a strategy to enhance working partnerships with families and carers. It advocates that the implementation of the NSF requires a comprehensive awareness and basic skills training for all

staff in order that the consideration of families and carers becomes a routine part of mainstream services. Whereas this proposal is specifically aimed at implementing the National Service Framework for adult mental health services, it is important to recognise that much of this training emphasises inter-agency and inter-specialty collaboration and therefore the potential for joint training.

These proposals are generally applicable to all trusts in the UK and we would be interested in the experience of other trusts who are considering a similar strategy to enhance their services. In Somerset we are fortunate to be considering these issues in the context of a history of both specialist family therapy services (Brennan and Challenger, 1995; Burbach et al, 1997; Procter & Pieczora, 1993) and successfully training and establishing family interventions teams across Somerset (Burbach & Stanbridge, 1998; 2004, Stanbridge et al, 2003, Bailey et al, 2003). A significant factor is that our trust is an integrated health and social care trust and the trust board has recognised the wider relevance of a family/carer perspective by recently adopting a strategy to enhance working partnerships with carers and families. Implementation will require prioritisation of this in the face of other demands to develop mental health services. Time will tell whether creating more family oriented services continues to remain an aspiration rather than a reality.

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Somerset's family interventions in psychosis service: an update

Frank Burbach^a and Roger Stanbridge^b

This paper describes a project in which family interventions in psychosis services were successfully established in a routine clinical setting. This has involved the development of a whole-team training approach, an accredited one-year training course, and a clinical approach which integrates the systemic and cognitive-behavioural psychoeducational approaches. Since the original description of this project (Burbach and Stanbridge, 1998) the training course and service have been evaluated and the clinical approach has been further developed. These developments, particularly the 'cognitive interactional' approach and collaborative therapeutic stance, are detailed. The paper explores the factors which have contributed to the successful establishment and maintenance of the service, and describes more recent initiatives to bring about more family/carer-friendly mental health services.

Introduction

Although evidence for the efficacy of family interventions (FI) when a family member experiences psychosis/schizophrenia is robust (see reviews of randomized controlled trials by Bustillo *et al.*, 2001; Dixon *et al.*, 2000; Mari and Streiner, 1996; Pharoah *et al.*, 2002; Pitschel-Walz *et al.*, 2001), and FI has been included in national policy (e.g. National Service Framework, 1999; NICE Guidelines, 2002), this has not led to the widespread establishment of family intervention services in routine clinical settings (Brooker, 2001; Fadden, 1998). This paper reviews the progress of a project to establish a trustwide FI service in the Somerset Partnership NHS and Social Care Trust (Burbach and Stanbridge, 1998). The project has a number of unique features. First,

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the integration of the systemic and psychoeducational approaches. Second, the model of developing new services by means of *in-situ* multi-professional team training. Third, a focus on the wider service context which has subsequently led to the trust adopting a strategy to enhance working partnerships with families and carers throughout mainstream services.

Current situation

During the period 1996 to 2001 we have sequentially developed a family intervention service (Family Support Service) in each of the four service sectors/Primary Care Trust areas in Somerset. Each service sector covers a largely rural population of between 110,000 and 140,000 people. Each team consists of approximately eight members who, with the agreement of their line manager, devote a minimum of half a day a week to the Family Support Service. Each team includes staff from the range of local units (e.g. inpatient units, CMHTs) which enables good liaison between the family interventions team and the rest of the service. Each team is also designed to include a wide range of professions including social workers, psychiatrists, nurses, psychologists, art therapists, occupational therapists and support workers. One of the team members takes on the role of coordinator and is responsible for processing referrals and gathering audit data. Each team meets monthly for half a day of peer supervision, review of cases and to deal with organizational issues.

The Family Support Service is available to people who are in regular contact/living with their family members or significant others (e.g. carers) who are experiencing psychotic symptoms (including prodromal symptoms). We aim to intervene as early as possible and to encourage early referral which may be during the acute phase and before a diagnosis has been made. Although the evidence base for FI was originally developed with people with enduring symptoms who were vulnerable to relapse (NICE, 2002), our service works with a wider spectrum of people with psychosis. This is in line with national initiatives to develop early intervention in psychosis services (NSF-DoH, 1999; IRIS, 2001) and we therefore prioritize those with first and second episode psychosis. The procedure is for two therapists to meet with individual families in the location most conducive to engagement. The aim is to collaboratively negotiate with each family a therapeutic contract which reflects their particular needs and to continue supporting them as long as required.

While the main focus of the work is often described as seeking to improve outcome and quality of life for the person experiencing psychotic symptoms, our systemic thinking leads us to place emphasis on relationships and therefore the needs of all family members. Indeed, there is gathering evidence that family work benefits other family members as well as the individual (Cuijpers, 1999; Law and Crane, 2000).

We find that a number of interventions can result in a helpful reduction of stress for the individual with symptoms. These may include increased competency in problem-solving and communication within the family, combined with developing more realistic expectations of the person's functioning. Whereas information sharing may be helpful in this, in itself it has not been shown to be sufficient to significantly effect clinical outcome (Lam, 1991; NICE, 2002). In most cases an exploration of feelings (e.g. guilt; loss), and interactional patterns and beliefs which maintain problems, is required in order to effect change in attitudes and behaviour. For further details regarding the Family Support Service see Burbach and Stanbridge (1998) and Table 1.

Having established a trustwide service our current focus is on its maintenance. Clearly over the passage of time there are inevitable movements of staff which, in our case, are exacerbated by major organizational change within the Trust. We are therefore providing

TABLE 1 *Family Support Service – key features*

-
- A competency-based approach which integrates recent psychosocial (individual- and family-CBT) approaches with a systemic perspective.
 - The service supports families where a member has psychotic symptoms.
 - Early intervention for first or second episode psychosis is prioritized. We also work with longer term psychosis where systemic factors are apparent.
 - The FI service complements existing services.
 - The service is provided by a multi-disciplinary team of ± 8 clinicians trained in FI in each locality.
 - The Family Support Service is embedded in all parts of the local mental health service – team members allocate a minimum of half a day per week to the FSS from their existing posts in inpatient units, CMHTs, etc.
 - Families are seen in a variety of settings (e.g. home, CMHT) by two clinicians.
 - Families are supported through the various parts of the mental health system by the same pair of clinicians.
 - Co-therapy and monthly supervision groups ensure quality and therapists' motivation.
 - The therapeutic contract between individual families and clinicians is collaboratively negotiated to meet family members' needs.
-

ongoing training courses to maintain teams at full strength. In addition, we have established quarterly study days in order to enable existing team members to update their knowledge and skills, encourage the sharing of good practice between teams and to maintain morale. We also continue to give feedback to managers and clinicians (e.g. reports/presentations to the Trust Board and Clinical Governance Committee) and liaise with managers to resolve any operational problems or difficulties that may arise.

Evaluation of the service

Whereas the efficacy of family interventions is now evident, relatively few services have been established in routine clinical settings, and evaluation of the approach is particularly difficult in such circumstances. In Somerset we have attempted to evaluate the Family Support Service in a number of ways in order to improve the service we offer.

We routinely collect data on all cases which enables us to monitor our service and provide feedback, and thereby influence the wider mental health system. For example, the fact that team caseloads vary between eight and sixteen cases or that referrals per annum range from seven to twenty-one has led to renewed efforts to publicize the service and educate referrers in the service areas which make less use of our service. Over the past four years we have seen an increase in the proportion of referrals of people with first episode psychosis (from 44% to 76%) which suggests that our focus on this client group is increasingly being recognized by the wider service. Similarly, the fact that in one year one of the team's 'Did Not Attend' rate increased from the usual 2% to 17% and that the cancellation rate also increased from 3% to 11% resulted in useful discussions regarding the convening of families. It has also been useful to examine figures such as the number of families who were assessed but declined further contact (13 to 15%), the number of families who completed the intervention (65 to 70%) and the number of people who dropped out of therapy (17 to 20%). We have conducted a number of other analyses including examining the number of families seen where the client has been involved in sessions (86%) and the number of families seen where the relative was a parent (89%) or a partner (11%).

We have also conducted an in-depth study of families' satisfaction with the first Family Support Service to be established (Stanbridge *et al.*, 2003). We were particularly interested in this under-researched area because research into the implementation of family interventions

in routine clinical settings has identified a difficulty in engaging with families (Fadden, 1997). In addition, we wanted to evaluate our ability to deliver a collaborative, needs-led service. Fifteen of the first twenty-two referrals to the service agreed to take part in semi-structured interviews regarding family satisfaction, clinical outcome and the therapeutic alliance. All family members expressed satisfaction with the service overall, ten families rated themselves as 'very satisfied' and three families as 'partially satisfied'. The other two families were unable to evaluate the service, as they felt they had been referred 'too late' (e.g. on their son's discharge from hospital when their situation had already improved) but reported that they would have welcomed the service if it had been offered earlier.

The high level of satisfaction and engagement found in this study is interesting given that 73% of the sample reported feeling apprehension prior to being seen in the Family Support Service.

The study highlighted some of the ingredients which may be associated with successful outcome. Satisfaction was related to families' needs being met (e.g. coping with symptoms, problem-solving, improved communication in the family, better liaison with the services), them developing new perspectives, as well as feeling listened to in the context of an empathic, non-judgemental therapeutic relationship. A number of factors specifically emphasized in the Somerset Family Support Service appeared to contribute to the establishment of a positive therapeutic relationship and to be particularly valued by families, namely mutually agreed therapeutic aims, regular evaluation of the usefulness of sessions and the opportunity for open discussion. These factors reflect the service's broad, flexible therapeutic approach which enables clinicians to offer a range of interventions suited to different families' specific needs. These findings are perhaps best summed up by one family member's response to the question regarding their overall satisfaction with the service:

'Surprised and satisfied. The most important thing was that they listened and responded to the family's needs, not followed their own agenda, and that happened.'

Service development through whole-team training

In order to establish family interventions in psychosis services in Somerset we developed an approach which integrates individual skills-based training with team and service development (Burbach

et al., 2002). We designed a one-year course (accredited by the University of Plymouth at degree and diploma level and the Association for Family Therapy at foundation level) to train multi-disciplinary groups of staff in their local workplace.

The Family Interventions (Research, Skills, Theory) in Psychosis course (FIRST) consists of three twenty-credit modules. Module 1 covers systemic theory, research and basic practice skills. Systems thinking, the importance of context, and the way in which problems arise/are maintained are introduced from a 'cognitive-interactional' perspective. The family life cycle, family beliefs/narratives, the individual's/caregivers' experience of psychosis and the stress-vulnerability model are also introduced. Clinical skills relevant to the various stages of therapy are developed by means of role play. Module 2 critically examines the systemic family therapy and cognitive-behavioural/psychoeducational family intervention approaches to psychosis and further develops their integration. Theory and research about early intervention, ethical issues and risk are also examined. Behavioural family therapy, systemic interviewing, and formulation skills are developed in role play and in supervised work with families. Module 3 further develops clinical skills through direct supervision and considers their application in the service context. Cognitive-behaviour therapy techniques for psychosis (hallucinations, delusions, negative symptoms) are introduced. Further systemic theory and skills, narrative approaches and relapse prevention strategies are also introduced.

Students begin supervised work with families midway through the second module. For training purposes we augment our co-therapy approach with live supervision involving an observing team (including one-way screen, earpiece and audio/video links). An advantage of our approach is that by the end of the course a local 'Family Support Service' has been established. We then ensure the continued development of clinical skills by means of ongoing supervision (cf. Quarry and Burbach, 1998).

Although the FIRST course has remained fundamentally unchanged, retaining its original key features (see Table 2 and Burbach and Stanbridge, 1998), it has gone through a process of continual refinement based on student evaluation, evolving clinical experience, new theoretical developments and the need of the service to work with adolescents with a first episode psychosis. The course has now developed to the point where it has a detailed teaching programme with accompanying handouts which enables it to be delivered by other trusts.

TABLE 2 *Family Interventions (Research, Skills, Theory) in Psychosis course (FIRST) – key features*

-
- A one-year course (three modules), which is accredited by Plymouth University (degree and diploma level), and the Association for Family Therapy (foundation level).
 - The main aim of the course is to establish local family intervention services.
 - Each course is delivered by the course tutors in a local centre to a multi-disciplinary staff group.
 - Staff are drawn from the locality inpatient unit, CMHTs, day hospital and rehabilitation units.
 - Students are selected in conjunction with line managers on the basis that they will be able to continue to provide the service at the end of training.
 - Trainees have included: nurses, social workers, psychiatrists, psychologists, art therapists, occupational therapists and support workers.
 - The course philosophy is based on an integration of family therapy and family management approaches to psychosis.
 - The course teaches basic family therapy theories, skills/techniques and research findings.
 - Trainees begin supervised work with families midway through the second module – co-therapy, observing team/one-way screen.
 - By the end of the course a local 'family support service' is operational.
-

As we have moved from the setting up of the trustwide service to ensuring its maintenance we have also adapted the course. Our 'top-up' courses train staff from across the Trust to augment the existing Family Support Service teams. During the year the trainees from these courses join their respective local teams in order to meet some of the practical skills requirements of the FIRST course as well as to facilitate integration with the team. Our most recent course included staff from the child and adolescent mental health services which has enabled teams to intervene early with a younger age group (i.e. age 14 and over).

Evaluation of the training approach

Although the most important measure of the efficacy of our training approach is the fact that we have successfully established four family intervention teams, we have also conducted a study into the ability of FIRST trained staff to implement the approach. This is significant in the light of previous studies (Brennan and Gamble, 1997; Fadden, 1997; Kavanagh *et al.*, 1993) which found that staff trained in family interventions had great difficulties in implementing the approach in routine clinical practice and saw few families post training. Fifteen

TABLE 3 Overall level of difficulty implementing the family approach in three studies

Study	Difficulty rating (%)		
	Not at all or a little difficult	Moderately or very difficult	Extremely difficult or impossible
Somerset, UK (Bailey <i>et al.</i> , 2003)	80	20	0
Buckingham, UK (Fadden, 1997)	44	45	11
Sydney, Australia (Kavanagh <i>et al.</i> , 1993)	31	48	22

therapists who had completed the FIRST course participated in the study which involved questionnaires used in previous studies and focus groups (Bailey *et al.*, 2003). All reported working with families using the Family Support Service approach since completing the FIRST course. The average number of families seen since completion of training (an average of twenty-six months, range three to thirty-five months) was 3.5. This compares favourably with the findings of both Fadden (1997) and Kavanagh *et al.* (1993) where the mean number of families seen was 1.7 (nine to forty-two months post training) and 1.4 (six to twenty-six months post training), respectively. Staff trained on the FIRST course also reported fewer difficulties in implementing the approach (see Table 3).

Participants were also asked to indicate the amount of difficulty experienced with regard to thirty-five different areas potentially affecting their ability to implement the approach taught, on a scale from 0 (no difficulty) to 4 (extreme difficulty). In common with the previous studies the two main areas of difficulty reported were having sufficient time to do the work and its integration with caseload and other responsibilities at work. These organizational factors were rated as less than 'moderately difficult'. However, in contrast with the previous studies, the Somerset staff did not experience any difficulty in tailoring their approach to the needs of individual clients and families, nor in accessing consultation and supervision.

In the focus groups, staff identified a number of specific aspects of the service which enabled successful work with families despite some of the seemingly inevitable organizational difficulties of prioritizing family interventions. In particular, they highlighted the flexible nature of the service, the multi-disciplinary nature of the teams, the use of co-working and regular supervision as being beneficial.

Influencing the wider system

It has been important to consider, from the beginning of the project, the relationship of the new family interventions services to their wider service context. Besides a strategic focus on management this has also involved attempting to influence the wider clinical culture. To date we have provided brief packages of training regarding family work generally and family interventions in psychosis. This has now become established as an essential part of the training of new teams; for example, we provided a three-day course to the new Crisis Resolution/Home Treatment and Assertive Outreach teams in Somerset. The importance of working with families and carers is recognized in the National Service Framework (NSF) for Mental Health and this has led to our Trust adopting a Strategy to Enhance Working Partnerships with Carers and Families.¹ This has involved the appointment of a consultant family therapist (Roger Stanbridge) as clinical lead to take the strategy forward and the formation of a multi-agency Carers and Families Steering Group. To date this has led to improved information and support services for carers, the development of best practice guidelines regarding information sharing with families/confidentiality,² amendments to operational policies to encourage family involvement in assessments, and the implementation of an extensive staff awareness/skills training programme (Stanbridge and Burbach, 2004). We have also contributed to local primary-secondary care treatment protocols for psychosis and schizophrenia which should ensure that family work and specialist family intervention services are routinely integrated into treatment.

The therapeutic approach

The integration of cognitive behavioural/psychoeducational family interventions with systemic theory and practice forms the basis of our approach (Burbach and Stanbridge, 1998). We will not repeat the details regarding our clinical approach as described in this initial paper under the headings 'individualized'; 'collaborative'; 'informative'; 'systemic'; and 'solution-focused and cognitive-behavioural', but some of the main aspects are summarized in Table 4. We will,

¹ Copies available from the second author.

² Copies available from the second author.

TABLE 4 *The approach*

(1)	<p><u>Collaborative</u></p> <ul style="list-style-type: none"> ■ Therapist does not take the 'expert' position ■ Therapist as enabler <ul style="list-style-type: none"> – help develop new perspectives – aid in evolving solutions ■ Assume family members are the most knowledgeable about their own situation.
(2)	<p><u>Competency-based</u></p> <ul style="list-style-type: none"> ■ Focus on the whole person, not just pathology ■ Solution-focused ■ Normalizing ■ Counteract problem-saturated stories ■ Externalizing symptoms/problems
(3)	<p><u>Individualized</u></p> <ul style="list-style-type: none"> ■ Assess each family's needs and agree a therapeutic contract
(4)	<p><u>Informative</u></p> <ul style="list-style-type: none"> ■ Psychosis ■ Stress-vulnerability model ■ Coping strategies ■ Services
(5)	<p><u>Systemic</u></p> <ul style="list-style-type: none"> ■ Non-blaming, circular view of causality ■ Seeing individuals in their relational context ■ Considering socio-political contexts (inc. gender and culture) ■ Interactions which maintain problems ■ Transitions in family life cycle stage ■ Family organization (boundaries, roles, power) ■ Family beliefs/scripts/narratives ■ Developing a systemic perspective within services (e.g. improving liaison, advocacy)
(6)	<p><u>Cognitive-behavioural</u></p> <ul style="list-style-type: none"> ■ Goal-setting ■ Practical problem-solving ■ Manage/cope with hallucinations ■ Modify beliefs about the symptoms/current situation ■ 'Individual CBT' in a family context

however, elaborate on the subsequent development of our approach and describe the nature of our therapy sessions.

Most of the specific techniques relating to psychotic symptoms which we use with families have been well researched and documented (Anderson *et al.*, 1986; Barrowclough and TARRIER, 1992; Falloon *et al.*, 1987; Kuipers *et al.*, 2002). Our sessions routinely include

discussion of the stress vulnerability model (Zubin and Spring, 1977), coping strategies, the optimum use of medication and relapse prevention strategies. We also regularly use a range of behavioural (e.g. goal-setting, problem-solving) and cognitive-behavioural techniques. We find it helpful to conduct 'individually focused' CBT for hallucinations and delusions (see e.g. Chadwick *et al.*, 1996) within family sessions. Weaving this into the family sessions has the advantage of enabling supportive conversations about the client's ongoing symptoms which might otherwise not take place. In addition, the presence of family members makes it possible for a more detailed exploration of the context in which the symptoms occur. Family members can also sometimes take on a helpful role between therapeutic sessions (e.g. supporting coping strategies, reality testing). These psychosocial interventions are a response to specifically agreed needs rather than being offered as a set package.

In addition, our approach involves holding 'therapeutic conversations' with families using narrative and solution-focused techniques. We have found the technique of externalizing the problem together with maintaining a focus on solutions particularly helpful (Bertolino and O'Hanlon, 2002; de Shazer, 1985; Eron and Lund, 1996; Street and Downey, 1996; White, 1987; White and Epston, 1990).

Another systemically based focus in our sessions is the exploration of interactional patterns. We find that the interactional approach is particularly helpful, since it enables families to explore and resolve issues in a non-blaming manner.

We have found it helpful to explore interactional cycles not only in behavioural terms (e.g. pursuit and withdrawal) but also in terms of the constructs related to those behaviours (Dallos, 1991; Procter, 1985, 1996). In common with other cognitively oriented family intervention workers we often find that a successful outcome is linked more to shifts in family members' beliefs and appraisal of the situation than to changes in behaviour. On our course we have found it helpful to teach these concepts by combining cognitive-behavioural and interactional perspectives into a 'cognitive-interactional' approach. Conducting a cognitive-interactional analysis is also a useful therapeutic technique (Burbach, 2000). This involves mapping the thoughts and behaviours associated with a situation identified as a problem by the family. With the family we would construct a diagram which illustrates how they have become 'stuck' in an unfortunate interactional spiral to which they all contribute (an example is provided in Figure 1).

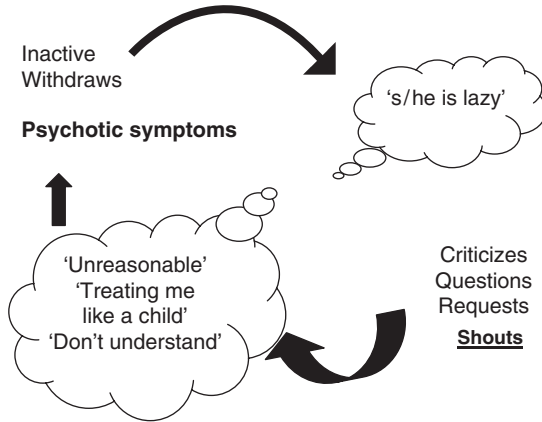


Figure 1. An example of a cognitive-interactive analysis

Subsequent discussion often leads to family members re-construing their situation. In the example shown, the parents might develop a more complex perspective around their child's behaviour as at times relating to illness and at times reflecting normal adolescent behaviour, and become aware of the fluctuating nature of the recovery process and adopt the concept of 'convalescence'. Such a change in construal would then lead to a shift from criticism/unreasonable demands, or disengagement/lowered expectations to increased tolerance/initially lowered expectations which would be raised incrementally over time. As the parents discuss the young person's capabilities with them and negotiate reasonable expectations, the young person may gradually feel that s/he is being treated with increased respect and understanding and therefore be more motivated to carry out agreed tasks. The process of change in this example will also be aided if this young person reconstrued his parents' behaviour as understandable in terms of their concern rather than as criticism. Behavioural interventions may also change this cognitive-interactive cycle (e.g. enhancing communication skills, goal-setting).

Our integration of various approaches and techniques is possible due to the adoption of a particular therapeutic stance (Burbach and Stanbridge, 2001). Our therapeutic stance is informed by both mental health service users' perspectives and contemporary (postmodern) family therapy ideas.

Mental health service users/carers have expressed dissatisfaction with the level of service provision as well as the nature of the care

provided. Users often report feeling disempowered by the system (e.g. not being listened to, not being treated with respect), and carers often feel unsupported by professionals (e.g. lack of information, excluded from decision-making) and inadequately acknowledged as partners in care (Leavey *et al.*, 1997; Shepherd *et al.*, 1994). Such difficulties seem to arise when professionals adopt a 'modernist' directive, instructional approach with service users and their families. This assumes that there is a single objective 'truth' which is known, or waiting to be discovered, by experts. In contrast, 'postmodern' perspectives have challenged this notion and recognize the validity of multiple and subjective perspectives.

Therapeutic stance

As therapists we aim to work collaboratively with family members, rather than adopting an 'expert' position. We assume that family members are the most knowledgeable about their own situation. We seek to work within a family's own value system.

We view therapy as a process in which families build on existing strengths, construe their situation in more helpful, flexible ways and develop their own coping resources. The therapist combines qualities such as empathy and curiosity to create a therapeutic space for families to address their needs, for example, by resolving practical issues or reflecting on their situation. Although the focus of sessions is largely determined by the family's expressed needs, the therapist is active and enabling in the therapeutic process.

The following examples illustrate the ways in which this stance informs our practice:

- Where possible we are open about the source of our ideas which may include other users' experiences, research literature and personal experience if appropriate.
- When questioned we respond fully, discussing the source of our information and its current status, and acknowledging our own lack of certainty.
- We share information/knowledge, often emphasizing other users' experiences, rather than providing the consensus view of the experts or one's own 'expert opinion/solution'.
- The information we provide is tailored to fit the family members' construal of their situation and we do not routinely educate people regarding diagnosis unless asked to do so by the family. We usually

discuss the individual's particular symptoms and use the term 'psychotic episode'.

- Ideas and techniques are offered rather than prescribed. Family members may therefore choose those techniques or ideas that 'fit' their values and needs.
- We do not seek to impose our views on family members, but attempt to enter into dialogue with the family members to help them to develop their understandings or story/narrative.
- While acknowledging the severity of the sufferer's and family members' distress, we aim to de-catastrophize the situation, for example, by exploring competencies or normalizing.
- Valuing multiple perspectives is particularly helpful in our work within the medically oriented mental health system. Bearing in mind the idea that, although dominant, the medical discourse is only one 'story' among others, we are also able to explore other perspectives (e.g. spiritual beliefs; Hearing Voices Network perspective on 'voices').

The significance of our therapeutic stance is both that it enables us to integrate a variety of techniques and approaches, and that it enables the development of a strong therapeutic alliance. In the context of the stigmatizing views of mental illness prevalent in our society it is important to create a therapeutic relationship in which families feel empowered and maintain realistic hope.

It has now been recognized that the quality of the therapeutic alliance is perhaps the most significant factor determining good clinical outcome in terms of a reduction in symptoms. However, we view the quality of the therapeutic alliance as more than a means to an end in that the most effective recovery for each individual requires them to develop a sense of personal agency, power and control (cf. literature on the 'recovery process', e.g. Coleman, 1999; Rethink, 2003).

Discussion

This paper has described how one trust is meeting the challenge of delivering a family intervention service.

The challenge of translating research-based psychosocial approaches into clinical practice is faced by all mental health trusts. A convincing evidence base (NICE, 2002) has not guaranteed routine provision of such approaches due to a lack of suitably trained staff and

unsupportive service structures. Somerset's response to the challenge of providing family interventions services has been to invest in a team training approach which equips staff with a broad range of therapeutic skills to enable work with a wide range of families and to establish local services (Burbach and Stanbridge, 1998; Burbach *et al.*, 2002). This paper reflects on the evolution of this project which began in 1994.

We would like to highlight a number of key ingredients which have been important in the development of this project. First, the use of a team training approach has enabled us to establish viable, local family interventions services to serve the population of the rural county of Somerset. Team training has also enabled sufficient like-minded staff to influence the wider service culture in their area.

Second, the flexible combination of systemic and cognitive-behavioural psychoeducational approaches enables engagement and work with people experiencing initial or subsequent episodes of psychosis. Due to the focus on intervening early the Family Support Service has evolved into the first phase of the Trust's Early Interventions in Psychosis service (and Frank Burbach is the clinical lead for Early Interventions in Somerset), while continuing to work with people who experience more enduring problems (cf. NICE guidelines for schizophrenia).

Further, in addition to its influence on clinical practice, our particular background in systemic thinking has been important in other areas. In an organizational sense we have found it crucial to see the interrelatedness of parts of the system and to influence all levels. We not only sought to collaborate with those who held the most power (e.g. the then 'purchasers', Trust Board, Consultant Psychiatrists) but also focused particularly on locality and team managers whose support was necessary to enable their staff to attend the training course and to devote time to the service. The positioning of the Family Support Service in relation to the other elements of the service system has also been fundamental to our project. Given that some families experienced difficulties in appropriately accessing the various parts of the services, we have sought to maintain consistent therapeutic relationships with the family and to advocate on their behalf. Having Family Support Service team members represented in each of the parts of the local mental health service enables us to support families throughout the system. It also enables us to provide a family/carer focus on the various units and to facilitate timely appropriate referrals to our service. Having an awareness of common care pathways, our

focus has been not only on the mental health service but also on our links with primary care. To this end we have been involved in developing treatment protocols to facilitate good practice in terms of involving families and carers.

The success of the project is also due to our emphasis on evaluation, reflective practice and quality assurance. In addition to conducting research into the training and the service (e.g. Bailey *et al.*, 2003; Stanbridge *et al.*, 2003) we encourage team members to reflect on their practice and to adopt the stance of practitioner researchers. We strive to improve our service in the light of the feedback we receive. This ongoing process of evaluation occurs not only in the auditing of the service, or in the formal evaluation by clients at the end of their contact with us, but also on a clinical level on a session-by-session basis.

As the research study (Bailey *et al.*, 2003) indicated, the maintenance of the service not only requires supportive management but also the continued motivation of team members. Therefore we have placed a high priority on team members attending monthly supervision sessions as well as quarterly study days. Regular contact with supportive, like-minded colleagues is crucial both in order to carry out the challenging clinical work and to cope with service pressures. As in many trusts, our staff face ongoing pressures as services are reconfigured and roles changed. We are hopeful that our emphasis on a team approach throughout will help our teams to be more resilient and to ensure a continuation of the service.

We are encouraged that the successful establishment of a trustwide service through team training has led to our Trust adopting a Strategy to Enhance Working Partnerships with Carers and Families and to seek to train staff throughout the Trust in awareness/basic skills in family inclusive approaches (Stanbridge and Burbach, 2004), as well as supporting specialist-level training in family work.

We are also encouraged that another trust in the region has adopted the FIRST course and our model of service development through team training. During times when wider service pressures strain the maintenance of the FI services, the prospect of wider support being available for families and collaboration with like-minded colleagues in another trust is heartening.

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Chapter 5

Assertive Outreach and Family Work

Frank Burbach, John Carter, Jane Carter and Matthew Carter

Key Points

- Assertive outreach (AO) services have been established throughout England as a result of a large evidence base and following their inclusion in *The National Service Framework for Mental Health* (NSF).
- AO is a model of service delivery in which teams work intensively with people with severe mental health problems and complex needs and includes their care-givers.
- If provided in a collaborative, flexible and holistic manner, AO is an effective vehicle for the delivery of psychosocial and medical interventions.
- Family intervention (FI) is highly effective in reducing relapse in people with severe mental health problems and also has benefits in terms of improved social functioning, reducing family stress/burden and a reduction in overall treatment cost.
- Despite the establishment of numerous FI training courses, relatively few FI services have been established in routine clinical settings.
- The literature contains very few reports of the integration of AO and FI, although logically integrating them can maximise the benefits of both services.
- In Somerset FI and AO services have been successfully developed in each of the four Primary Care Trust (PCT) areas.
- 'John's' parents were critical of the mental health services offered in the first 10-year period following John's initial presentation, and did not feel valued as partners in care.
- The 'Carter' family valued the collaborative approach of the AO and FI services, which helped to reduce misperceptions and miscommunication and develop coping strategies within the family.

Introduction

I (Frank Burbach) have drawn this account together to demonstrate the value of integrating family interventions (FI) and assertive outreach (AO). As a founder of the Somerset family support service (FSS) and consultant to and originally the manager who established AO locally, I regularly train and supervise workers in these services. It is from that overview position that I write my reflections on the work carried out with this family.

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This chapter is the product of extensive collaboration between the 'Carter' family and the first author. 'John Carter' decided he preferred to remain anonymous as it enabled him to be remarkably open and honest.¹ We are using the names 'Matthew' and 'Jane' for John's parents and 'Linda' for his sister.

Although initially concerned that the process of writing this chapter might be stress-inducing, it soon became clear that the careful retelling of the story was also therapeutic for John and his parents.

John acknowledges that although we 'covered fresh ground in writing this chapter, a lot of the intimate things had already been talked about in the family sessions'. He felt that seeing it in print was 'helpful . . . a declaration . . . recognising that I am possibly unwell'.

Matthew described the process as 'mentally stocktaking . . . it enabled us to look at the whole'. Jane found it 'quite shocking to read the first draft . . . horrible to see it written down', but felt that ultimately she 'really valued it', and felt like saying 'eureka' when John began to revise some of his long-standing beliefs as a result of our detailed exploration.

Writing this chapter is thus part of John's recovery. It describes the mental health services experienced by the Carters: the traditional psychiatric services which were experienced as unsupportive over many years and, more recently, the AO and FI services. It also provides a brief overview of these two services and argues that integrating them is essential if mental health services are to maximise their effectiveness.

The Evidence – Assertive Outreach and Family Intervention

Although there is a growing evidence base for a range of psychosocial interventions (PSI) for schizophrenia and other psychoses, reviews agree that, to date, only FI and AO (or assertive community treatment – ACT) have unequivocal evidence of efficacy (Lehman 1999). These approaches would appear to have much in common. Both have a recovery philosophy – assuming that people with severe mental health problems can live satisfying lives in the community as long as they have appropriate medical treatment, develop adaptive coping strategies for ongoing symptoms, acquire community living skills and have appropriate social support from family and friends. It is surprising therefore that there are few published reports of the integration of these two evidence-based approaches.

Assertive outreach

AO originated in the USA in the late 1970s when multi-disciplinary teams moved into the community, providing intensive, comprehensive services to people who were at high risk of hospital readmission and who could not be maintained by more usual community-based treatment (Stein and Santos 1998). Randomised trials have consistently shown that 'assertive community treatment' leads to a reduction of inpatient admissions and promotes continuity of outpatient care (Marshall and Lockwood 2005). However, later studies did not demonstrate the same effect in reducing the need for hospital care as the earlier US studies, which led to considerable debate about the 'essential ingredients' for AO (Burns 2002). Nonetheless, there is substantial agreement about the nature of AO.

AO provides high levels of input for people who present a risk to themselves or to others

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and who tend to be difficult to engage in standard services; most have experienced many relapses in the past. It is distinct from other mental health services in that the qualified staff members have small caseloads (10–12) and are able to maintain daily contact, if necessary, for seven days a week. Other distinctive features are that the team members go out to see clients (for example, at home, in local cafés) and the use of a team approach – caseloads are managed jointly by clinicians rather than being assigned to individuals. The (largely USA) research evidence led to the inclusion of AO in the UK *The National Service Framework for Mental Health* (NSF) (Department of Health 1999). Major investment in the new model of service followed the publication of *The NHS Plan* (Department of Health 2000) and AO services were established throughout England based on the service specifications published in the *Mental Health Policy Implementation Guide* (Department of Health 2001).

In Somerset, following a four-week training programme, four dedicated AO teams (one in each PCT area) began delivering this new service in April 2001. In order to emphasise the particular philosophy and clinical approach of the new service, following discussions with service user representatives, we adopted a different name for the Somerset AO service – the enhanced community support (ECS) service. It indicates that the service works closely with the existing mental health services, providing additional (community-based) input for this particular group of clients. It also reflects our collaborative, holistic approach which includes PSI and medical interventions. The service name is also appropriate in that all clients are on *enhanced* integrated care programmes.

Family interventions

Following a number of randomised controlled trials in the 1980s, which indicated that the addition of FI to standard care significantly reduced relapse rates for people with schizophrenia, the UK government specifically recommended the establishment of FI services in 1993 (Department of Health 1993). The importance of involving families/carers in routine mental health treatment was further recognised throughout the NSF (Department of Health 1999), with its revolutionary focus on the ‘rights of carers’ (see Stanbridge and Burbach 2004).

Robust research studies indicate a four-fold reduction in relapse rates one year after FI; relapse rates increase in the second year but are still only half what they are when only medication is provided. There is also evidence of improved social functioning, a reduction in family burden and a reduction in overall treatment cost (see Fadden 1998). Recent reviews of the trials of FI throughout the world (Bustillo et al. 2001; Dixon, Adam and Lucksted 2000; Mari and Streiner 1996; Pharoah et al. 2003; Pitschel-Waltz et al. 2001) has led to FI being recommended as a routine treatment for schizophrenia in the 2002 NICE guidelines (NICE 2002).

Despite substantial efforts to train the workforce in FI, at the time we were developing our services, relatively few FI services had been established in routine clinical settings (Brooker 2001). Studies at that time (for example, Kavanagh et al. 1993; Brennan and Gamble 1997; Fadden 1997) found that difficulties in the implementation of FI were due both to trainees returning to unsupported work environments and to a difficulty in meeting the range of needs presented by families.

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In this context we decided to develop an in-situ, whole-team training approach to promote multi-disciplinary and multi-agency partnerships, transcending existing training structures (Burbach et al. 2002) to try to establish sustainable FI services in Somerset. We combined cognitive-behavioural and systemic family intervention approaches within a one-year university accredited course and between 1996 and 2001 successfully trained staff in each of our four PCT areas (see Burbach and Stanbridge 1998 2005). We have since trained further FI workers to 'top up' the teams. Two AO team members conducted the FI described in this chapter; they began working with the family during a FI training course, and continued after completing their training.

The Case Study

Background information

Childhood and early adulthood

John describes himself as having been 'quite a spirited child' and found it quite easy to make friends, which he says 'is a contrast to how I am now'.

Jane describes his early years:

I look back on John's childhood and early teenage years as times of great fun and happiness. [We] had two children in our middle twenties; Linda is only fourteen months the senior and they were almost like twins. We moved around southern England with Matt's work. I worked part-time, school-terms only, so life was pretty good. Linda was an extremely hard-working girl and did very well indeed at school and university. John always seemed to make it by the seat of his pants, but using his charm and good luck did reasonably well at school and university. He travelled in his teens quite extensively with school friends, always keen to visit new countries. He returned home full of enthusiasm, always broke financially. [He] worked in local shops and factories to repay loans.

He was close to his sister and proud of her career in advertising. In retrospect he did not appear to be carving out a career himself, [instead doing] various jobs for local people and agencies.

Despite 'indifferent' A level results at the local boys' grammar school, which John ascribes to 'laziness', he achieved a BA in American Studies. Although he had been drinking heavily, it was not until age of 21, when he spent a year living and studying in the USA, that he began using cannabis. Following graduation John decided to work in the Sudan, teaching English. He says he enjoyed his work and the experience of such a different culture, but reports that he 'lacked maturity'. He and the three other young men with whom he shared a house all drank heavily, 'smoked a lot of pot', and 'consorted with prostitutes', which resulted in John contracting sexually transmitted infections (STIs).

It was during a second period of work in the Sudan that his parents noticed changes in his behaviour.

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In the words of his mother:

We were dismayed when he returned for another period to continue this work. We did not know about the cannabis and heavy drinking until several years later, [but] at this time his personality and loving attitude changed. He did not correspond from Africa for such a long time that Matthew contacted the Foreign Office. Eventually he returned to the UK, worked part-time for 18 months teaching English to immigrants and applied for a place at university for a MA in Development Studies. Obviously we all thought that everything was going to be all right.

John remembers that on his return from Africa he felt 'worried/anxious because I feared I had STIs' and that this 'got in the way' of a relationship with Jackie who he had met at work.

His parents hoped that John would 'settle down' following the successful completion of his MA degree. However, this was not to be.

Onset of psychosis

When he had completed his MA, John returned to London and his relationship with Jackie became sexual. This resulted in John becoming 'very worried' and he 'broke down'. Within two months, John (aged 29) unexpectedly returned to Somerset to live with his parents for three months. He was depressed and vulnerable, went for long solitary walks, and needed a lot of emotional support. He wanted to discuss past relationships and, as a result of his concerns about sexually transmitted disease, his parents arranged for private tests for STIs, and although these were negative he continued to believe he was infected. When Matthew rang Jackie at John's request her mother told Matthew of their concern: 'We are praying for John every day but he needs professional help'. Their local vicar showed his concern by giving Matthew and Jane a copy of a book about mental health problems.

Jane recalls thinking that 'John had overdone it – doing his MA in one year', but also 'thought he might have AIDS'. He would come back from job interviews saying that the interviewer 'wouldn't look at me', and when started a part-time job he soon left, reporting that colleagues 'were talking about me'. In retrospect his father regards this as the 'start of a persecution complex'.

John appeared delighted when they decided to start a family business, which would provide him with employment. However, shortly afterwards, he became agitated and returned to London. Thereafter John's parents became increasingly concerned for his mental health. When they met in the summer of 1990 (John aged 29), his father was struck by John's 'grubby appearance'. He refused to change into a suit for the MA graduation ceremony and showed no pleasure on being awarded the degree. Jane remembers feeling 'horrified . . . his trousers were dirty and he refused to change'.

John's parents described an agonising 18-month period of 'isolation' for John on his return to London.

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Jane recounts:

He slowly deteriorated into a life of drinking, some occasional work, no communication with family, not eating. We attempted to visit but he was always angry and abusive or never turned up to arranged rendezvous. He phoned once or twice, saying people were against him. We became quite desperate, not knowing what to do . . . living in Somerset became problematic. Mental health [problems] was something we had no experience of . . . Samaritans were kind but not really practical. John's GP said if we could persuade John to visit him he would let us know. We contacted the Maudsley Hospital – same response really.

Eventually we visited in person the local Social Services department in south London . . . we thought they were going to make it all okay but we came right up against the 'rights of the individual' . . . it had to be [John's] decision to make contact. There was no one at the time to really talk to.

After several awful scenes in London we slowly realised that sectioning could be looming. Matthew and myself did all this intervention on our own, finding out facts, helped by an acquaintance working in Bristol Social Services. Fortunately John agreed at the eleventh hour to go for treatment voluntarily. In our ignorance we hoped he would recover and return as the lovely boy that he once was.

John's account of the onset of psychosis includes many factors described by his parents, particularly moving house in childhood, alcohol and cannabis misuse and worries about STIs:

John says:

My college days (1980–4) were characterised by heavy drinking and cannabis abuse. I grew up during that time, living independently in the USA for a year, aged 21 to 22 . . . I decided to work in Africa on graduation, where I consorted with prostitutes and struggled to cure venereal infection. The alcohol and cannabis abuse persisted on my return to England. A friend in London suggested that I was trying to impose Africa on Europe. I think this attempted transition from England to Sudan and from Sudan to England was really the root of my slowly developing schizophrenia. Although I went back to college I could no longer stop events unravelling.

I care-took a flat in London but there was no escaping the fact that my family was suppressing the knowledge that I had five illegitimate children. I don't think they had the courage to talk to me about it. As a consequence I isolated myself for a year. During the summer of 1990 I was involved in two violent incidents and I began to see people as a threat. On neither occasion was anyone badly hurt.

Reflections

With many people it is notoriously difficult to pinpoint precisely when someone's mental health problems began. John was an intelligent, happy-go-lucky person who drifted into heavy alcohol and cannabis use. His lifestyle was not particularly unusual and mental health problems were not suspected by his parents until the age of 28/29 when he spent three

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months with them, apparently depressed. At this time he also expressed some paranoid ideas and in retrospect this appears to have been the 'prodrome' (referring to the early symptoms and signs that someone experiences before a full blown syndrome becomes evident) of his psychosis.

Following his return to London on completion of his MA, John became increasingly withdrawn and socially isolated, and in the summer of 1990 lost his job following a serious assault on a colleague whom John thought had turned his girlfriend against him. During this time John also thought that a person on television was telling him what to do and he gave his sister's boyfriend a black eye because 'they were managing knowledge I had a right to know'. The clinical notes from that time record that John believed he had fathered five children, whom he knew by 'metaphorical' means. He severed contact with his family because he believed that his parents and sister were communicating 'metaphorically' and were keeping information regarding his children from him. He believed he was being followed by the colleague he had assaulted, and continued to believe that he had sexually transmitted diseases despite investigations proving negative. He felt symbols and noises had special meanings and experienced auditory hallucinations.

During this time his parents became increasingly concerned about John but as Matthew reports: 'It took until November 1991 before we could get regular treatment for John. We had no offer of support; in fact we were dealt with throughout as interfering parents.'

Although John's parents experienced difficulties 'getting into the system' as described by other families (Howe 1998), it should also be acknowledged that it is often difficult to ascertain whether someone is experiencing psychotic symptoms, particularly if they are bright and socially skilled. In June of 1991 a letter from John's consultant psychiatrist to his GP notes that 'information from John's family indicates that he is clearly psychotic' but that in her consultation he was 'polite, reasonable, pleasant and did not say anything unequivocally delusional or psychotic'.

Treatment phase 1

Once John agreed to accept medication his symptoms appeared to lessen, although he says he still heard voices after a year on anti-psychotic medication. Mental health professionals recorded that medication was effective and a subsequent forensic review (November 2001) noted that John's three relapses over the previous 10 years had all been linked to changes or cessation of medication.

However, it was John's family who provided the 'psychosocial interventions' that enabled him to achieve a reasonable quality of life; these included meaningful work, support, housing and structure. Possibly the most important of these was his parents taking him on as an employee in the family business. John worked for his father for seven years, initially staining, waxing and lacquering furniture, and later doing administrative tasks such as organising deliveries and producing invoices on the computer.

Matthew reports:

[Initially] he was only able to do manual jobs . . . As John improved [he] became less inhib-

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ited; I gave him more and more responsible jobs till it reached the stage where he could stand in for me. He managed 10 employees.

Although John had improved substantially working with me, and I believe that we had created an environment in which he could work and find satisfaction, this was probably due to good luck, which ran out in 1999/2000. I decided to merge the business with another and John would not come.

Following his redundancy John tended to stay longer in bed, remained alone in his flat and drank more heavily. His father reports that John was offered little help or support by the community mental health team (CMHT); he (John's father) found their attitude 'appalling': 'We made numerous requests to his support worker and psychiatrist for help, none was forthcoming. John voluntarily went to hospital in June 2001.'

John generally learned not to discuss his long-standing beliefs, but his ongoing symptomatology continued to cause difficulties. For example, in 1996 he had an altercation with a colleague, Martin, over a remark that John believed he made regarding sexual attraction towards Jane. Five years later John committed a serious assault on Martin, who he was convinced was hounding him, was affecting his sleep and wished to do 'obscene' things to him.

After his admission in 2001 to a psychiatric inpatient unit and despite medication, John continued to experience psychotic symptoms, repeatedly absconded, was detained under the 1983 Mental Health Act, transferred to the psychiatric intensive care unit and was assessed by the forensic team owing to ongoing paranoid ideas. During this nine-month period of inpatient treatment he had a number of violent altercations with male patients. He was finally stabilised on Clopixol 400 mg weekly (having previously been prescribed Sulpiride, Risperidone and Prozac) and transferred to Brook House, a rehabilitation unit (24-hour nursing staffed house in the community). However, he continued to experience delusional ideas regarding Martin while living there. John was finally discharged to his parents' home after three months at Brook House, with the hope that he would be rehoused nearby in due course. Referrals were made at this point to the AO and FI services.

Reflection on events leading up to the relapse

The family reported feeling 'totally let down' by the services prior to his admission to hospital . . . the monitoring of John was abysmal'. They felt that more appropriate help might have prevented traumatic experiences such as being arrested and sectioned under the Mental Health Act.

Tracing the sequence of events leading up to this relapse it is clear that services did not respond well. After leaving the family firm in September 1999 he remained unemployed for many months and when he gained employment at a garden centre in September 2000, he soon began misinterpreting events, feeling certain people were against him. John's increasingly concerned parents eventually met with his psychiatrist in January 2001, armed with information provided by Rethink (a mental health charity) regarding medication, and it was agreed that he should try Risperidone. Thereafter, his parents noticed that he became increasingly withdrawn, was drinking more heavily and was preoccupied with thoughts of his 'children'. They returned to the psychiatrist in June 2001 to report that the 'medication

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was not working' and the psychiatrist telephoned John and arranged for him to take a higher dose. A week later Martin telephoned John's parents to complain that John had been bothering him. They in turn contacted the mental health services and a community psychiatric nurse (CPN) went to visit John later that afternoon. By this time John had made repeated visits to see Martin and had been arrested. As John put it: 'I asked him what he had been doing, bothering me at night . . . I went back a few times and then there was a fight'. When the police took John home to get his medication his CPN was there. Jane remembers that the CPN 'waved goodbye to him in the police car and didn't even tell us'. This was an extremely traumatic experience for John and his parents. Jane continues: 'It was a nine-month period with us floundering . . . [but] we never thought that John would assault anyone'.

His parents were left uninformed again when six weeks later John left the inpatient unit in order to find Martin, was arrested, spent the night in police cells and was subsequently sectioned. Poor communication clearly added to the traumatising effects of the situation and they all agree that it was 'an awful time'.

Treatment phase 2 – enhanced community support (ECS) service

John and his parents clearly recognised the benefits that the ECS offered and contrasted it with the service received prior to this.

Matthew notes:

For the first time we started to have confidence that a structured support system had been put in place . . . Until the ECS team came along we did not feel involved as partners and from time to time felt shabbily dealt with.

John remembers:

They were more thorough, friendlier, more human. Matthew considered them to be a vital support to assist in his recovery programme.

At the time of considering discharge from hospital, an intensive service appeared to be appropriate, owing to John's unstable mental state and concerns about risk. He was one of the first clients to be taken on by the ECS.

During the year that the ECS team worked with John and his family, the team focused on some jointly determined goals: independent housing, developing a larger social network, work/meaningful occupation, finance/benefits and medication management. Team members helped John to complete housing application forms, accompanied John and Matthew to meetings with housing officials, arranged for him to attend walking and yoga groups, and helped him to find work in an internet café. Although these objectives are not significantly different from those found on CMHT care programmes, they were carried out in a more intensive, supportive manner, both on a regular, planned basis as well as in response to crises. For example, an ECS support worker would regularly provide John with transport to and from his supported employment and would sometimes have lunch with him.

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ECS workers took a cognitively orientated reality-testing approach to help John to cope with ongoing psychotic symptoms (auditory hallucinations or misinterpretations and delusional beliefs). For example, John believed that Martin was outside his new flat when he heard noises outside. By gently exploring his understanding of these situations John was able to reassure himself that alternative explanations were more likely. His responses were also normalised in terms of a stress-vulnerability model by exploring the context in which John had these worrying experiences, for example, when he was tired and concerned about family matters.

Jane summed up the ECS team's input:

The team visited regularly – helped to maintain benefits, etc. The support worker and the CPN became well known to all of us, they were like friends. This was the first time in our son's long illness that help and advice was at the end of the phone, and also visits in person could be requested and acted upon almost immediately.

Reflections

The ECS team members were able successfully to deliver cognitively oriented interventions because they were people with whom John had developed an open, trusting relationship, who responded quickly and spent the required time with him, and had the skills to help John develop his own coping strategies. This work was complemented by more formal FI sessions within which similar cognitively orientated coping strategy enhancement was undertaken. The formal, regularly scheduled FI sessions and the more flexible support provided to John and his family by the ECS thus provided an effective package of support.

Family support service

John summarised the purpose of the FI sessions as being 'to perpetuate the harmony between the three of us . . . to smooth things over'. Matthew agreed: 'if we three are a motor, they are the lubricant to make sure we work harmoniously together'. Jane felt that the sessions had been helpful because each person's views were elicited and taken on board: 'We blossomed in that room with them . . . it was during these regular meetings we first were able to listen to John explaining much of his fears, terrible thoughts he had endured. I feel this was due to skilful questioning by the team and total privacy'.

John remembers that sessions often focused on his fears: 'They asked about my stress levels when I go past Martin's house'.

As a result of these conversations Jane acknowledges: '[We have] more respect for John – he states his case so succinctly, so well . . . we see a flash of the old John . . . [They taught] us a lot about how to deal with John's stress'.

John agrees: 'They deal with me better as a result of sessions. They understand my fears and how to cope with my fears'.

They contrasted these sessions with the 'noncommittal' responses or unclear/contradictory information previously provided by professionals. Matthew states that: 'For ten years

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we sought professional advice on how to react to different aspects of John's illness and no one gave us any straight answers'

Jane agrees: 'One said don't agree with John, challenge him and another said don't challenge him, be sympathetic.'

Reflections

The two clinicians conducted the FI sessions using a model that is both cognitive behavioural and systemic (Burbach and Stanbridge 1998, 2005). While focusing on ways people construe one another and their actions (as is the case with most family intervention in psychosis services), our approach also focuses on the interactional patterns in which people have become 'stuck'. In the early sessions it was soon apparent that this family had experienced a high burden of care over the years; they needed to express their justifiable frustration and anger with the mental health services to date. This had to be balanced with the need to facilitate more open dialogue between John and his parents, as John tended to be somewhat withdrawn and silent in the sessions. The pattern that had been established over the years could be summarised as in Figure 5.1.

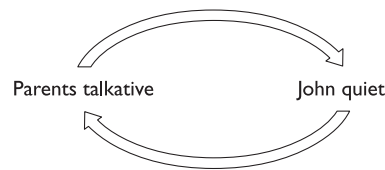


Figure 5.1

Understanding behaviour as part of an interactional pattern is helpful because it provides a non-blaming perspective based on the notion of circular causality, rather than linear causality. We can hypothesise that the pattern between John and his parents had arisen over many years for understandable reasons. As is common in such situations, John appears to have learned, over the years, not to discuss his beliefs with others, as disclosure was met by a range of dismissive reactions. Like many other sufferers of severe and enduring mental health problems, John has tended to become less active, more withdrawn, and dependent on others. Simultaneously, his parents had to take on increasingly active roles in supporting him, but did not know how to react to John when he occasionally shared some of the psychotic experiences which were preoccupying and troubling him (see Figure 5.2). Their understandable responses to one another have thus been mutually reinforced, with the result that they have become locked in a repeating pattern. Such patterns have a major effect, with people acting 'automatically', having come to expect a particular behaviour of the other.

This dynamic was most apparent when considering the relationship between John and his father. Matthew, a forceful man who was used to running a business and solving problems, confirmed that he was 'a bit intolerant' as he did not understand John's difficulties. Until John had received his diagnosis he tended to 'dismiss/ignore his fears . . . used to feel he should snap out of it'.

Exploring this interactional cycle in relation to the family members' goals in the FI ses-

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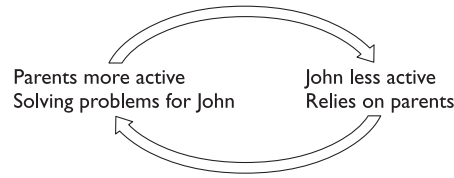


Figure 5.2

sions provided helpful ways of normalising and de-catastrophising, and enabled them to begin practising alternative ways of being with one another. Because increasing withdrawal was an indicator of impending relapse, John's parents would sometimes become concerned and consequently become more watchful. In turn, this would be associated with John withdrawing further – another interactional cycle which resulted in a self-fulfilling prophecy.

An example of reframing that took place after such interactional cycles were explored was when John had explained to his parents that he withdrew to his room in the evenings to 'give his parents time together'. It was extremely reassuring for his parents to realise that John was being 'considerate' rather than 'ill/relapsing'.

This technique, known as cognitive interactional analysis (Burbach 2000, see Figures 5.3 and 5.4), provided a means to explore and elucidate 'vicious circles' (for example, John not talking about his symptoms led to increased stress and therefore resulted in more symptoms).

Exploring current difficulties from a cognitive interactional perspective promotes a revision of attitudes and beliefs as well as facilitating behavioural change. It is possible to reverse 'downward spirals' or 'vicious cycles' which maintain problems and to establish 'virtuous cycles' in their place, by 'tracking' the sequence of actions and the associated constructions of each other and by using techniques such as goal setting (see Figure 5.5). Exploration of cognitive interactional cycles led to more positive perceptions of John, which enabled some of this family's initial goals, such as John becoming increasingly independent, to be focused on; significant achievements included his parents going away for long walks, weekends and longer holidays together, John going away (for example, visiting his sister in the city in which she lives) and John moving into his own flat. These behavioural goals were achieved in a gradual step by step manner.

Others issues focused on in FI sessions included John's ongoing positive symptoms and concern about his alcohol and tobacco use. Indicators of relapse included John trying to stop smoking and his increased alcohol use. By scaling the level of distress caused by various symptoms, or concern about John's alcohol use at various times, on a 1–5 scale, it was possible to track stress levels and develop coping strategies. This exercise also revealed that Matthew was much more concerned about John's alcohol use than Jane and John and that he feared relapse whenever John drank. Open discussion reassured Matthew that John had some control over his drinking and this helped to change the watchfulness–withdrawal cycle.

The symptom-focused work largely consisted of exploring John's anxiety-provoking beliefs to enable him to develop more neutral 'reality based' perspectives. These CBT based techniques (see Chadwick, Birchwood and Trower 1996) were combined with a normalising/psychoeducational approach. For example, in the ninth session John revealed that he had been

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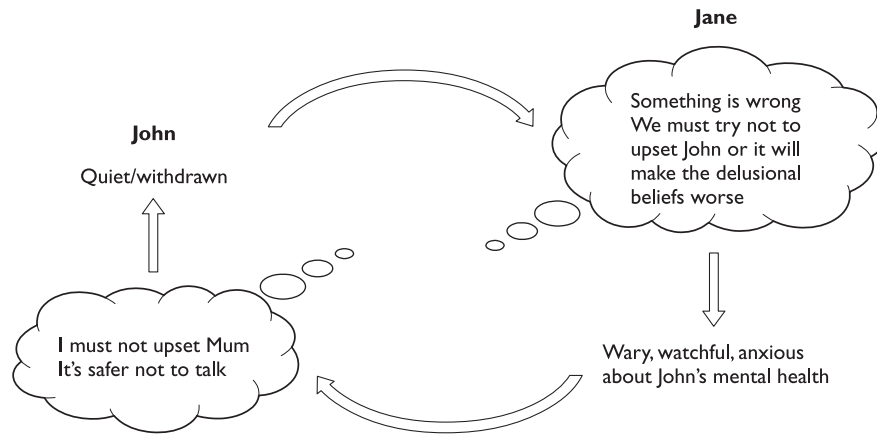


Figure 5.3 An example of a cognitive interactional analysis which indicates both the link between each individual's beliefs and behaviour, as well as the mutual reinforcement which maintains/exacerbates these behaviours.

'hearing voices for the past three weeks'. His parents had been unaware of this and described this as a 'bombshell'. Besides normalising the increase in symptoms as probably relating to John's impending move to his own flat (utilising a stress vulnerability model) the therapists modelled how to explore John's experiences. His parents observed how the therapists calmly accepted his symptoms (rather than interrogating him about them or dismissing them), focusing on his coping strategies and beliefs about the voices. In subsequent sessions it became apparent that both auditory hallucinations and misinterpretations of noises such as voices from the street could trigger John's paranoid beliefs regarding Martin. With encouragement, John began to test the reality of his beliefs by checking outside to develop alternative explanations, rather than remaining inside the flat, becoming increasingly anxious. As the CBT was conducted in the context of FI, rather than in individual therapy, Jane and Matthew were able to provide ongoing support between therapy sessions and enable the ongoing practice of CBT techniques.

More recently John became concerned about a man who moved in nearby. John reported his increasing preoccupation and thoughts of assaulting this man to his psychiatrist, so was admitted as a voluntary patient for six days. At this admission John's medication was changed to Clozapine and Sulpiride, which was 'helpful' and it was reported that John 'appears less robotic'. In the subsequent FI session his parents began by reporting the hospitalisation had been a 'major set back'. The therapists positively reframed it as John successfully recognising and talking about these escalating thoughts, seeing his psychiatrist and spending only six days in hospital, a marked contrast to previous admissions. This new perspective – a blip handled well rather than a disastrous relapse – was extremely helpful to the family.

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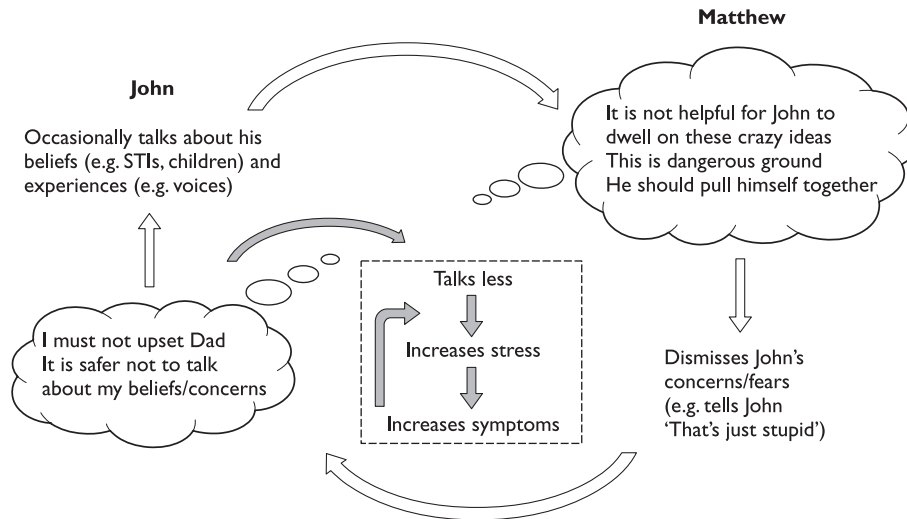


Figure 5.4 Another cognitive interactional analysis which also indicates the possible link between this interactional cycle and the maintenance/exacerbation of symptoms.

Outcome of FI

Although the FI sessions are ongoing at the time of writing this chapter, the family is moving into a maintenance phase. Sessions are likely to end by mutual agreement relatively soon, with the proviso that, as stated in the FSS operational policy, any member of the family may contact their FSS therapists at any time in the future if they would like further sessions.

The focus on interactional cycles has resulted in significantly altered family dynamics. This is reflected in their contributions within the FI sessions. Matthew remarked: 'John takes control in meetings sometimes now . . . we realise John is better able to fend for himself and we don't have to say things for him.'

Although John still experiences auditory hallucinations and delusional beliefs, he has developed his coping strategies and he now tends to have shorter 'blips' rather than extended periods where he is overwhelmed with fear. His parents' new attitudes have played a crucial part in this. Prior to FI they believed it was safer not to talk about John's symptoms, and especially his beliefs about Martin; now they encourage him to talk about his experiences in order to reduce his distress. They help him to examine a particular experience in detail and encourage reality testing and the generation of alternative perspectives.

Initially John's parents, and especially his father, were very angry at the mental health services. They had hoped he would be given the right medication and (as a result of this medication) simply stop being preoccupied with Martin. As a result of the open discussion engendered by FI and their increased understanding of his difficulties, they now accept that John's recovery will be slow and steady. They know that their role will continue to be crucial, and hope that further progress may also be made through CBT sessions.

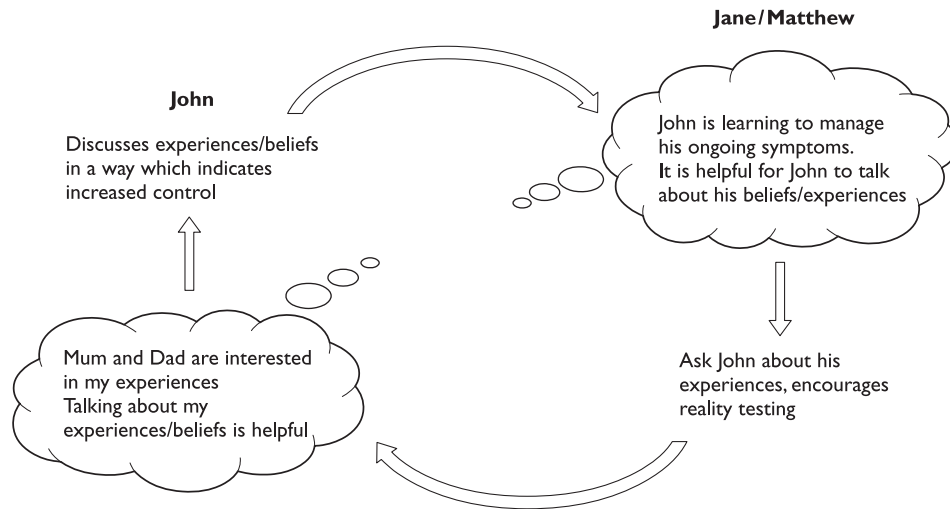


Figure 5.5 A 'virtuous' cognitive'-interactional cycle

Discussion

This case study highlights a number of important issues related to the nature of AO, service design and organisation, training approach and family intervention models.

The nature of AO

One way of making sense of the differing research findings with regard to AO/ACT is that some of the services appear to have simply provided a more intensive 'treatment as usual', focusing on medication compliance. The finding in the large multi-site randomised controlled trial, the UK700 study – that smaller caseloads were not associated with better outcomes – could be partially explained in this light (Burns 2002). On setting up the services in Somerset I (Frank Burbach) was mindful of what Len Stein (one of the originators of ACT) has repeated on numerous occasions – AO is a *vehicle* for the delivery of effective treatments. Although services need to be provided in a collaborative, flexible and holistic manner in order to establish and maintain engagement, the frequent community-based contacts simply enable the delivery of a more sophisticated range of interventions. Staff in AO services are uniquely well placed to provide PSI, including maximising medication adherence, and where these are provided, they are likely to contribute significantly to the improved clinical outcomes reported in many studies.

It is noteworthy that, despite research evidence for both the AO/ACT and FI, it appears that the two are not often provided to service users in combination. This is despite the clear recommendations in the MHPIG (Department of Health 2001) that 'assertive outreach services should provide family/carers and significant others with support and intervention' (p. 31). That there are so few reports of a combination of the two approaches no doubt

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reflects the widespread difficulty experienced by mental health services in establishing FI in routine clinical practice. It is also possible that the development of AO out of 'rehabilitation' services has led to many staff still holding traditional beliefs that a patient's contact with their family may hinder successful treatment.

A notable exception to the dearth of information in the literature about the combination of the two approaches is a report by McFarlane and colleagues (McFarlane and Deakins 2002) about the combination of psycho-educational multi-family groups with ACT in New York. They report that:

The merger of these two treatment methodologies formally integrates the family as a partner in the ongoing treatment and rehabilitation work being conducted by the ACT clinicians. It combines the unique efficacies of each approach, potentially enhancing outcomes additively or perhaps synergistically.

(p. 176)

Psycho-educational programmes for groups of families who are caring for people with ongoing positive and negative psychotic symptoms provide an additional benefit over individual family sessions in that family members not only learn new coping strategies from one another but also develop a new supportive social network.

Service design and organisation

John and his parents clearly benefited from the recent establishment of these two services in Somerset and, in this particular case, the benefits of the two services have been maximised by their integration. This has been enabled by the organisation of both services according to PCT boundaries, with some AO staff devoting part of their working week to the delivery of FI. Although some FSS teams do not at present contain a representative of the local AO team, the effective integration of the work with the Carters illustrates the benefits of our FI service development strategy. We select staff to attend our one-year FI course on the basis of their formal contracting of at least one session per week to the FSS. We specifically attempt to maximise representation from all the local teams and try to achieve a wide multi-disciplinary spread (see Burbach and Stanbridge 1998 and 2005 for more details). Not having a stand-alone team of full-time FI practitioners has proved to be an effective, natural method of ensuring that FI is well integrated with the local services.

Training and clinical approach

Our in-situ whole team training approach has been an effective way of developing FI services. A study we conducted in 2000 (Bailey, Burbach and Lea 2003) found that graduates from our one-year FI course had fewer difficulties in applying the approach than trainees from other courses. This is illustrated by this case study, in that the two therapists started work with the family with live supervision while on the course (nine sessions in six months) but subsequently successfully continued to work with the family on their own (with routine monthly supervision discussions with colleagues). In addition, the integration of

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psycho-educational and systemic approaches as taught on our FI course has been effectively demonstrated in the sessions with this family. We would argue that our integrated approach offers significant advantages over a purely psycho-educational one, in that the systemic (interactional) view of causality as circular enables a non-blaming exploration and resolution of family dynamics which may be maintaining problems. This non-linear view of causality is combined with a postmodern therapeutic stance which enables an integration of the various FI models within a more open, collaborative therapeutic relationship (Burbach and Stanbridge 2001). Therapy based on these concepts is particularly valued by families who have used our service (Stanbridge et al. 2003) and therapists trained in Somerset have found it much easier to engage families than clinicians trained in more prescriptive psycho-educational family intervention models (Bailey et al. 2003).

Final Comments

This family benefited from responsive, flexible support from an AO team as well as more specific skilled FI, and receiving it from people who worked in *both* services, ensured a consistent approach. As the services develop in Somerset we hope that the integrated package of care offered to the Carters will increasingly become the norm rather than the exception.

Note

- 1 Accordingly, all names of people (other than my own) or local services have been changed to ensure confidentiality.

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Developing family-inclusive mainstream mental health services

Roger Stanbridge^a and Frank Burbach^b

This paper argues that the current national policy context offers an opportunity to develop more family-inclusive mainstream mental health services. It outlines a strategy to enhance working partnerships with carers and families and discusses its training implications. The first phase of a trust-wide training programme in Somerset is described and the potential role for family therapists in promoting the wider application of systemic ideas is considered.

Introduction

It is heartening to see that there is a common thread of seeking to enhance working partnerships between professionals and families/carers in most of the recent government proposals for mental health services. How this can be achieved, however, is less clearly defined. We would argue that mental health services require a comprehensive family/carers workforce development strategy in order to equip staff to meet this challenge and that family therapists are particularly suited to take on this influential role. In this paper we argue that the current national policy context offers an opportunity to develop services which place a social network perspective at the heart of the mental health services. We outline the policy guidance and discuss the needs of families and carers. We propose that helping services make the shift from a focus on the individual to a systemic perspective may be achieved by bringing together initiatives under a service-wide strategy. We describe a range of initiatives which might be included and provide details of the Somerset Strategy to Enhance Working

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Partnerships with Carers and Families¹ and its implementation. The work of the Carers and Families Steering Group is discussed and a staff training programme is described. The initial results from the first phase of this training programme are presented and the importance of systemic thinking is considered.

The national context

At a national level it has been increasingly recognized that families, friends and relatives of people with mental health problems have often felt unheard and excluded from their relative's care. This is in spite of the fact that they are often the first to become aware of difficulties (both at onset and relapse), encourage the person to seek help and, in cases of enduring mental illness, provide much of the day-to-day support. The involvement of families with services can be considered along a continuum, with some families being offered specialist forms of psychological therapy and others being involved, at minimum, in assessment and care planning. Family therapists may not be aware of the strong policy guidance regarding the involvement of significant others in all aspects of mental health care as this appears in references to 'carers', and these are scattered throughout policy documents (see Table 1).

Definition of 'carer'

While helpfully identifying a group of people with particular roles/needs, the term 'carer' has been unacceptable to many service users and family members as it appears to define a relationship of dependency. The term is also confusing in that it is sometimes defined narrowly, in terms of the amount and type of care being provided and sometimes defined more broadly. For example, Standard Six of the Mental Health National Service Framework (NSF) (DoH, 1999) focuses on carers' assessments and care plans for those who provide 'regular and substantial care for a person on the Care Programme Approach', but there are references to the benefits of routine closer working partnerships with family members/carers throughout the rest of the NSF and other documents such as NICE Guidelines (DoH, 2002a, 2002b, 2004a, 2004b) and in other government mental health

¹ Available from the first author.

TABLE 1 National policy guidance

<i>National Service Framework (NSF) for Mental Health</i> DoH, 1999, p. 69	'Carers play a vital role in helping to look after users of mental health services, particularly those with severe mental illness . . . responsibilities of caring can also have an impact on carers' own mental and physical health, and these needs must also be addressed by health and social services.'
<i>National Service Framework (NSF) for Older People</i> DoH, 2001a, p. 92.	'Carers of older people with mental health problems often need support. They may have physical and mental health needs of their own. They also need information, advice, and practical help to support them in caring for the older person.'
<i>Valuing People: A New Strategy for Learning Disability for the 21st Century</i> DoH, 2001b, p. 5.	'Caring for a family member with a learning disability is a lifelong commitment. Our objective is to increase the help and support carers receive from all local agencies in order to fulfill their family and caring roles effectively.'
<i>NSF for Children, Young People and Maternity Services. Executive Summary</i> DoH, 2004c, p.14.	<i>Standard 2:</i> 'Parents and carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.'
<i>Mental Health Policy Implementation Guide: Community Mental Health Teams</i> DoH, 2002c, p.13.	'Families and carers should be involved in the Care Programme Approach as much as possible.'
<i>Mental Health Policy Implementation Guide: Adult Acute Inpatient Care</i> DoH, 2002d, p.11.	'With the involvement of the service user (and carer/family if possible) an initial short term collaborative care/treatment plan should be agreed, if not before or on admission then as soon as possible afterwards.'

Continued

TABLE 1 (Continued)

<p><i>Mental Health Policy Implementation Guide: National Minimum Standards for General Adult services in Psychiatric Intensive Care Units (P.I.C.U.) and low Secure Environments</i> DoH, 2002e, p. 19.</p>	<p>'Carers should be involved in every appropriate aspect of the patients care and the treatment in order to maximise positive experiences and reduce stigma. All PICUs/Low secure environments should respond to carers concerns regarding treatment in a secure environment.'</p>
<p><i>National Institute for Clinical Excellence (NICE) Clinical Guidelines for Schizophrenia</i> DoH, 2002b, p. 54.</p>	<p>'Family interventions to be offered to 100% of families of individuals with schizophrenia who have experienced a recent relapse, are considered to be at risk of relapsing, or who have persisting symptoms, and are living with or in close contact with their family.'</p>
<p><i>NICE Clinical Guidelines for Eating Disorders</i> DoH, 2004a, pp. 4 and 5.</p>	<p><i>Anorexia nervosa</i> 'Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.'</p>
<p><i>NICE Clinical Guidelines for Depression</i> DoH, 2004b, p. 28.</p>	<p><i>For all eating disorders</i> 'Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders.' 'Couple focused therapy should be considered for patients with depression who have a regular partner and who have not benefited from a brief individual intervention.'</p>

guidance. This broader definition² implies the need to include the clients' wider social support network in the provision of mental health care.

Needs of families and carers

Carers' initiatives (e.g. IRIS, 2001; NIMHE/West Midland 'Carers in Partnership', 2003) and research studies (e.g. Leavey *et al.*, 1997; Pinfold *et al.*, 2004; Shepherd *et al.*, 1994) have recommended ways in which mental health services can more effectively meet the needs of informal carers and families. What they would like from services includes to be listened to, supported, and to be involved in planning their relative's care. In addition, they require information about diagnosis, treatment and services, benefits, and whom to contact in an emergency. They also request advice on ways to respond to their relative and wish to develop additional coping skills.

These views have informed national mental health policy which now advocates working in partnership with families as well as prescribing evidence-based family interventions. A recent briefing paper (DoH/Rethink, 2006) provides pointers to good practice regarding sharing information with carers. However, a 'cultural shift' in mental health services is required if partnership working is to become a reality.

Evidence base

More than two decades of high-quality research has demonstrated that family and carer involvement in the client's treatment has a beneficial effect on clinical outcome for a range of mental health problems. There is a good evidence base for family therapy for a range of disorders (Asen, 2002; Carr, 2000a, 2000b; Shadish and Baldwin, 2003; Stratton, 2005) which has resulted in family therapy being recommended in national clinical (NICE) guidelines. However, this is sometimes renamed as family interventions rather than being described as family therapy (Eisler, 2005). The evidence base is

² A recent Rethink/Department of Health leaflet defined a carer as 'someone who provides or intends to provide practical and emotional support to someone with a Mental Health problem. You may or may not live with the person you care for. You may be a relative, partner, friend or neighbour. You may be a young person but you now find yourself in the position of needing to support an unwell person' (A commitment to carers; DoH/Rethink, 2006).

particularly strong for schizophrenia (for recent reviews see Bustillo *et al.*, 2001; Pharoah *et al.*, 2002; Pilling *et al.*, 2002) and research in this area reports the additional benefit of reducing carer stress/ 'burden', which may precipitate mental health problems in carers (Cuijpers, 1999; Kuipers, 2006). Two other studies (Law and Crane, 2000; Law *et al.*, 2003) highlight the benefits of family therapy for the other family members in terms of their subsequent reduction in healthcare use.

Implementation difficulties

Despite families' clearly expressed wishes to be more included in their relative's care, the clear policy guidance regarding partnership working with families and carers and the strong evidence base for specialist family interventions, these approaches are not routinely available.

There have been a number of research studies which have highlighted common difficulties in the implementation of specialist family interventions (FI) in psychosis (Brennan and Gamble, 1997; Brooker *et al.*, 2002; Fadden, 1997; Fadden and Birchwood, 2002). Strategies which may be used to overcome 'barriers' to the implementation of family interventions are discussed by Fadden (2006).

In establishing family intervention services in Somerset (Burbach and Stanbridge, 1998, 2006; Stanbridge *et al.*, 2003) we have found that training is more likely to alter clinical practice if it is accompanied by endorsement and encouragement by management at all levels, with a formal strategy and a 'champion' to take it forward. In addition, other workplace issues need to be addressed; for example, team managers must ensure that their staff have manageable workloads and appropriate supervision.

There is mounting evidence that difficulties regarding implementation are reduced if training is team-based (Bailey *et al.*, 2003; Corrigan and McCracken, 1998; Wilshaw and Bohannon, 2003). We have found that in-situ multi-professional team-based training with subsequent supervision (Quarry and Burbach, 1998) enables the required changes in culture and practice for service development (Burbach *et al.*, 2002).

Influencing mainstream practice in Somerset

In Somerset, as in many other parts of England, the introduction of the National Service Framework focusing on carers' rights to their

own assessment and the provision of support services and networks led to the development of new services for carers. The responsibility for these developments lay with Social Services and, in our integrated health and social care Trust, this meant that the Director of Social Care was responsible for the implementation of Standard Six of the NSF. Our Trust began to employ new carers in order to establish this additional service. While providing new services for carers is clearly a positive development, we became concerned that this would lead to existing mental health staff becoming less involved with families, if they felt that this was the responsibility of the new carers service. This would not have brought about the change to more family-inclusive practice which is advocated by national policy.

Having established a Somerset-wide specialist family interventions in psychosis service, we were aware that many parts of our mental health service were still primarily focused on the individual. We were also aware that some of the positive outcomes associated with specialist family interventions might be achieved by an increased involvement of families in mainstream mental health services. At this time, while we were thinking about training initiatives, we were asked by Trust management to develop guidelines around family work in the Trust. This followed a Mental Health Inquiry which had recommended increased family involvement following the tragic death of a young woman. We were approached because we were senior family therapists already involved in many aspects of service development and provision. This seemed an ideal opportunity to think more broadly about the development of family-focused services, not just in terms of specialist family therapy but also in terms of more family-oriented mainstream services.

Developing a strategy

Over a period of eighteen months we consulted with a range of colleagues, service users and their families to develop the Trust's 'Strategy to Enhance Working Partnerships with Carers and Families', which was ratified by the Trust Board in December 2002. The extensive consultation was a sensitive process. Some groups, such as the majority of service users and carers, were clearly in favour. Others, such as some social care staff, felt that they already worked in this way. Many healthcare staff, steeped in individual approaches, were suspicious of this direction, feeling that it would involve an increase in workload and would expose them to difficult situations without having adequate skills and guidelines. For some staff, however, this

strategy provided them with support and encouragement to develop their work with families.

Developing the strategy proved a useful exercise in bringing together the various services focusing on families/carers as well as identifying other needs (see Table 2).

Implementation of the strategy

Following its adoption by the Trust Board, a clinical lead (Roger Stanbridge) was appointed to take forward the strategy. Systemic thinking was helpful in this role, as the focus of the post was on bringing together different parts of the organization and the devel-

TABLE 2 *Extracts from Somerset's strategy to enhance working partnerships with carers and families*

Vision

The Somerset Partnership NHS and Social Care Trust will strive to respond to the needs of carers and families in all parts of the service. This entails having a social network perspective to all assessments and interventions provided by staff and the involvement of families and carers in service delivery wherever possible.

In practice this means that our services would need to develop to the point where they routinely offer:

- Family-friendly units with appropriate facilities and where staff welcome relatives and carers.
 - Interventions which consider the client in the context of their relationships (e.g. including a family perspective when working with individuals).
 - Involvement of families and carers in the initial care programmes or equivalent assessment/admission process where appropriate.
 - Close working between colleagues across specialities and agencies (Adult Mental Health, Child and Adolescent Services, Older Adults, Primary Care, Social Services, non-statutory organizations and education) to meet the needs of all family members.
 - Formal carers' assessments and care plans where appropriate.
 - Carers' support initiatives (e.g. carer support groups, carers' newsletters, psycho-educational groups for carers).
 - Early referral for specialist forms of therapy offered, when appropriate, to all family members.
 - Specialist carer/family interventions (e.g. Family Intervention in Psychosis services, family therapy clinics).
 - Greater consideration of the needs of children in families, including child protection issues, impact of adults with mental health problems, children as carers.
 - Greater consideration of the needs of adults who care for children with severe developmental or mental health problems.
-

opment of a staff training programme which would significantly influence mainstream clinical practice.

Carers and Families Steering Group

One of the first steps was to set up a Carers and Families Steering Group with the aim of supporting the implementation of the strategy. This group brought together a broad-ranging membership representing carers, service users, managers, clinicians and those providing services for carers. The multidisciplinary and multi-agency group had representatives from adult, older people, child, learning difficulties and drug and alcohol services. The setting up of the group provided the first forum in the Trust designed specifically to focus on family and carer issues and has done much to counteract the fragmentation and isolation described by staff and carers working in this area. In its first two years of operation, this bimonthly group has carried out work in the following areas:

- Improving information and support services for carers.
- Increasing the involvement of families/carers in the assessment and treatment process.
- Raising staff awareness and skills for working with families.
- Influencing Trust policies and guidelines.

For example, the input of the group into the review of the operational policy for all community mental health teams led to the routine invitation of family members and carers to the initial assessment process. A welcoming invitation to families/carers is now included as standard practice in all initial appointment letters to new service users.

Another example of the group's work is in the area of confidentiality and information sharing. The central importance to families/carers of their relationship with staff/information sharing with professionals involved in their relative's care has already been mentioned. Difficulties in this area are well documented both by families (Shepherd *et al.*, 1994) and professionals (Clarke, 2004), and are raised in most research and national guidelines as a significant impediment to good partnership working. A subgroup explored the issues involved and researched existing work in the area (see e.g. Royal College of Psychiatry, 2004) which led to the production of best practice guidelines on information sharing and confidentiality with families and carers. These guidelines emphasize a three-way partnership between

service users, families/carers and professionals, stress the benefits of information sharing and use case scenarios to illustrate good practice. They are intended to give families and carers a sense of what they might reasonably expect from services and provide staff with more information on which to base their practice. Having been endorsed by the Caldicott Committee, they are now part of community mental health teams' and inpatient services' operational policies and form the basis of ongoing further training in this area.³

Staff training programme

Most professionals' basic training does not include specific skills for working with families. We therefore decided to develop a range of awareness/basic skills training packages tailored to the needs of specific clinical teams. We envisaged the workforce being able to access a continuum of training from basic awareness/skills to specialist skills. We approached this in a phased way.

The initial phase has been to provide a series of education and awareness-raising sessions to clinical teams accompanied by a survey of staff involvement with families and their training needs. In addition, a three-day package of education, awareness and skills training was piloted with new teams. The second phase consists of the systematic implementation of the training programme throughout the Trust.

Attitude/awareness and skills training

The balance of attitude/theory and practice provided within these short courses depends upon the needs of the particular part of the service. For some staff, an increased awareness of issues facing families and carers, and how to access further help and resources, may be sufficient; for others with more direct contact, developing skills in conducting family meetings will be required.

We have found that when training extends over a day or more it is possible to include some skills development (e.g. genograms); however, a focus on staff attitudes is always essential.

While many staff welcome the shift to more family-oriented services, it is still the case that some staff view family members either as a cause of the client's difficulties or as interfering, and thus resist contact with families, while many others might not see a need to

³ The Somerset Partnership Best Practice Guidelines on Confidentiality and Information Sharing are available from the first author.

involve families in the clients' care. There is thus a need to inform staff members about the benefits of involving families and carers and to explore their attitudes and beliefs. This training is informed both by the theory and evidence for family work as well as an awareness of families' views on mental health services and our increasing knowledge of the challenge of caring for someone with a mental illness. We have found that involving carers in the provision of the training is an effective way of achieving the required shift in attitudes. The training also focuses on helping staff to extend their commonly held client-centred values and therapeutic skills to working with families. The qualities of empathy, warmth, genuineness and a non-judgemental approach also make up the therapeutic stance required to develop collaborative working partnerships with families and carers. In addition, the training explores the challenging practical and theoretical implications involved in making services truly family/carer-friendly (e.g. confidentiality issues).

Phase 1

Over a period of one year, between September 2003 and October 2004, the first author (RS) met with a range of clinical teams across the Trust. These were predominately community-based teams in the adult services but also included one inpatient and two home treatment/crisis resolution teams. The sessions varied from one and a quarter hours to whole-day workshops using a combination of didactic and pair/small group work. The content of the sessions included providing research-based information on family and carers' views on mental health services (Leavey *et al.*, 1997; Shepherd *et al.*, 1994) and the subjective and objective aspects of family 'burden' (Fadden *et al.*, 1987; McCarthy *et al.*, 1989; Schene *et al.*, 1994) associated with living with a relative who experiences a severe mental health problem. It also covered the benefits of including families and carers at an early stage in the assessment and admission process in terms of addressing issues of confidentiality/information-sharing, identifying carers and young carers, offering information and carers' assessments to families together with the evidence for these benefits in terms of outcome both for the client and other family members. Sessions also included outlining national policies which emphasize working in partnership with families and carers and presenting the Somerset Partnership's Strategy to Enhance Working Partnerships with Carers and Families. Staff attending were also invited to consider

ways in which they were currently working which were sensitive to the needs of families, areas they would wish to develop and what obstacles there might be to implementing these ideas.

In addition, a survey questionnaire was handed out at the beginning of each session and completed prior to the session commencing. The survey questions included:

- 1 Have you received training in working with families?
- 2 How much experience do you have in working with relatives/families of clients? (*on a 5-point rating scale, 'none to a great deal'*)
- 3 In the past month, how often have you sat in a room with the client and family members to discuss issues?
- 4 How confident are you about your skills in working with families? (*on a 5-point rating scale, 'not confident to very confident'*)
- 5 Would you welcome further training in working with families?

Results from the first nine teams' responses to the survey (ninety-one returns from a possible ninety-four who attended the sessions) were as follows.

Eighty-two per cent of staff in the survey had received no training in working with families. In the previous month, 18 per cent of staff surveyed had met with no families at all and 63 per cent had met with three families or less. When asked about their confidence in working with families, 18 per cent expressed confidence in their skills (39 per cent did not feel confident). All staff ($N = 70$) in the survey wished for further training in working with families. Sixty-nine people had conducted 279 family meetings. Within the sample, a subgroup of seventeen staff (19 per cent) had worked with more than six families in the previous month and had seen 52 per cent of all appointments. This subgroup also rated themselves as more confident in their skills (100 per cent rating three or above vs. 40 per cent). On the basis of data from seven of the nine sessions, 152 meetings were prearranged appointments and eighty-eight unplanned meetings. Twelve (14 per cent) of this sample group of staff had held 66 per cent of the planned appointments.

Of course it should be recognized that this survey is a snapshot of staff who attended specific sessions and the results may not be generalizable. In addition, the sample group is made up of predominantly community-based staff and the results may vary for inpatient staff. However, a number of conclusions may be drawn from the data:

- The majority of staff in the survey had received no prior training in working with families.
- Only a few staff were 'confident' in their skills in working with families.
- A small subgroup of staff were identified who saw a greater number of families per month than their colleagues and who expressed higher levels of confidence in their skills.
- All staff in the survey wished for further training in working with families.
- Sixty-nine people had conducted 279 family meetings. This seems a good baseline in spite of the general lack of confidence, training and experience.

Example of training package delivered to crisis team

As part of this first phase the authors have developed and piloted a three-day training package with a newly created crisis resolution/home treatment team consisting of eight staff members. A service user representative also attended the training days.

The three-day training package. The aim of this package is to provide an introduction to thinking systemically and considering individuals who present to our services in their relational and social context. It also provides training in basic family interviewing skills and problem-solving.

The focus on Day 1 is on education and awareness. The relevance and benefits of a family/social network perspective, including its evidence base and links with national policy, are considered. Systemic thinking is introduced and the beliefs and behaviours involved in interactional cycles within families which can maintain problems are examined. These ideas are explored by means of exercises and pairs/small group discussions using staff's own clinical experience and are supported by didactic teaching. Issues around information-sharing and confidentiality are explored.

Day 2 concentrates on teaching the basic interviewing skills required for convening, engaging and conducting a session, including problem-solving. This is done by means of role play techniques using prepared vignettes and situations based on staff's own clinical experiences.

Day 3 is scheduled for a minimum interval of one month after the initial two training days in order for staff to have time to put their

learning into practice. The focus on this day is on hearing how the team got on in their meetings with families, what went well or not so well, and providing supervision on cases. Additional skills are taught as required, and follow-up training and consultation sessions are planned.

Evaluation

Staff in this crisis resolution/home treatment team had previously worked in inpatient and community mental health settings. At the point of starting the training they did not feel confident about their skills in working with families (on a 5-point rating scale the average score was 2.1). This is not surprising, since only two members had any previous training in family work and in the previous month nobody had seen more than three families, with a total of eleven family meetings having been held by these eight staff members.

Approximately six months later, at the follow-up session, seven of the original eight staff attended and reported that most team members had radically increased the number of families seen. Four staff had seen more than ten families in the previous month, two had seen between six and ten and one had seen three. They reported sixty-three meetings with families in the past month. In addition, their confidence ratings had also increased substantially to an average of 3.1.

Of course, the increase in the number of families seen and increase in staff confidence could simply reflect the fact that crisis work often involves contact with families. However, it is interesting to note that twenty of the sixty-three family meetings were prearranged, which seems to suggest that staff members are actively seeking to work with families.

In addition, we asked which aspects of our previous training had been of most use to them, and followed this unstructured question with a more detailed evaluation of the initial two days of training in a second questionnaire.

Without prompting, the team members reported that they particularly valued being able to consider the individual in the context of their relationships. They also highlighted the skills training (e.g. problem-solving) by means of role play exercises. In the more detailed evaluation of the course, all the areas covered in the training were rated as useful (the lowest rating on a scale of 1–5 was 3 and nearly half of the total ratings were 5 (extremely useful)). See Table 3 for mean scores.

In the six-month follow-up session it was very apparent that team members were able to conceptualize cases using a systemic

TABLE 3 *Evaluation of the working with families course*

Please would you rate how useful the ideas/skills have been:						
1	2	3	4	5		
Little use		Some use		Extremely useful		
					<i>Range</i>	<i>Mean</i>
Group exercise on the relevance of a family perspective (5 scenarios)					4–5	4.8
Benefits of partnership working with families and carers, including evidence base, national policy and Trust strategy					3–4	3.5
Introduction to systemic thinking and interactional cycles (including group exercises based on video and case examples)					3–5	3.8
Convening and engaging the family (including role play)					4–5	4.7
Role play of first session, including case vignette					3–5	4.2
Introduction to problem-solving techniques and role play					4–5	4.8

framework, and that they felt relatively confident in using the skills taught in straightforward cases. However, they expressed the need for further training to deal with more complex cases, particularly requesting further interviewing skills training for the middle stages of therapy. Although we are hopeful that some team members may go on to do further family therapy training we have agreed that we will provide further time for regular case consultation. It would also be helpful if we could provide additional interviewing skills workshops.

We recognize that providing brief skills training with limited ongoing systemic supervision falls short of the ideal; however, these staff members are required to work with families as part of their clinical role and approach this work with little or no previous training in this area. We have therefore decided, in conjunction with Trust management, to equip staff more realistically to competently carry out this aspect of their role. We envisage that ongoing intermittent training and supervision will enable them to consolidate these skills. In addition, the team is able to refer families on to generic family therapy clinics or the Family Support Service for people where there is psychosis, both of which are readily available within the Trust.

Phase 2

The next phase is to provide these packages of training across the Trust. We have begun to provide three-day awareness/education and

basic skills training for all trained staff on all of our five inpatient units, aimed at increasing involvement of families in the assessment/admission process and the inclusion of family/carer needs and systemic issues in the written care plan. In order to maximize the impact of the training on clinical practice we are providing the training to each unit in turn using a team training approach. We plan to supplement this with additional awareness-raising training for non-professionally trained staff.

We have also recently completed a three-day training package tailored to the specific needs of our Eating Disorders Service. This virtual team consists of a hub of therapists and specialist 'link workers' based in the range of clinical teams. The training had to take into account that this group consisted of experienced therapists who practised individual cognitive behavioural therapy and cognitive analytic therapies, as well as Community Mental Health Team (CMHT) workers with a special interest in eating disorders. The training therefore included the evidence base for family therapy with eating disorders and the recommendations of the NICE guidelines (DoH, 2004a). It also included a presentation by a carers assessment worker on their role and the resources available for carers, as well as a demonstration of the recording of family/carer information on our electronic patient record system (RiO). This training package was very well received (see Table 4) and the group reported on Day 3 that they had achieved their action plan goals from the first two days. These goals included amending the operational policy, increasing the involvement of families in the assessment phase and increasing assessment/support for families and carers. Open-ended feedback on the course included the following:

'This has been a really useful "consciousness raising" for me, making me very aware of being constrained within a very individual model – not so much in terms of the relevance of the family where I've always worked on the family inside someone's head but more the potential for actually seeing more of other family members.'

When asked to give examples of how this training had influenced practice, another person commented:

'More confident in meeting with families. More aware/conscious systemic thinking when working with individuals. Some more tools to offer practical/signposting support and information to carers. Genograms will be very useful to use more.'

TABLE 4 *Evaluation of the working with families training eating disorders key workers*

<i>Topic</i>	<i>Average rating</i>
(Each topic was rated on a scale of 1 to 5 where 1 = little use, 5 = extremely useful)	
Small group exercise – family stories about food (Day 1 a.m.)	4.0
Relevance of a family perspective – vignettes (Day 1 a.m.)	3.9
Carers' views of services and family burden (Day 1 a.m.)	4.1
Introduction to National Policy and Trust Strategy for partnership working with families and carers, including exercises discussing current practice and personal/organizational obstacles (Day 1 p.m.)	4.2
Introduction to systemic thinking and interactional cycles (Day 1 p.m.)	4.6
Information-sharing and confidentiality (Day 2 a.m.)	4.4
Family therapy research and clinical models (Day 2 a.m.)	4.0
The initial family meeting (including role play) (Day 2 p.m.)	4.5
Operational issues and action plan (Day 2 p.m.)	4.0
Review of team's action plan (Day 3 a.m.)	4.0
Genograms (Day 3 a.m.)	4.8
Young carers' video and discussion (Day 3 p.m.)	4.0
RiO and carers' assessment (Day 3 p.m.)	4.0
Clinical discussion (Day 3 p.m.)	3.9
Overall, how useful have you found the two days plus follow-up third-day training package? (Day 3 p.m.)	4.6

Whereas some of the Eating Disorders Team members will influence the CMHTs in which they are based and most CMHTs have also received brief awareness-raising talks, we are planning more extensive skills-based training tailored to the needs of CMHTs. This would focus on skills for convening and interviewing families as part of the assessment process. We have also agreed to provide tailor-made three-day packages to other teams, and are providing training to the Older People's Inpatient Services.

Discussion

Many mental health services are in the process of developing information and support services for carers. Although this is a response to the needs expressed by families, we would argue that this alone is insufficient to change mainstream clinical practice. If staff are to be encouraged to work in partnership with families in all aspects of assessment and intervention rather than simply adding on services for

carers, then they will require additional training. Family therapists are particularly well placed to provide staff with the required training in attitudes and skills for working with the social support network. This brief, broad-based training of large numbers of staff might enable the less complex needs of a large number of families to be met (Pearson *et al.*, in preparation). However, this would require family therapists to seek wider organizational roles and to work in partnership with colleagues who are developing services for carers. In addition to offering training, family therapists will need to draw on their understanding of organizations in order to influence the management system which has the responsibility for the delivery of services. We have found that taking on these wider roles in addition to direct clinical work enables more people to benefit from a systemic approach.

It is important to note that it is not the aim of our training strategy to train large numbers of staff to be family therapists, but rather to increase awareness of the needs of carers and families and to create more family-sensitive mainstream services. Organizations also need to support the training of a smaller number of specialist-level qualified therapists in both systemic family therapy and family interventions in psychosis in order to meet more specific needs. This group would also be well placed to provide much of the training required by the strategy.

We would argue that family therapists should also contribute to the routine supervision of staff in order to encourage the incorporation of systemic ideas in case formulations. Staff usually welcome supervision/consultation following team-based skills training and this can be an effective way of consolidating the application of systemic ideas.

Consideration of patterns of interaction within families is often part of systemic supervision. In addition, we have introduced 'interactional cycles' as a useful way of looking at the relationships between staff and families. This can be illustrated by the experience described to us by a mother and father when visiting their son following his admission to an inpatient unit. Some months previously they had noticed signs of their son relapsing and had approached their GP for help, only to be told that they could not receive help until something more tangible happened. Their son deteriorated further, experienced paranoid delusions and was admitted after trying to take his own life. Against this background of feeling let down and left to cope on their own by services, the parents arrived on the inpatient ward for the first time to visit their son. They wandered around for a while without being

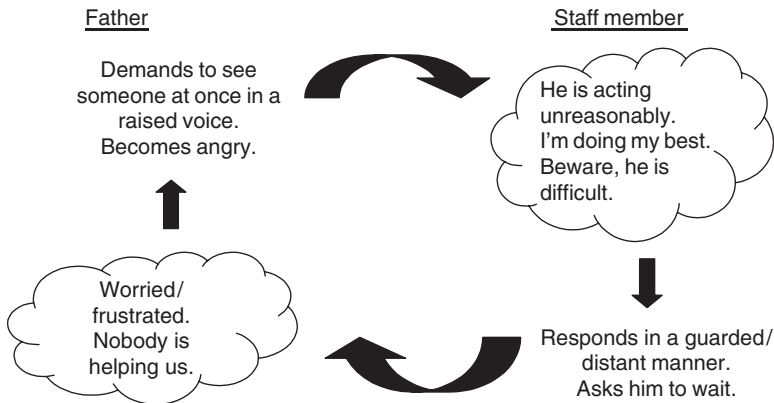


Figure 1. Pursuit cycle

approached and, feeling frustrated, the father went to the nursing station and asked to speak to someone. The staff member was busy and asked him to wait. The father, already feeling let down and stressed by his previous experiences, felt ignored and became angry and demanded to be seen. The staff member became wary, distanced themselves, and insisted on his waiting. Thus a pursuit cycle emerged which was mutually reinforcing. This could be illustrated as in Figure 1.

Using this example in training sessions it is possible to look at staff beliefs and behaviour, and consider how things might be done differently to interrupt this unhelpful pursuit cycle. For example, in terms of behaviour, if the ward were to have a policy of staff greeting all visitors on arrival and including families and relevant others in the admission process, this interactional cycle may not have developed. In terms of beliefs, if staff were to appreciate the background of stress for families and their difficulty in understanding and accessing services, they may be more inclined to seeing a 'stressed relative needing support', rather than a 'problem relative from which to distance themselves'.

Conclusion

The scenario detailed above illustrates how systemic ideas can be helpful in the broader clinical context. We have been encouraged by the response from staff to these training initiatives and the

accompanying shift in practice, embodied in team action plans, to more family-inclusive ways of working. We hope that this will lead to a better experience for families and improved outcomes for service users. This paradigm shift to considering the individual in the context of their social network will require much support, training and consolidation if it is to move to being 'core' mainstream practice rather than 'optional'. We hope that this paper, which has reviewed the policy context and provides examples of the work done by two family therapists in a mental health trust, will be of interest to family therapists who are working in similar settings and encourage them to develop roles 'outside the clinic'. We would be interested to hear from other family therapists who may be working in a similar way.

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CHAPTER 5

Involving Carers

Carers play an important role in many service users' lives. Their knowledge and expertise represent an enormous resource for statutory and voluntary mental health services. These are reasons why it is so important to include them through sharing information (U.K. Dept. of Health, 2006).

This chapter is in two parts. Part 1 is written from a service perspective, and describes how professionals can actively involve families/carers in different aspects of service development and training. Part 2 is written by a carer and describes the various roles that family members can take on at local levels and also more widely in national roles.

Part 1

Including Carers in Staff Training and Service Development in Somerset, U.K.

Roger Stanbridge and Frank Burbach

The involvement of family members/carers has been a fundamental element of our service development and training initiatives in Somerset. Carers' contributions have been integral to the development of our family intervention in psychosis service (Burbach & Stanbridge 1998, 2006) and our strategy for the development of more family-inclusive mainstream services (Stanbridge & Burbach 2004, 2007). Carers' descriptions of their lived experience, together with their feedback and suggestions regarding mental health services have shaped the way in which our services have developed.

Developing Family Intervention Services to Meet Families' Needs

Even when families have been offered family interventions, they have not always felt that this has addressed their needs. (Hatfield 1983; Reimers & Treacher 1995). One explanation might be that professional frameworks (e.g. assessment; theoretical models) may sometimes get in the way of listening to families. Assessed needs may not be the same as expressed needs. It is clear from the literature that the quality of the relationships between professionals and family members is a key ingredient for a successful outcome and requires a collaboration regarding the aims/goals of the sessions.

In the approach we have developed in Somerset, our family intervention sessions with each family are based on a shared agreement regarding their needs and goals that we have mutually agreed upon. At the end of sessions, we ask whether family members have found the meeting to have been useful and plan future sessions. The approach has evolved in the light of this routine feedback from families, as well as a more formal research study (Stanbridge et al. 2003). This study involved semi-structured interviews with 15 families involved with the first of four teams established in Somerset.

In the study a majority of families described feeling apprehensive on referral to the service. For some, this was based on having had previous poor experiences of mental health services: (Note: To protect privacy where individuals are referred to, false initials will be used.)

“I had a lack of confidence in the process. I was also prejudiced against the service generally because of our first contacts.” (father)

Others felt that sessions would be unhelpful or make things worse:

“Nervous for J. (son) due to his fearfulness and worry about going. Worry that he would feel worse after coming.” (mother)

“I was hesitant as to how I would be treated. A sense of trepidation as to whether or not we would be treated sensitively. Whether therapists would be trained and could be trusted with sensitive issues.” (father)

In spite of this, families were overwhelmingly satisfied with the service they received.

“Surprised and satisfied. The most important thing was that they listened and responded to the family’s needs, not following their own agenda.” (aunt)

What Families/Carers Valued

When asked what they valued most about the service, a number of themes emerged:

- ***Openness of Discussion Within Sessions:***

“Open discussion in a safe and supportive environment.” (mother and son)

“The non-judgmental nature of the service has helped most, but not in a wishy-washy way.” (father)

- ***Therapist’s Qualities:***

“Talking to someone about J. who knows and understands him and is sympathetic.” (mother)

“A feeling of concern and warmth.” (mother)

- ***Support Offered:***

“Knowing someone is there to talk to, to explain or answer a problem in sessions or on the phone.” (mother)

“We liked the flexibility in the timing of appointments, which vary depending on what is happening and how much help we need. You only need to pick up the phone to arrange a session.” (mother and father)

- ***Managing the Burden of Care:***

“An easing of the pressure, burden at the time. Especially after the meetings. We didn’t feel so much on our own.” (mother and father)

- ***Access to the Mental Health Services:***

“Another point of contact with the system.” (mother and father)

Therapeutic Relationship

Family members were asked a number of questions about the qualities of the relationship between themselves and their therapists. Most felt understood by their therapists and often described this as a powerful experience.

“I felt very much understood. That was very overwhelming in a way, having come from a place where we weren’t understanding each other at home, to have two people who were empathetic there for me and for our son.” (mother)

People valued the ongoing evaluation of the usefulness of sessions and the fact that the sessions were mutually agreed upon.

“They asked at the end of each session if we were happy to continue and if it was useful or not.” (client)

“It felt as if we had the first say and they (therapists) would follow what we wanted, but they might come up with suggestions as well, but it felt as if our needs came first.” (client and wife)

“We agreed together. That was the whole point of the counselling – to get agreement about what you’re talking about, otherwise you’re not getting anywhere.” (mother and father)

All families identified helpful qualities in their therapists. These included:

- ***The Ability of the Therapist to Listen:***

This was referred to explicitly by seven families and implicit in many families’ reference to other qualities.

“The therapists didn’t take sides or become judgmental, but listened to the problems we had as a family.” (mother)

- ***Non-judgmental Attitude of Therapists:***

This was referred to by five families.

“Parents are concerned about being judged. This didn’t happen. We were not made to feel responsible or judged or put in a box in any way.” (mother and father)

- ***Therapists Answered Questions and Shared Views:***

This was referred to by five families.

“It was possible to ask questions and discuss things. They would give frank answers.” (mother and father)

“They were very open, sympathetic and shared their views.” (mother and father)

- ***Therapists Worked Well Together:***

This was referred to by five families.

“They had two very clear roles and confidently interacted with us and each other.” (mother and father)

- ***Helpfulness of Therapists:***

This was referred to by four families.

“It has helped us to cope with the situations that do arise with A. from time to time when his psychosis flares up.” (father)

- ***Interest of Therapists:***

This was referred to by three families.

“They were very interested in the problems we were having as well as P’s (son). That was the first time that had happened; they knew that we were having problems, we were worried and we were suffering from stress. They realized that.” (mother and father)

- ***Therapists Created a Calm and Quiet Atmosphere:***

This was referred to by three families.

“The therapists were pleasant, calm, helpful and patient. You didn’t feel oppressed in any way.” (mother)

Most Common Problems

The most commonly identified problems for which families/carers sought help related to the impact of the sufferer's behaviour on family relationships. Themes identified included:

- ***Managing Specific Behaviours*** (e.g. domestic chores, irregular sleep patterns, aggressive behaviour, suicidal ideas):

“Conflicts with my Mum over household chores were a specific problem and stress.” (client)

“J.’s suicidal thoughts were high on the agenda.” (mother and father)

- ***Difficulties Created in Close Relationships:***

“We were concerned that we might be giving mixed messages to M., you saying one thing and me saying another, and the impact of different approaches.” (mother and father)

- ***Making Sense of the Experience:***

“How best to manage it and how best to understand what had happened and what it meant to my wife and me.” (client)

- ***Support for Family Members’/Carers’ Personal Needs:***

“It was for us, to carry on trying to live a normal life with A. the way he was.” (mother and father)

Many families described improvements in their relatives' symptoms and related concerns/problems. They felt that the family sessions had helped them to cope better and deal more effectively with their relative's symptoms.

A number of themes emerged when people were asked what had helped with their problems or symptoms:

- ***Developing Improved Coping Strategies:***

“J. has been able to use her relapse strategy and has not had a full-blown episode.” (relative)

- ***Improved Communication:***

“Changing our communication between ourselves, improving that. Avoiding certain triggers.” (client and wife)

- ***Increased Understanding of Mental Health Problems:***

“Helping us understand mental illness. I learnt a lot about it I didn't know. (father)

- ***Availability of Support:***

“They were clearly communicating well as a network. Everyone seemed to know what was going on elsewhere in the service and what they were doing and we admire that because it’s not common.” (mother and father)

- ***Reduced Contact with Relatives:***

“His leaving home, space to get away from us, otherwise I think he would be in hospital again.” (mother)

Timely Referral to Family Services

The study also indicated that early referral was associated with successful engagement in family work. Two families felt that being referred at the point of their son’s discharge from hospital was “too late”. They would have welcomed the offer of the family service at the point of their greatest need (i.e. when first contacting mental health services).

Views on Participation in the Research

All those interviewed felt positive about taking part in the research. Many expressed a sense of passion about the service they had received. They felt that carers’ needs had been overlooked in the past and were keen that the new family interventions’ service would continue to be available:

“I think that it is a must to have a service like this. There must be a support service for families.” (mother)

Many saw participation in the research as a tangible way of helping others:

“We’re pleased to be of help and will do anything in the future, for all that’s been done for us ... without the help, I don’t think we’d have been in business. I don’t think we’d have been able to carry on normally. It was a 24-hour constant worry.” (mother and father)

Involving Families in Staff Training

In addition to seeking families’ views in order to create more responsive services, families also help service development by contributing to staff training programs.

1. Family Interventions in Psychosis Course

Like many other courses, families are invited to come and describe their experiences in order to raise trainees’ awareness of the stress felt by families and their experience

of accessing services. In addition, some families have agreed to take part in family sessions within our one-year training course. Although our clinical approach involves pairs of therapists meeting with families in a variety of settings (e.g. at home), for the purposes of training we have found that it is helpful to use a “live supervision” model. This involves the therapists meeting with the family in one room whilst the observing/supervising team is in an adjoining room, connected by a one-way screen, video and audio-link. This enables the co-therapist to receive messages from the tutor/supervising team, which can then be fed into the session in a congruent manner. The one-way screen/video-link enables trainees to observe family sessions and provides rich material for subsequent discussion/supervision.

All aspects of these somewhat unusual arrangements are fully discussed in advance with all family members. Clearly not all families would feel comfortable with this procedure, but often families are willing to help with the training, and see the advantage of having the input of an experienced multi-disciplinary group of staff (the 8-10 observers routinely include doctors, nurses, social workers, psychologists and a range of other therapists).

The advantage of integrating the skills training within the course (as opposed to trainees developing their clinical skills in separate placements) is that our trainees do not have the usual difficulties in putting their newly developed skills into practice. In addition, by delivering the course to the new team in-situ we are able to create a new family intervention service that is fully operational by the end of the course. The families who participate, therefore, also gain the benefit of family work in advance of the new service.

2. Family Inclusive Mainstream Services

There have been recent changes in policy in the U.K. that have raised the profile of the needs of carers/families, and have led to the development of education and support for carers. However, this has not addressed the needs of the majority of mental health staff who have not had training in working in partnership with families. It is in this context that we have developed a three-day training program that we are delivering to existing in-patient and community mental health teams throughout Somerset. This program is described in detail below.

Each training course starts with a presentation by a carer. This takes the form of the family member (or sometimes this is two parents) telling their story. We encourage people to talk about both good and bad experiences of services, but specifically ask them to comment on the following areas:

- Events leading up to contact with services
- First experiences/impressions of services/in-patient unit
- Subsequent impressions/experiences

- Whether they felt included by staff
- Quality of the communication with staff
- Any recommendations they might have

In our evaluation of the training we have found that the experience of hearing directly from a family member/carer is very highly rated and has a major beneficial effect on staff attitudes. Staff frequently describe feeling emotionally affected by hearing the carers' experiences and often identify closely with their struggles. In terms of impact on attitudes, these presentations are usually far more effective than the presentation of research findings or policy, although we find that both of these aspects are also important parts of the training. Starting with the carer's story literally and symbolically puts this at the centre of the training, and trainees and trainers often refer back to the carer's experiences throughout the course. Staff appear more receptive to the training package and more willing to consider changes in practice as a result of the carer's contribution.

We are aware that carers could be involved throughout training courses of this kind, or these courses could be run by carers' organizations. We have found, however, that staff appreciate the opportunity to reflect on their practice as a group and that we have been able to facilitate more open communication with the course structure described. This acknowledges that the challenge in this training package is to work with a wide range of staff attitudes. Addressing unhelpful, institutional attitudes is an important part of the training and can take place only in a non-defensive environment. It is for this reason that we also ensure that the families invited to share their experiences have not personally been involved with the staff group that they are speaking to.

Developing Family-Oriented Mainstream Mental Health Services through Staff Training

In order to implement Standard Six of the National Service Framework described in Chapter 7 (Department of Health 1999), which entitles carers to their own assessment and written care plan, our Trust, like many other U.K. Mental Health Trusts, started to employ Carers' Assessment Workers. Whilst providing new services for carers is clearly a positive development, we became concerned that this would lead to existing mental health staff becoming less involved with families, if they felt that this was the responsibility of the new carers' service. This would not have brought about the change to more family-inclusive practice which is advocated by national policy. We therefore began to develop proposals to integrate carers' support services with mainstream clinical practice. Our Trust in Somerset encouraged the development of a strategy to enhance working partnerships with carers and families (see Table 1).

Table 1

Extracts From Somerset's Strategy To Enhance Working Partnerships With Families/Carers' Vision:

The Somerset Partnership NHS and Social Care Trust will strive to respond to the needs of families/carers in all parts of the service. This entails having a social network perspective to all assessments and interventions provided by staff and the involvement of families/carers in service delivery wherever possible. In practice this means that our services would need to develop to the point where they routinely offer:

- Family friendly units with appropriate facilities and where staff welcome relatives and carers.
- Interventions that consider the client in the context of their relationships, e.g. including a family perspective when working with individuals.
- Involvement of families/carers in the initial Care Programs or equivalent assessment/admission process where appropriate.
- Close working between colleagues across specialities and agencies (Adult Mental Health, Child and Adolescent Services, Older Adults, Primary Care, Social Services, non-statutory organizations and education) to meet the needs of all family members.
- Formal carers' assessments and care plans where appropriate.
- Carers' support initiatives, e.g. carers' support groups, carers' newsletters, carers' education courses and psychoeducational groups for carers.
- Early referral for specialist forms of therapy offered, when appropriate, to all family members.
- Specialist family/carer interventions, e.g. Family Intervention in Psychosis Services, Family Therapy Clinics.
- Greater consideration of the needs of children in families, including child protection issues, impact of adults with mental health problems, children as carers.
- Greater consideration of the needs of adults who care for children with severe developmental or mental health problems.

Families/Carers Steering Group

One of the first steps was to set up a Families/Carers Steering Group with the aim of supporting the implementation of the strategy. This group brought together a broad-ranging membership representing carers, service users, managers, clinicians and those providing

services for carers. This multi-disciplinary and multi-agency group had representatives from adult, older people, child, learning difficulties and drug and alcohol services. The setting up of the group provided the first forum in the Trust specifically designed to focus on family and carer issues and has done much to counteract the fragmentation and isolation described by staff and carers working in this area. In its first two years of operation, this bi-monthly group has carried out work in the following areas:

- Improving information and support services for carers
- Increasing the involvement of families/carers in the assessment and treatment of the people with mental illness
- Raising staff awareness and developing skills for working with families
- Influencing Trust policies and guidelines

For example, the input of the group into the review of the operational policy for all community mental health teams led to the routine invitation of family members/carers to the initial assessment process. A welcoming invitation to families/carers is now included as standard practice in all initial appointment letters to new service users.

Confidentiality and Information Sharing

Another example of the group's work is in the area of confidentiality and information sharing. Of central importance to families/carers is their relationship with staff and the ability to share information with professionals involved in their relative's care. Difficulties in this area are well documented both by families (Shepherd 1994), and professionals (Clarke 2004), and are raised in most research and national guidelines as a significant impediment to good partnership working. A sub-group explored the issues involved and researched existing work in the area (e.g. Royal College of Psychiatry 2004; Department of Health 2006), which led to the production of best practice guidelines on information sharing and confidentiality with families and carers. These guidelines emphasize a three-way partnership between service users, families/carers and professionals; stress the benefits of information sharing; and use case scenarios to illustrate good practice. They are intended to give families and carers a sense of what they might reasonably expect from services and provide staff with more information on which to base their practice. These are now part of community mental health teams' and inpatient services' operational policies and form the basis of ongoing further training in this area. In addition we have embarked on an extensive staff education and skills training program.

Developing a Continuum of Training

Most professionals' basic training does not include specific skills for working with families. We therefore decided to develop a range of awareness/basic skills training packages tailored to the needs of specific clinical teams (Stanbridge & Burbach 2004,

2007). We envisaged the workforce being able to access a continuum of training from basic awareness/skills to specialist skills. We approached this in two phases.

The initial phase has been to provide a series of education and awareness-raising sessions to clinical teams, accompanied by a survey of staff involvement with families and their training needs. The results of this survey highlighted a lack of confidence and prior training of staff in working with families and a wish for further training. In addition, a three-day package of education, awareness and skills training was piloted with new assertive outreach, home treatment/crisis resolution and eating disorders teams. The second phase consists of the systematic implementation of the training program throughout the mental health service.

Training to Raise Awareness, Change Attitudes and Develop Skills

The balance of theory and practice provided within these short courses depends upon the needs of the particular part of the service. For some staff, an increased awareness of issues facing families/carers and how to access further help and resources may be sufficient; for others, with more direct contact, developing skills in conducting family meetings will be required.

We have found that when training extends over a day or more it is possible to include some skills development (e.g. holding a family meeting which includes the patient), however a focus on staff attitudes is always paramount. (For initial family meeting format used in training see Table 2.)

Table 2

Initial Family Meeting
<p><i>Aims:</i></p> <ul style="list-style-type: none">• To create a rapport with the family.• To identify and value the role of the family, and to encourage the maintenance of family relationships.• To create a platform for future collaboration (3-way partnership), including discussions around confidentiality.• To develop a shared understanding/aims.• To understand the context of the individual's problems.• To provide information on services, support networks (including carer's assessment) and services.

Content:

1. Contact details; problem-free talk (e.g. did you have to take time off work; occupations); rationale for meeting (working together; family's expertise/knowledge); procedures/plans for session.
2. Family's account of development of client's problems:
 - Initial onset of problems (what, when, triggers).
 - How did family members respond (what helped/didn't help)?
 - Experience of (accessing) services.
 - Who else has been involved?
 - How have things developed?
 - How have they made sense of what has happened?
3. Impact of the problem on the family/family members.
4. Expectations regarding treatment, including family's goals.
5. Family members' attitudes to working collaboratively:
 - Discussion around confidentiality and information sharing.
 - Involvement in care planning process.
6. Provide information about support and practical help for carers:
 - Offer carer's assessment.
7. Genogram (family tree):
 - Who is in the family/what do they do/how do they get on?
 - Family history of mental health problems.

Many staff welcome the shift to more family-orientated services. However, some staff view family members either as a cause of the client's difficulties, or as interfering, and thus resist contact with families. Many others might not see a need to involve families in the client's care. There is thus a need to inform staff members about the benefits of involving families and carers and to explore their attitudes and beliefs. This training is informed by both the theory and evidence for family work as well as an awareness of families' views on mental health services and our increasing knowledge of the stress of caring for someone with a mental illness. We have found that involving carers in the provision of the training is an effective way of achieving the required shift in attitudes.

The training also focuses on helping staff to extend their commonly held client-centred values and therapeutic skills to working with families. The qualities of empathy, warmth, genuineness, and a non-judgmental approach also make up the therapeutic

stance required to develop collaborative working partnerships with families and carers. In addition, the training explores the challenging practical and theoretical implications involved in making services truly family/carer friendly (e.g. confidentiality and information-sharing issues).

Inpatient Staff Training Program

Having piloted the three-day package with new teams, this was then provided to all trained staff on all five of our inpatient units. A team training approach was used to maximize the impact on clinical practice with follow-up consultation to teams. Day three was held approximately one month after days one and two. An important aspect was the building in of evaluation processes throughout. For content of the three training days see Table 3.

Table 3

Three-Day Inpatient Staff Training Program
<p><i>Day One:</i></p> <ul style="list-style-type: none"> • Carer’s story and discussion. • Introduction to National Policy and Trust Strategy for Partnership Working with Families and Carers, including exercises discussing current practice and personal/organizational obstacles. • Focus on information sharing and confidentiality using best practice guidelines and case examples. <p><i>Day Two</i></p> <ul style="list-style-type: none"> • Introduction to systemic thinking and interaction cycles (including case scenarios). • Presentation by the Carer’s Assessment Worker: assessments and resources for carers and Electronic Patient Records’ demonstration. • The initial family meeting (introduce format and role-play). • Development of a unit action plan. <p><i>Day Three:</i></p> <ul style="list-style-type: none"> • Discussion of team progress and implementation of action plan. • Genograms (family tree). • Young Carers’ video and discussion of services for young carers. • Values Questionnaire. • Clinical discussion with examples from the group. • Evaluation of the training.

Evaluation of Inpatient Training

The project has been evaluated in a number of ways. Staff responded positively to the training program, which they rated highly in terms of the appropriateness of its level, teaching methods and whether they would recommend it to colleagues. In a pre- and post-training survey they reported a significant increase in confidence in their own skills in working with families. In terms of changes to clinical practice, a pre- and post-training case note audit involving two separate randomly selected groups of 10 current inpatients' case records from each inpatient unit showed an increase on all the dimensions measured (see Table 4). This was accompanied by a modest increase in the average number of families seen.

Table 4

Five Inpatient Units: Pre- and Post- Training Audit (N=50)		
	PRE	POST
1. Is there a carer registered?	24%	44%
2. Family or friend recorded in "contacts"?	92%	94%
3. Is there a reference in the care program approach (CPA) to carer need, roles or contribution to care? (<i>family history, support network, carer's views are sections of CPA focused upon</i>)	46%	84%
4. Is there carer involvement in relapse prevention plan?	6%	18%
5. Any carer "responsibility" for issues identified as problems within care plan?	12%	20%
6. Systemic issues identified and referral to specialist services:		
a. Carer's assessment	14%	44%
b. Carer's support group/education group	6%	30%
c. Family therapy/family support service	4%	9%

In addition, a range of actions were initiated to improve communications, visiting arrangements, consideration of children and young carers, provision of leaflets and resources, and the inclusion of families and carers in the assessment/admission processes.

This is being followed up by a questionnaire survey of families, carers and others visiting all inpatient units during the six months following the training program asking about their satisfaction with the level and quality of their contact with staff on the unit.

Discussion

Many mental health services are in the process of developing information and support services for carers. Although this is a response to the needs expressed by families, we would argue that this alone is insufficient to change mainstream clinical practice. If staff are to be encouraged to work in partnership with families to integrate all aspects of assessment and intervention, rather than simply adding-on services for carers, then they will require additional training.

Those professionals with more specialized training in family work are particularly well placed to provide staff with the required training in attitudes and skills for working with the social support network. This brief, broad-based training of large numbers of staff might enable the less complex needs of a large number of families to be met (Pearson et al., submitted for publication). However, this would require family work specialists to seek wider organizational roles and to work in partnership with colleagues who are developing services for carers. In addition to offering training, they will need to draw on their understanding of organizations in order to influence the management system that has the responsibility for the delivery of services. We have found that taking on these wider roles in addition to direct clinical work enables more people to benefit from family-based approaches.

It is not the aim of our training strategy to train large numbers of staff to be family therapists, but rather to increase awareness of the needs of families/carers and to create more family-sensitive mainstream services. Organizations also need to support the training of a smaller number of specialist-level qualified therapists in both systemic family therapy and family interventions in psychosis in order to meet more specific needs. This group would also be well placed to provide much of the training required by the broader training strategy.

Specialist family workers should also contribute to the routine supervision of staff to encourage the incorporation of systemic ideas in case formulations. Staff usually welcome supervision/consultation following team-based skills training, and this can be an effective way of consolidating the application of systemic ideas.

Conclusion

In summary, we would argue that to move more family-inclusive ways of working from aspiration to a reality, they will need to become embedded in routine services. In the U.K. the national policy guidelines already support this direction, but it will require mental health services to develop strategies and “champions” to take this forward. In addition to providing resources, education schemes and support for carers, it will also

require a higher level of family inclusion and a comprehensive staff training program to bring about the shift from a culture based on the individual to one that sees the individual in the context of their social network.

Our experience has been that a team training approach is most effective in bringing about the cultural change required. In providing this training, it is important for trainers also to be aware of the current working context of mental health staff. Training needs to be carried out in a positive way. It needs to take into account the pressures and conditions in which both staff and carers work on a daily basis and provide support to staff through education and skills development to enable the setting of achievable personal and organizational goals.

Part 2

Involving and Training Carers

Peter Woodhams

This section is about the role carers can have in being involved with services in many different ways. It starts with my own story in becoming a carer and then how I have developed into becoming a carer actively involved in many different aspects of the world of mental health, both as a volunteer and in a paid capacity. Inevitably the early part of the section relates my own personal experiences, but the second part attempts to give more general guidance on how other carers might make a similar journey.

Clearly I have to use my experiences in the U.K. as my knowledge base, but I believe that similar opportunities to become involved exist for carers (or caregivers) in most parts of the world. Indeed mental health services throughout the world need to receive the input of carers as stakeholders, because it is the carer alone who has the unique perspective of knowing the person before and after illness strikes and of the difficulties in accessing services, particularly in the early stages of mental ill health.

I do appreciate that many carers will not have the time, background, experience or opportunities that I have had but I do hope that in reading this chapter, they may feel encouraged to get involved even if it is just in a small way.

Becoming a Carer

As with most carers, my wife and I knew nothing about the world of mental health when our son first developed mental health problems in 1994, nor did we know the implications of the word carer. Until then our lives had been fairly straightforward.

It is not relevant to this chapter to detail the roller coaster that then ensued for us, particularly as I know that readers who are carers will have been through a similar phase. But it is relevant to explain that my wife and I felt very helpless and removed until we

were offered psychoeducational family therapy some five years later. This gave us the support and knowledge we needed, and the skills we learned helped us to contribute to our son's care and recovery. There is absolutely no doubt in my mind that I would not have become so actively involved without the benefits of Behavioural Family Therapy. Most important of all, my son started to improve and at the time of writing he has made really good progress and is living a relatively normal life.

Early Stages of Carer Involvement

The social worker who delivered our family therapy often reminds me of the time I said to him: "Do you think there is anything I can do to contribute to mental health?" Ever since then I have become a totally involved carer. I was just about to take early retirement and I was wondering about what to do with my time. We discussed this question in some detail and as a result three things happened;

1. The social worker passed my name forward to the Meriden Family Programme, and my wife and I were invited to speak about the benefits we had gained from Behavioural Family Therapy. This speech was given at an awards ceremony when certificates were presented to professionals who had successfully completed training in this approach to helping families.
2. I was put in touch with a local carer who was trying to start a local Active Carers Group.
3. A meeting was arranged at the local psychiatric hospital to discuss the possibility of me becoming an Associate Manager (someone who sits on a hospital panel to hear appeals under the Mental Health Act).

In each case one thing led to another and opportunities to become more involved opened up on all fronts.

It is important to emphasize that neither my wife nor I had attended local carer support groups. For both of us our respite was in our work, and at the end of our busy working days a support group was not attractive to us. However for me the concept of involvement was much more appealing in that it meant trying to do something positive. I had spent a lifetime in meetings and trying to influence decision takers. I found the idea of using this experience to try and improve mental health services for patients and carers very challenging and exciting. Indeed since becoming an involved carer I have never had a boring day. I look forward to every day.

Becoming an Involved Carer Locally

The early days of my involvement "career" were very much in my own local area as a volunteer helping to facilitate the development of a local active carers' group. I am

indebted to a highly respected local carer who taught me so much about mental health services and about pathways to involvement. We worked together to develop our group and were encouraged in this by our local authority, which has a statutory duty to carers. This group is now well established as South Warwickshire Carers in Partnership and it coordinates all aspects of carer involvement in the area. We are fortunate that the local health Trust set up groups called Service Development groups, which enabled stakeholders including patients and carers to contribute to the way mental health teams were run. In the U.K., health services are divided into areas known as Trusts, with each Trust covering a particular geographical area. Some Trusts provide services while others commission services.

I joined the Acute Care Forum, which reviews practices in the local psychiatric hospital. Here I began to understand the way in which mental health services are run. I am still a member of this very important group and feel confident about the way I contribute. I also became a member of the Service Development group for the Assertive Outreach team, spoke at training courses for professionals and sat on interview panels.

I was energized by the fact that I was gaining an understanding of mental health services. This in turn helped me be a more effective for my son, particularly in being able to speak to his clinicians more confidently. By this time I had been appointed as an Associate Manager at the local hospital. I was paid a small fee when I sat on an appeals panel. At this time hospitals were required to have their own internal appeals procedure under the Mental Health Act.

From Local to Regional

When my wife and I gave the talk to the clinicians and trainers of the Meriden Family Programme (described in Chapter 4), we met the Chair of Carers in Partnership (CiP) in the West Midlands. This group promotes carer involvement in the way services are planned, set up and delivered. It runs a network of carers and carer support workers with an interest in involvement, and has one part-time staff member. Carers attend meetings on an entirely voluntary basis. I accepted an invitation to join this group.

Soon I was asked to join the Meriden Advisory group as the CiP representative. I also attended conferences as a carer representative and contributed to training courses. I enjoyed the involvement with CiP as a volunteer and was rapidly gaining confidence in my knowledge of mental health infrastructures.

CiP was able to get funding for another part-time staff member whose principal role would be to promote the development of active carers groups in each area of the West Midlands. This in effect was a “field worker” role. I applied for this post and was successful. I joined initially as a staff member contracted through the mental health charity Rethink in August 2003. Since then carer involvement has become a substantial and rewarding part of my life.

Regional Involvement

Carers in Partnership has been fully funded by the Care Services Improvement Partnership, which has been commissioned by the Department of Health to help implement national policies for local benefit. Whilst I contribute to all aspects of the work program, my particular focus has been on the development of the following initiatives:

Local Active Carers' Forums

For such a forum to evolve, two ingredients are essential:

1. A small group of carers willing and eager to get involved
2. An ally within the local mental health service, as carers cannot easily access involvement opportunities without a supporter

Each group works in a different way. Some are exclusively made up of carers, whilst others invite professionals to attend as appropriate. They are all working towards having a carer as chair and ensuring carer representation at all key strategic meetings within the locality so that the views of carers can be taken forward. Other activities include arranging for carers to sit on interview panels, contributing to training and generally being available for consultation on strategic issues. Once local mental health managers know of the existence of the active carers' forum, then they will channel requests and invitations through to it.

It is helpful if a carer worker from the local mental health service is linked to the forum to provide access to an administrative resource. The running costs of such forums are very small and in most cases the local Trust or local authority will provide financial assistance. It is important that carers are paid an appropriate fee when attending strategic meetings.

Carers with Special Needs

There are particular groups of carers who may have special needs, for example, children with caring roles. I will use as an example carers from black and minority ethnic groups. It has been a priority of CiP to try and build up a group of supported and engaged carers from minority ethnic groups.

Working through a sub-group of families with black and ethnic-minority members, two very successful events have been run for those carers to raise their voices and encourage involvement. A major achievement has been facilitating the commissioning of a specific black- and ethnic-specific Carer Education Programme delivered by the Meriden Family Programme. This was a training trainers' course attended by five teams from different services (including carers), with the objective that each team gained the knowledge and skills to deliver an 11-week modular (2 hours per module) education program to these carers within their respective areas.

Hosting Events that Highlight Carers' Needs

One of the key targets for CiP has been to influence improvements to the services delivered to carers in each of the localities in the region. Examples of good practice in carer services were showcased in workshops presented by selected teams from within the region. The target audience was a delegation of four-to-six representatives from each of the 14 areas in the region. Eleven of these areas sent delegations and attended workshops on several aspects of care including:

- Carers' assessments
- Carer involvement
- Carer support
- Carer education
- Information for carers
- Family work
- Services to BME carers
- Carers of older people
- Young carers

The event proved to be very successful and raised the profile of carers throughout the region.

Royal College of Psychiatrists

My initial involvement with the Royal College of Psychiatrists came through a campaign called "Partners in Care" that promoted a working partnership between psychiatrists and carers/family members. I was invited to join the regional Steering Committee and helped to facilitate Partners in Care events in each area of the region. I was asked to speak on carer perspectives at many of these events and whilst I was initially quite nervous at this prospect, I soon got used to the idea of giving presentations.

This involvement resulted in me being invited to join the West Midlands Executive Committee of the Royal College as a carer representative and at the time of writing I believe that I am still the only carer representative on any of the regional executive committees. I am allocated time at each meeting to present carer issues and with the cooperation of the regional Chair, I enlisted other carers to contribute to a leaflet: *A Message to Psychiatrists from Carers*.

Working with the Meriden Family Programme

Behavioural Family Therapy helped our family so much to become an active supporter of family interventions and of the work of the Meriden Family Programme in particular. This has led to very active involvement in the work of Meriden, both on their Programme in the West Midlands and throughout the U.K. and Ireland. I do some of this work on a carer consultancy basis. This involvement includes;

- Chairing the Meriden Advisory Group – a group of Meriden stakeholders that meets three times a year to review the work of Meriden.

- Regularly speaking on the benefits of Behavioural Family Therapy to all family members on many Meriden training courses. I also speak occasionally on this topic within mental health Trusts when they are training their own therapists.
- Completing a Meriden training trainers' course with particular emphasis on the development of facilitation skills.
- Working as a trainer on all deliveries to date of the Carer Education Training Programme, particularly in contributing a carer perspective to this initiative. I also taking a lead in marketing this initiative, because it is so beneficial to carers.
- Contributing to several other activities in my role as carer member of the team.

National Involvement

In England, the way in which carers are involved nationally is very ad hoc. There are groups such as Rethink and the Manic Depressive Fellowship that support the needs of family members. However, there is no national mental health carers' forum as such, so there is much work to be done to develop mechanisms that enable carers to be involved in national initiatives and to have a representation "constituency" enabling them to seek views on national issues from other carers. As a result the opportunities outlined below are the only groups I have been able to contribute to at national level, and these have come through my own contacts.

National Psychosocial Intervention (PSI) Group

This is a multi-disciplinary group that includes service users and carers and promotes the development of psychosocial interventions including family work. I have spoken on the benefits of Behavioural Family Therapy at a national PSI conference (as indeed I have done at a World Fellowship of Schizophrenia and Allied Disorders conference in India).

Royal College of Psychiatrists

My involvement in the Partners in Care campaign led me to give a number of presentations to national meetings promoting the importance of carer involvement in the training of psychiatrists. I produced a paper that outlined proposals on how best this new training concept could be implemented and I presented these proposals at the Annual Meeting of the Royal College in 2006.

I have also joined the National Patients and Carers Committee of the Royal College.

A Summary of Involvement Outlets for Carers

My own involvement has been extensive and varied. This is because I have been fortunate to have had the opportunities for involvement. My earlier career may have helped me

acclimatize quickly to this new world of meetings and presentations. Most important of all, I had the time and I wanted to be involved because of the satisfaction and sense of achievement it brings.

This is not going to be the case for all carers and it is really important that carers find involvement outlets that suit them and that they are comfortable with. Everyone has different strengths they can contribute. It is not essential that to be an involved carer you have to go to lots of meetings or give lots of talks. I have summarized below in very general terms the different types of carer involvement in services in England:

Local Mental Health Services

All local authorities will have meetings that carers can attend to review different strategies to do with improvements in these services. It is important that carers explore all local opportunities for involvement. A good example is where carers sit on interview panels for which training should be provided by the local authority.

Regional Forums

There will be new health and social care initiatives that are introduced on a regional basis. Sometimes collaborative groups will be formed by the relevant health service agency that carers will have the opportunity to join. There will also be regular regional conferences at which carers can often get a free place.

Training of Professionals

Training professionals is a growth area of carer involvement in England and it divides into two main categories of training:

- Staff induction and staff development training. Carers should give their perspectives on induction courses for new staff or when existing staff are being re-trained to implement changes in areas such as mental health legislation, family work, or new mental health team development.
- Professional training within universities. Many courses being provided to train new mental health professionals now include an element of carer involvement. Tutors will often look for carers who are prepared to have a regular involvement with courses, for which a fee should be paid. In the West Midlands we have established a “Helping Professionals Learn” sub-group and members of this group have each developed a working relationship with a particular university in the region and are working closely with tutors.

Participating in Consultations

On a national level there will be many consultation processes to which a group of carers will have the opportunity to contribute. It is important that carers organize themselves into a group, review the proposals and put their suggestions and comments forward in accordance with the procedure laid down in the consultative document. From time to time individual professions will review their ways of working, and the relevant professional body will instigate a consultation process. In recent times, Carers in Partnership has contributed to two major consultations – Nursing and Occupational Therapy – in which each body was reviewing its role in mental health. The Carers in Partnership submission for Occupational Therapy was included in full in the final report, and can be viewed online at <http://www.westmidlands.csip.org.uk/carers-in-partnership.html>

Local health authorities will also often have a formal consultation process when introducing a new method or strategy that affects the way mental health services are delivered.

Speaking at Conferences and Mental Health Promotion Events

Public speaking is often daunting to many people, and carers are no exception to this. However as many have found, the more practice you get the easier it becomes and very often the key is in preparing a talk that the presenter is comfortable with. Many carers will have put together a talk on their own story and although this is an emotional experience, it will often have a profound impact on the audience. Carers who have developed a presentation should make known their availability to trainers within health Trusts, local authorities, regional agencies, universities and professional bodies. An appropriate fee should always be paid.

The Written Word

Letter writing to local health Trusts is a common communication method for carers with a grievance, although the appropriate complaints procedure is probably the best method of taking a grievance forward.

Some carers find that they can best express their experiences in poetry. Increasingly authors and editors of clinical mental health books will be seeking contributions from carers, and other mental health publications will be keen to include an item on a carer perspective on a specific topic.

Involvement with Mental Health Charities

Mental health charities always welcome the involvement of carers in many aspects of their work and for some carers this is the type of involvement with which they feel most comfortable. The involvement can include:

- Working as a volunteer in services provided and run by the charity.

- Fundraising activities – organizing or attending such events.
- Serving as a trustee of the charity.
- Being a committee member of a working or governance group.
- Participating in lobbying activities of the charity. Charities such as Rethink have been successful in campaigning on particular issues such as mental health legislation, and raising awareness of the risks of cannabis. They have been actively supported by carers who have highlighted their personal experiences.
- Attending meetings such as support groups.

A Few Suggestions for Further Carer Involvement

There is no prescriptive formula for effective carer involvement. Much depends on the number of carers with an interest in being involved, their own particular skills, the availability of funding and the attitude taken by the local services to carer involvement. If the local services are supportive, then very often carers will respond appropriately. The following are just a few ideas that may be helpful.

Form an Active Carers' Group

- Forming an active carers' group will enable carers to be recognised as a stakeholder group by mental health services and involvement opportunities will then be channelled through to this group.
- The group will then share the different involvement opportunities taking into account individual interests, knowledge and capabilities.
- The group can also be used as a means of seeking the views of other carers on issues and will be a reference group for carers to report back to.
- It may also wish to facilitate training for its members, particularly new ones. A training course might cover an explanation of local services, a talk from a clinician such as a psychiatrist, accessing involvement opportunities, and the attitude of local services to carer involvement and how it can be made more effective.
- Develop members' skills through courses on interpersonal relations, skills needed to understand conducting meetings, negotiating, influencing and giving presentations.

Maintain a Positive, Objective Approach

- Airing personal grievances should be avoided in general carer involvement, as these should be handled privately or through the proper mechanisms.
- A negative carer attitude or approach will not endear carers to a mental health service. Every effort should be made to keep a positive approach by making

constructive suggestions. Managers tire of hearing negative comments all the time and may well switch off or at least move the agenda on.

- Angry carers can often be very effective if they can harness their anger and add a constructive element to their contributions.

Participate in Meetings

- Even if carers have difficulty in contributing to formal meetings, it is important to remember that their very attendance at the meeting will often increase staff awareness of carer issues.
- It takes time to develop an understanding of what meetings are about and who is who at the meeting. Carers therefore need to be patient, as eventually an appropriate understanding will develop.
- Carers should be paid for attending meetings run by the local services, and they should also ensure that appropriate means of communicating meeting papers, minutes, agendas are agreed upon, e.g. email or post.
- It may be helpful for new involved carers to be mentored by more experienced involved carers.
- An open meeting for carers when carer involvement is explained is often a successful way to recruit carers into involvement, particularly if the meeting includes a subject of specific interest such as understanding medications.
- Questions that can help to motivate carers become involved are: Are you satisfied with local mental health services? If not, do you want to do something to try to improve these services?
- Involved carers should also identify and build up relationships with key allies in the local services – effective involvement is very difficult without the assistance of allies who can help prepare the way.

It is important to remember that carers can speak for those who might not otherwise be heard.

Is It Worth the Effort? What Are the Benefits?

- The knowledge and confidence gained through involvement helps carers become more effective and less stressed. They feel less isolated and more supported. In particular, they feel far more able to speak to professionals in their caring role.
- Carers find involvement challenging, but also very satisfying. They feel they are trying to do something positive.
- Carers can influence mental health strategies locally, regionally and nationally.
- Involvement helps carers to be seen as genuine stakeholders. As carers gain

knowledge, they can pass this knowledge on to other carers.

- Carers have a mechanism to take their concerns forward.
- For some carers, involvement is a form of respite – as indeed it has been for me.

So please encourage carers to become involved. (You can contact Peter Woodhams by email at woodhamspema@btinternet.com, or phone him at +44 178 926 6485 or +44 780 0253 9415.

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Training to Develop Family Inclusive Routine Practice and Specialist Family Interventions in Somerset

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Abstract

Current national policies present a challenge to the existing mental health workforce as most staff have not been trained to work with people within the context of their social support network. This paper presents two complementary training initiatives designed to enable mental health staff to meet the range of needs of families: (1) An in-house accredited (1- year) course which has enabled the successful creation of specialist Family Intervention in psychosis teams; and (2) a whole-team trust-wide training programme (3- day course) to promote partnership working with families by both community and inpatient teams. Issues which have enabled the successful translation of training to practice are considered.

Key words: training, implementation, family Interventions, partnership working with families

Introduction

National Policies (eg *The National Service Framework*, (DoH,1999); NICE Guidelines for Schizophrenia, (DoH, 2002)) advocate a holistic bio-psychosocial approach to mental health care. In particular, they emphasise the importance of involving families/carers as partners in care, as well as providing specialist family interventions. This has considerable implication for workforce development, as services have traditionally focused on treating the individual, and most mental health professionals would therefore not have had training in working with families.

In Somerset we have implemented an extensive training programme to develop the workforce. There are two distinct strands to this – first, the development of a county-wide family interventions (FI) service by means of in-situ accredited team training and, second, the training of inpatient and community staff in family-inclusive practice. This article will describe both of these training initiatives and consider their complementary nature in equipping the workforce to deliver a more comprehensive service.

Family Interventions Services

The NICE Guidelines reflect the strong evidence base for family interventions in psychosis. A number of randomised controlled trials indicated that the inclusion of family work with standard care, including medication, significantly reduces relapse rates, improves social functioning, reduces 'family burden', and reduces overall treatment costs (see Pharoah *et al*, 2002; Pilling *et al*, 2002, Pitschel-Waltz *et al*, 2001). These studies have led to the development of a range of training initiatives (Brooker, 2001) but there have been difficulties in implementing these approaches (originally developed in research settings) in standard mental health services (Brennan & Gamble, 1997; Fadden, 1997 & 1998; Kavanagh *et al*, 1993).

One of the main implementation difficulties identified was that practitioners were not able to prioritise family work within their caseload due to a lack of support from colleagues and managers. In addition, they reported that skills taught were insufficient to engage with the range of families.

It was in this context that we decided to develop our own training course – the Family Interventions (Research, Skills, Theory) in Psychosis (F.I.R.S.T.) course – to establish family interventions services in the rural county of Somerset. Our response to the implementation difficulties identified was two-fold: first, to deliver the course to multi-disciplinary groups of staff who would go on to provide the new service in each of the four service areas in turn, second, to integrate psychoeducational (cognitive) behavioural approaches for psychosis with systemic psychotherapy, theory and skills (Burbach and Stanbridge, 1998, 2006), developing a flexible approach that is suited to all families affected by psychosis, including those with first episode psychosis (Burbach *et al*, 2008).

The F.I.R.S.T. course

A distinguishing feature of this course is that it was specifically developed in order to create a service. The course was developed by the authors, and is delivered by trust staff under a partnership arrangement with a local university. This means that the course is delivered by people who are grounded in clinical practice and allows the course to focus on service needs, whilst ensuring academic standards (Burbach *et al*, 2002). Course participants benefit from relevant, local training which is also externally accredited (the course is accredited by the Plymouth University [60 credits at degree level] and the Association for Family Therapy at foundation level). Although the course is dually accredited, the focus of the course has always been on establishing a service. This is reflected in the structure and content of the course, as well as the emphasis on creating a context for putting skills into practice.

We developed a year long course (half a day per week) in order to be able to include a wide range of theory and skills. This includes basic family therapy theories and skills, behavioural family interventions, CBT for hallucinations and delusions, relapse prevention, the history of work in this area and the research evidence. The emphasis throughout is on the acquisition of skills through role-playing the stages of therapy as well as live supervision of clinical work with families. As students begin to work with families half way through the year, the service can be established in a way that is

congruent with local conditions, and operational issues are worked out by the end of the course.

To ensure that the training can be put into practice we require that all applicants to the course have their line managers' agreement to be able to devote a minimum of half a day per week to provide the service on completion of the course. In addition, students are selected not solely on personal qualities, but also on their suitability for membership of the new team. We aim for the teams to be multi-disciplinary as well as representing the range of mental health services (e.g. in-patient units, CMHTs, assertive outreach) in the locality. This ensures that the family intervention service is well integrated into the local network of services, which facilitates referrals and good communication, and encourages wider cultural change.

The course focus on clinical practice is also evident in the student assessment process. Clinical competencies, which are evaluated throughout the course by means of self- and tutor- ratings, and evidenced by reflective portfolio entries, account for 50% of the assessment. The three written assignments that account for the remaining 50% include a practical focus. The first involves the application of theory to a clinical situation, the second includes an initial assessment report and clinical formulation, and the third is a case study, transcript analysis or video critique.

The F.I.R.S.T. course thus addresses the commonly experienced difficulties of integrating training and service delivery. By means of in-situ whole-team training the course equips trainees with a broad range of skills and also establishes a context in which they can practice.

Evaluation

Perhaps the most important point to make in terms of evaluation is that we have successfully established and maintained four family intervention teams in Somerset. In addition, the mental health services in Cornwall have used this course and training approach to develop a trustwide family intervention service of three teams. In a replication of the earlier evaluation studies we found that people who had completed our course went on to work with more families post-training and experienced less difficulty in implementing the approach (Bailey *et al*, 2003). Brooker and Brabban's (2004) review of psychosocial interventions training recognised that Somerset's trainees had far less difficulty in implementing family interventions than experienced in four other studies (see *table 1*). This appears to confirm that the broad content of the course, as well as the process of providing the training, the service context and the structure of the service (including the focus on ongoing supervision; Burbach & Stanbridge, 2008) are effective in establishing a service.

The effectiveness of the approach taught is also reflected in audit data, which show high engagement and low DNA rates, and in feedback from families. In an in-depth study of families who experienced the service, all families reported satisfaction with the service. They felt helped in terms of coping with problems and symptoms, and particularly valued the collaborative nature of the therapeutic alliance (Stanbridge *et al*, 2003).

Pros and cons of our service development approach

Trainees find it far less stressful to attend a local course with their colleagues, with no additional time lost due to travel. This leads to high levels of attendance and a low course withdrawal rate (three out of 31 staff did not complete the first four courses). Working together throughout the year also helps to develop a strong team spirit that continues as the course becomes the service.

Unlike other trainees who have to return to their workplace and set up a service, our trainees establish the service during the course. They are able to use their local knowledge to develop referral pathways, educate other colleagues and problem-solve any operational difficulties. In addition, the fact that there is ongoing clinical work with families at the point at which the course ends, means that the newly trained team is immediately operational.

Table 1: Overall level of difficulty reported implementing family interventions in five Studies (Brooker & Brabban, 2004)

Study	Difficulty Rating		
	Not at all or a little difficult	Moderately or Very difficult	Extremely Difficult or impossible
Buckingham, UK (Fadden (1997))	44%	45%	11%
Manchester, UK (Baguley <i>et al.</i> , 2002)	20%	55%	35%
Somerset, UK (Bailey <i>et al.</i> , 2003)	80%	20%	0%
Sydney, Australia (Kavanagh <i>et al.</i> , 1993)	31%	48%	22%
West Midlands, UK (Campbell, 1999)	36%	50%	14%

The team training approach conveys additional benefits for the ongoing service. Having a group of eight or ten trained staff in each locality enables them to influence the local culture. We would agree with Fadden (1997) on the importance of achieving a critical mass of trained staff in order to enable the implementation of family interventions. In our services the team of like-minded colleagues is able to provide the necessary initial support and encouragement to sustain this demanding work. The establishment of a team also enables the maintenance of service quality through clinical supervision, audit procedures, and continuing professional development.

Focusing training on service development conveys a number of advantages in that the knowledge and skills taught are clinically relevant. Providing this training in-house to

create whole teams is clearly a robust way of ensuring the transference of these skills into an effective service. That this was achieved in Somerset without significant additional funding may be seen as an advantage, however, in an ideal world this would have been a funded plan rather than a 'reconfiguration' dependent on goodwill.

Family Inclusive Mainstream Services

Whereas specialist Family Interventions Services are able to meet the needs of a particular group of families, research indicates that the majority of relatives feel unheard and excluded from their relative's care (Shepherd et al, 1994). This is in spite of the fact that they are often the first to become aware of difficulties (both at onset and relapse), encourage the person to seek help and, in enduring cases of mental illness, provide much the day-to-day support. Increased involvement of carers and families is central to the National Service Framework (NSF) but, paradoxically, the employment of carers assessment workers could lead to existing mental health staff becoming less involved with families, if they felt that this was the responsibility of the new carers service. Similarly, there is a danger that establishing a separate family interventions service will lead to other mental health staff seeing work with families as the sole province of the specialist FI workers. It is for this reason that it is important to focus also on the entire workforce's awareness, knowledge and skills in relation to working in partnership with families/ carers.

Strategy

It is against this background that the Somerset Partnership NHS and Social Care Trust have adopted a strategy to enhance working partnerships with carers and families see Stanbridge & Burbach, 2004). This strategy includes the following vision:

"The Somerset Partnership Trust will strive to respond to the needs of carers and families in all parts of the service. This entails having a social network perspective to all assessments and interventions provided by our staff and the involvement of families and carers in service delivery wherever possible."

In order to achieve the cultural change detailed in the strategy, we developed a two-phase staff training programme.

Staff training programme

The initial phase has been to provide a series of education and awareness-raising sessions to clinical teams, accompanied by a survey of staff involvement with families and their training needs. In addition, a three-day package of education/ awareness-raising and skills training was piloted with new teams. The second phase consists of the systematic implementation of the training programme throughout the Trust (Stanbridge & Burbach, 2007a).

Education/ awareness- raising and skills training

The balance of attitude/theory and practice provided within these short courses depends upon the needs of the particular part of the service. For some staff, an increased awareness of issues facing families and carers, and how to access further help and resources, may be sufficient; for others with more direct contact, developing skills in conducting family meetings will be required.

We have found that when training extends over a day or more it is possible to include some skills development (e.g. family interviewing, genograms); however, a focus on staff attitudes is always essential.

While many staff welcome the shift to more family-oriented services, it is still the case that some staff view family members either as a cause of the client's difficulties or as interfering, and thus resist contact with families, while many others might not see a need to involve families in the clients' care. There is thus a need to inform staff members about the benefits of involving families and carers and to explore their attitudes and beliefs. This training is informed both by the theory and evidence for family work as well as an awareness of families' views on mental health services and our increasing knowledge about the challenge of caring for someone with a mental illness. We have found that involving carers in the provision of the training is an effective way of addressing the required shift in attitudes. The training also focuses on helping staff to extend their commonly held client-centred values and therapeutic skills to working with families. The qualities of empathy, warmth, genuineness and a non-judgemental approach also make up the therapeutic stance required to develop collaborative working partnerships with families and carers. In addition, the training explores the challenging practical and theoretical implications involved in making services truly family/carer-friendly (e.g. confidentiality issues).

Phase 1

Over a period of one year, we met with a range of clinical teams across the Trust. These were predominately community-based teams in the adult services but also included one inpatient and two home treatment/crisis resolution teams. The sessions varied from one and a quarter hours to whole day workshops, using a combination of didactic and pair/ small group work. The content of the sessions included providing research-based information on family and carers' views on mental health services (Leavey *et al*, 1997; Shepherd *et al*, 1994) and the subjective and objective aspects of family 'burden' (Fadden *et al*, 1987; McCarthy *et al*, 1989; Schene *et al*, 1994) associated with living with a relative who experiences a severe mental health problem. It also covered the benefits of including families and carers at an early stage in the assessment and admission process, addressing a range of issues including confidentiality/information-sharing, identifying carers and young carers, offering information and carers' assessments to families, and the evidence for family interventions in terms of outcome both for the client and other family members. Sessions also included outlining national policies that emphasise working in partnership with families and carers and presenting the Somerset Partnership's Strategy to Enhance Working Partnerships with Carers and Families. Staff attending were also invited to consider ways in which they were currently working which were sensitive to the needs of families, areas they would wish to develop, and what obstacles there might be to implementing these ideas.

In addition, a survey questionnaire was handed out at the beginning of each session and completed prior to the session commencing. Results from the first nine teams (91 staff) revealed that the majority of staff had received no previous training in working with families and only a few staff were confident in their skills. All staff in the survey wished for further training in working with families.

We developed and piloted a more extensive 3-day training package with the assertive outreach and crisis resolution/home treatment teams and secured management support for an ongoing programme of staff training throughout the Trust.

Phase two

Phase two consists of the delivery of the three-day training package to inpatient and community teams. The general aims of the training are to raise awareness of the role families/carers play and to develop staff skills and confidence to work in partnership with families. (The learning outcomes are listed in *table 2*.) However, the training package is adapted to meet the specific needs of the team. To date we have delivered the training to all staff in five adult acute units, the eating disorders team, a new inpatient and day unit for older adults, and newly reconfigured community mental health teams (Assessment and Recovery Teams). The roll-out of this training has been agreed with Trust management and their support is key to ensuring that staff are released for the training. In order to enable each team member to attend we deliver the course twice (this enables clinical work to continue to be provided by the other half of the team). Whereas we delivered the 3-day course to the trained staff on the adult acute units, all nursing assistants and reception staff attended a modified one-day course.

Table 2: Learning outcomes for the family inclusive practice workshops

<p>Attitude and awareness</p> <ul style="list-style-type: none">• to have an awareness of Family/Carer views on mental health services• to have an awareness of research findings on the family burden associated with caring for someone with severe mental illness• to have an awareness of the benefits of involving families in treatment including the theory and evidence base for family work• to have an awareness of thinking systemically and be able to consider the person in the context of their relationships and social network• to have considered their therapeutic stance in relation to working with families• to have considered best practice in relation to confidentiality and information sharing <p>Skills</p> <p>To have practiced the following skills in family interviewing :</p> <ul style="list-style-type: none">• engaging with families• conducting an initial family meeting• balancing the needs of individual family members• information sharing and developing a collaborative relationship• genograms and additional skills

Besides our use of a whole-team training approach, we maximise the impact on clinical practice by holding Day 3 approximately one month after the initial two days. This enables us to follow up the action plans agreed on Day Two and to consult around clinical issues which have arisen in the meantime. The 3-day format also provides an opportunity for reflection on clinical practice and has a team building function.

Evaluation of the Training Programme

The training has been evaluated in a number of ways. We conduct pre- and post-training surveys of staff confidence, experience and number of families seen and assess changes in knowledge and attitudes regarding family inclusive working. This was supplemented by a case note audit and we are currently surveying family members/carers visiting all Trust inpatient units to see whether they felt included in the process of care. In addition, we evaluated the action plans developed by teams on Day 2 and asked staff to evaluate the training experience.

Staff responded positively to the inpatient units training programme (Stanbridge *et al*, 2008); 90% rated the teaching methods appropriate and stimulating; 95% rated the training as appropriate to their needs and 93% said they would recommend the course to their colleagues. A further evaluation was completed at the end of the third day follow-up training when 98% rated the three-day training overall as 'very useful'. They also described an increase in their confidence in working with families, and changes in their practice. This was supported by the case- note audit that showed an improvement in all the dimensions audited. For example, the number of carers registered on the inpatient units rose from 23% to 43%; detailed information recorded about carers increased from 38% to 83%; and referral for a carers assessment rose from 15% to 43%. Positive outcomes from the team action plans have included improved visiting arrangements for families, provision of information leaflets for families, and greater inclusion of carers in the assessment/admission process.

Discussion

The NSF and subsequent policies have described an ambitious programme of service development including the aim for workforce planning, education and training "*to enable mental health services to ensure that their workforce is sufficient and skilled, well-led and supported to deliver high quality mental health care.*" There is acceptance that "*not all mental health staff, even those trained relatively recently, have the skills and competencies to deliver modern mental health services*" (p108), and a "*fast track...of focused education and training to address the critical skills gaps, including competencies for...psychosocial interventions*" (p111) is recommended.

The development of staff skills in psychosocial interventions with families is integral to these plans. In addition, skills for working with carers/families are also recognised in the *10 Essential Shared Capabilities*, which include the following:

“Working in Partnership. Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks.”

“Providing Service User Centred Care. Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families.”

What is not so clear, however, is the means of achieving this development of the workforce. There have been a number of initiatives to address these challenges, ranging from sending selected staff on university accredited training programmes (e.g. Thorn Courses) to regional training programmes in behavioural family interventions (five days) and awareness raising workshops (e.g. Meriden Programme). Initiatives of this kind often struggle to facilitate the delivery of the newly acquired skills in routine clinical practice and there can be a tension between the academic requirements of a University and the service delivery focus of mental health trusts. It is for this reason that we have adopted an in-situ, whole-team training approach and have implemented two complementary trust-wide training initiatives in Somerset.

In Somerset the wider training of the workforce in family inclusive practice has followed on from the successful training of specialist family intervention teams. However, we are currently assisting another trust in delivering our family inclusive practice training with a view to subsequently training specialist FI teams. Local contexts will determine the priority order of the two initiatives, but we would strongly argue that **all** mental health services should develop staff skills in **both** areas. Basic involvement of families in assessment and treatment should be an integral part of the standard care of all mental health professionals; and a smaller group of staff should have more highly developed skills to work with the more complex needs of particular families.

The basic needs of families supporting people with mental health problems could be met appropriately via standard care. In a previous paper (Pearson et al, 2007) we have detailed the initial needs of families as including the need to talk about their stressful/traumatic experiences and to be listened to/ be heard by sympathetic professionals, as well as a need for understanding and information. Mottaghipour and Bickerton (2005) argue that successfully connecting with the family early on will enable a thorough assessment and the establishment of a strong partnership for future work. In addition, information about symptoms, treatment, mental health services and other resources should be provided as part of routine care. Many families will also have a need to develop coping strategies and processes for problem solving. This can be provided by specialist family intervention services or in routine care where staff have received further training (e.g. Behavioural Family Therapy).

Mottaghipour and Bickerton (2005) point out that some people remain highly distressed or may have major problems in connecting to the mental health services and will therefore need specialist family consultation to open up new therapeutic possibilities or may need to be referred for longer term family therapy. We would agree that all families have basic needs which should be met through standard care,

but some families will find themselves in more complex situations in which they will have the need to understand and change patterns of interaction, and need to make sense of how the psychosis fits with historical and contextual factors. This will usually require the skills of a more experienced therapist.

It would be utopian to think of all staff being able to meet the full range of family needs. What is more realistic is to develop the workforce so that all staff are able to meet basic family needs and a small group of staff have the skills to meet the more complex needs of a smaller group of families.

Services therefore need to develop robust team structures to enable supervision and the ability to co-work/refer families with more complex needs to the more experienced therapists. It is clear that the routine involvement of families as partners in care and the availability of specialist family interventions services are interdependent. It is for this reason that the Somerset Partnership NHS and Social Care Trust implemented the two complementary training initiatives described in this paper.

Organisational support

It will be evident that initiatives of this kind require support throughout the organisation. In Somerset both initiatives were endorsed by the Trust board and incorporated in Trust strategies/ business planning. Initially, Trust managers identified areas of concern and, following discussion and wider consultation, we developed specific strategies and action plans. This led to the identification of 'champions' to take these plans forward. A key to the success of these two projects has been the role of the trust-wide champions, but it has also been essential to encourage individuals to take the lead within their clinical teams. Middle management (locality/service managers) also had an important role in enabling the training and service development process.

Carers' involvement

In addition to working strategically at all levels of the organisation, we would argue that the involvement of carers in the training programmes has significantly contributed to their success (Stanbridge & Burbach, 2007b).

On the FIRST course, like many other family intervention courses, families are invited to come and describe their experiences in order to raise trainees' awareness of the stress felt by families and their experience of accessing services. In addition, some families have agreed to take part in family sessions as part of the course timetable (during the second half of our one-year training course).

The advantage of integrating the skills training within the course (as opposed to trainees developing their clinical skills in separate placements) is that our trainees do not have the usual difficulties in putting their newly developed skills into practice. In addition, by delivering the course to the new team *in-situ* we are able to create a new family interventions service, which is fully operational by the end of the course. The families who participate, therefore, also gain the benefit of family work in advance of the new service.

Each family inclusive practice workshop starts with a presentation by a carer. We encourage people to talk about both good and bad experiences of services, with a focus on the quality of communication with staff.

Starting with the family member/ carer's story literally and symbolically puts this at the centre of the training, and trainees and trainers often refer back to the carer's experiences throughout the course. Staff members appear more receptive to the training package, and more willing to consider changes in practice, as a result of the carer's contribution.

Conclusions

We have argued that developing the mental health workforce in order to deliver the new national agenda around family work requires a strategic trust-wide approach involving twin training initiatives, developing basic awareness and skills throughout the workforce to enable routine partnership working with families, and training staff to deliver specialist family interventions. We have found that in-service multidisciplinary whole team training with the involvement of family members in the training has been an effective way of training the workforce.

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Early Intervention in the Real World

The Somerset team for early psychosis

Frank R. Burbach, David J. Grinter and Sonia E. A. Bues

Abstract

Aim: To describe the development of an early intervention (EI) service in Somerset, and evaluate the progress after the first 2 years.

Method: The Somerset Team for Early Psychosis (STEP) has been developed in stages from 2003 to the present 'hub-and-spoke' model. The framework, which the team operates, is outlined, the assessment and outcome measures are presented, and the interventions, with the emphasis on working with families, are discussed.

Results: Two hundred fifty-nine referrals have been received in the first 2 years, with the caseload currently

standing at 153. The mean duration of untreated psychosis of STEP clients was just over 9 months; when those who developed psychosis before 2004 (pre-STEP) were removed, this was reduced to 6.4 months. Eighty-four per cent of STEP clients have had their families involved with our service in some way. Relapse rates of clients in the service for over 12 months have been encouragingly low (17%).

Conclusions: We reflect on the challenges faced in relation to the EI service model described in the Department of Health's Policy Implementation Guide and, in particular, on having successfully built on the existing family interventions service.

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Key words: early intervention, families, first-episode psychosis, rural health service, service evaluation.

INTRODUCTION

The Mental Health Policy Implementation Guide (MHPIG)¹ and A Window of Opportunity² describe models of early intervention (EI) in psychosis service delivery that have been utilized to reduce the duration of untreated psychosis (DUP) and achieve favourable clinical and functional outcomes. In particular, skills in psychosocial interventions (PSI) are essential if the services are to achieve the desired outcomes.³ In Somerset, we faced the challenge of developing a service that would enable the delivery of high-quality assessments and interventions in a large rural county. In addition, we wished to build upon our existing specialist family interventions (FI) in psychosis service,^{4,5} which offers an integrated psychoeducational/cognitive/systemic approach.

This paper describes the phased development of the service in Somerset, its structure and procedures, as well as the outcomes achieved in its first 2 years of operation.

METHOD

Context

Somerset is a mainly rural county of 3450 km² (1333 mi.²) situated in the south-west of England with a population of around 527 000. The south-west has the lowest population density in England, with four-fifths of the land used for farming.

The county of Somerset has a dispersed settlement structure and only three towns have populations of more than 30 000. Outside of these centres, the population density is below 100 km⁻². In order to serve this dispersed population, the county is divided into four service areas.

The county has a small but growing black and minority ethnic population and a significant number of migrant workers.

The population of Somerset is relatively healthy in terms of life expectancy and prosperity – although there are pockets of deprivation within some of the larger towns and areas.

The development of the Somerset EI service

Because of financial constraints, we were not immediately able to invest in the development of a new EI service and therefore implemented a phased service development strategy, maximizing the use of existing resources. Phase 1 (2003–2004) focused on research, staff training and the creation of new inter-agency partnerships. Phase 2 (2004–2006) was composed of the development of a pilot EI service, and the reorientation of the existing FI service to incorporate work with adolescents (aged 14 years and above). Phase 3 (September 2006 onwards) was the establishment of a full hub-and-spoke EI service across Somerset.

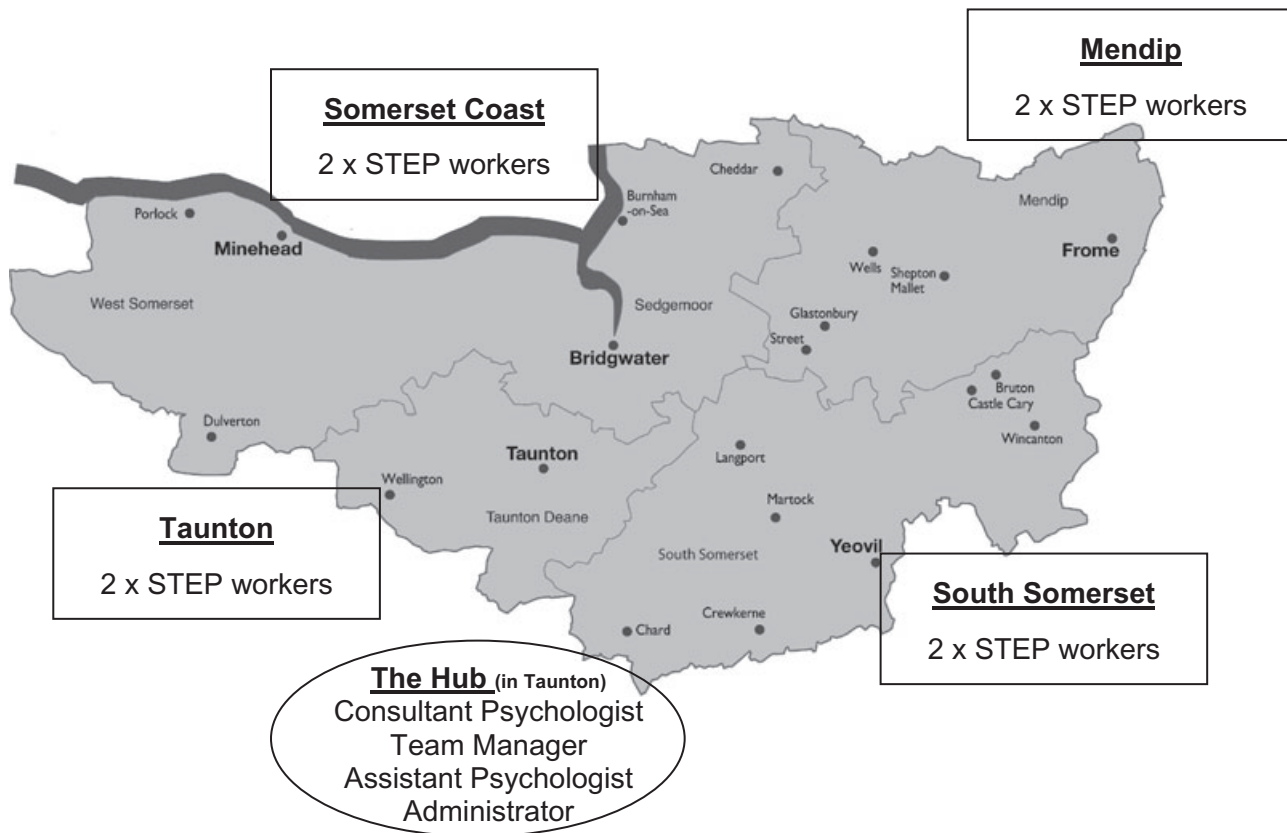
In 2003, the Somerset Partnership Trust appointed a lead clinician for EI and created an assistant psychologist post. The assistant psychologist conducted a baseline audit of services for people with first-episode psychosis (FEP) and their carers. We also established an EI Project Group, including user and carer representatives, to support the development of services in Somerset. Non-statutory mental health organizations, youth-focused agencies, and education and social services

representatives joined with adult mental health and Child and Adolescent Mental Health Services (CAMHS) clinicians to generate ideas about integrated services for people with FEP.

The accredited 1-year FI training course^{6,7} was adapted to include work with adolescents, and the existing four FI teams extended their age range from August 2004 to include those aged 14–17 years referred by CAMHS.

During 2004, the EI lead and assistant psychologist were joined by two community psychiatric nurses (CPN) (half a day per week) in order to pilot an assessment and consultation service. These workers already had dedicated time for EI work as part of the FI service and were allocated additional time to begin to develop a wider EI role. In 2005, one of the workers commenced work on a full-time basis in one service area. In September 2006, an additional three workers (one social worker and two CPNs), along with a part-time administrator, were appointed to cover the remaining areas. In April 2008, the social worker was appointed as part-time team manager and an additional part-time worker was recruited. This constituted the realization of the Somerset-wide hub-and-spoke model (see Fig. 1).

FIGURE 1. The Somerset hub-and-spoke model.



The new team was involved in the design of the operational policy, undertook a number of training courses and then launched its new comprehensive EI service as the Somerset Team for Early Psychosis (STEP). A year later, another team member was appointed to each of the four 'spoke teams' (one PSI practitioner and three CPNs).

STEP

Structure

STEP was developed to complement existing mental health services and works closely with the local CAMHS team, inpatient unit, community mental health teams (CMHTs), crisis resolution and home treatment teams, and general practitioners (GPs). Psychiatric input is provided by the consultant psychiatrist and their team in each sector, as well as by a dedicated consultant adolescent psychiatrist (half a day per week). The consultant and assistant psychologists based at the hub support the spoke teams. The whole team meets twice-monthly to discuss team business and clinical issues, and for supervision and support.

The STEP approach

STEP is a specialized service for young adults (14–35 years) experiencing, or at high risk of developing, FEP. STEP embraces diagnostic uncertainty, emphasizing symptom management rather than diagnosis and provides interventions in the least stigmatizing setting. We also monitor the mental health of those who are deemed to be at high risk.

In addition to providing a clinical service, we also attempt to reduce the stigma associated with psychosis and promote the need for early assessment by providing training for professionals working in health, education and other sectors as well as the general public. We have also produced innovative education materials.⁸

Referrals

Although we welcome self-referrals and referrals from other agencies, most referrals are made through the local CMHT/assessment team. STEP then contributes to the assessment process and in cases of FEP, will take the lead in the delivery of the treatment package.

Assessment

We respond to referrals as soon as possible (1–2 days) and conduct an initial assessment within five

working days. The assessment process normally requires a number of meetings but is usually concluded within 4 weeks. Two clinicians will conduct a standardized interview using either the Comprehensive Assessment of At Risk Mental States (CAARMS)⁹ or Positive and Negative Syndrome Scale (PANSS).¹⁰ Both measures are used in a naturalistic way to assess recent symptoms. The CAARMS is used in cases of suspected psychosis to identify those at high risk, and the PANSS is utilized to assess the severity of psychotic symptoms. General Assessment of Functioning¹¹ and the Health of the Nation Outcome Scale¹² are also completed to assess the clients' levels of functioning. Non-clinical information including the pathway into care, family involvement and education/occupation is also recorded during assessment.

Interventions

STEP workers meet with clients (and families) on a regular basis determined by individual need. We also provide social, psychoeducational and support groups exclusively for STEP clients. We place an emphasis on normal social roles and service users' developmental needs (particularly education and employment). STEP aims to reduce DUP, risk of suicide and relapse, and improve prospects for recovery. Stress management, medication concordance and a reduction in substance abuse are focused on within a stress–vulnerability framework. Clients will usually remain with the service for 3 years.

RESULTS

During the initial 24 months of operation (September 2006–September 2008), STEP received 259 referrals, wherein 183 clients were accepted into the service (71%) and 76 (29%) were deemed inappropriate for the service. At the end of this period, the caseload stood at 153 cases, with 30 discharges during the same period (12% of total referrals). Please refer to Figure 2 for an overview of how the active and monitoring caseloads have built up in the past 24 months. We have two monitoring categories: 'Watching Brief' (8% of clients) covers those who are at risk of psychosis, and 'Standby' (18%) encompasses those who have received active input and are being monitored for the remainder of their 3 years with STEP. As active caseloads are not meant to exceed 15, we envisage moving more clients onto 'Standby' and also hope to further expand the team in order to respond to referrals in year 3.

The Somerset team for early psychosis

FIGURE 2. How the Somerset Team for Early Psychosis caseload has built up in the first 24 months.

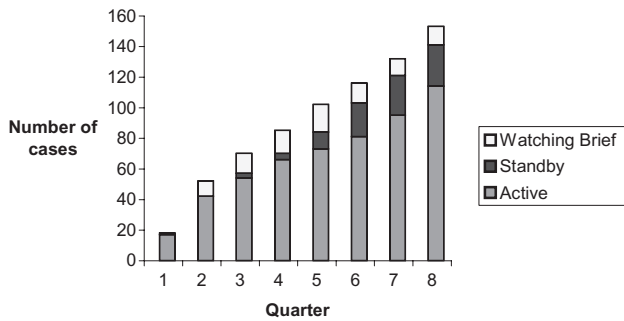


TABLE 1. STEP client demographics

	Male	Female	Total caseload
Number of cases	124	59	183
Age (mean)	20.0	20.8	20.9
Age (median)	20.0	18.2	19.8
Age range (minimum)	14.3	13.7	13.7
Age range (maximum)	30.9	35.3	35.3
PANSS P-total (mean)†	18.4	18.2	18.3
GAF‡ scores (mean)			
Symptoms	50.6	51.0	50.8
Disability	51.8	53.0	52.4
HoNOS§ scores (mean)	12.0	13.2	12.6

†Score range of 7–49, high score indicating higher incidence of positive psychotic symptoms.

‡Score range of 0–100, high score indicating low levels of symptoms and low levels of disability.

§Score range of 0–36, high score indicating a greater range of difficulties. STEP, Somerset Team for Early Psychosis; GAF, Global Assessment of Functioning; HoNOS, Health of the Nation Outcome Scale; PANSS P-total, positive and negative symptoms scale, positive symptoms sub-scale.

Up until September 2008, 18 clients were, at some point, being monitored using the 'Watching Brief' status. Eleven have been discharged and four continue to be monitored. Transition rates appear very low, with one client (5.5%) subsequently experiencing FEP. During the first 2 years, another client was re-referred and was subsequently accepted into STEP.

Two-thirds of our clients are male (see Table 1), with the vast majority of referrals (79%) made by GPs via the adult and CAMHS teams; these are the agreed common points of entry into our mental health services. Other referrals were made by agencies external to the Trust (19%), and we had some self-referrals (2%).

On initial assessment, our clients had significant levels of symptomatology and functional impairment (see Table 1). In addition, 44% reported

TABLE 2. Different types of family work offered by STEP and percentage of clients and their families that receive the service

Type of family work	Percentage of families
Assessment meeting with at least one family member present	60
Family has ongoing involvement in sessions	63
Family receives separate support from STEP	63
Family was offered FI service	65
Family receiving input from FI service	36

STEP, Somerset Team for Early Psychosis; FI, family interventions.

harmful substance use (mostly alcohol and cannabis) and 12% reported substance dependency.

Of those who had received STEP input of 1 year or more, 62.5% were unemployed, 20.3% were employed (including part-time and voluntary) and 17.2% were students at point of assessment. After 1 year, 42.9% were unemployed, 31.7% were employed and 25.4% were students. Vocational support is provided by STEP workers who also work in collaboration with other agencies.

The mean DUP for STEP clients (when those who developed psychosis before STEP was established, i.e. before 2004, are omitted, $n = 5$) was 6.4 months (median = 3 months). When all clients were included, the average DUP stood at 9.4 months (median = 3 months).

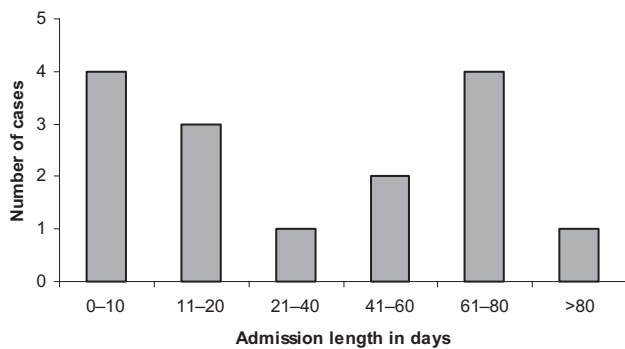
The high importance placed on working with clients and their families was reflected in our first year service evaluation. For more details on how families were involved, please refer to Table 2.

Of the 89 clients who had been receiving services from STEP for 1 year or more, there were only 15 incidents of relapse, averaging 38.4 inpatient days (median = 21 days). Relapse was defined as an increase in psychotic symptoms requiring hospital admission following remission from the FEP (see Fig. 3). This equates to a relapse rate of only 17%. This is favourable when compared with evidence that around 50% of people who are diagnosed with schizophrenia will relapse within 2 years.¹³

DISCUSSION

In common with other parts of the UK, we have demonstrated a need for EI services in Somerset, and have successfully established a specialized team. We faced the challenge of developing a service in a large rural area related to existing mental health services that are centred in towns throughout the county.

FIGURE 3. Admission lengths after relapse (in days).



Following careful consideration, we decided to develop a 'hub-and-spoke' service in order to provide the key elements of an EI service as detailed in the MHPIG.¹ This hybrid model has helped ensure fidelity as well as facilitate strong links with mental health colleagues, primary care and other local services/agencies.

It would have been difficult to have a centralized, specialized, stand-alone EI team because of both geography and a need to make use of existing mental health resources such as inpatient units.

Not having dedicated medical time within our service has made it somewhat more difficult to develop coherent medication strategies, but it has ensured that we are well integrated with the existing psychiatric and other services.

It has been valuable to have the input of a specialized adolescent consultant psychiatrist (half day per week) to help us consider psychiatric management of young people, and we would like to develop a similar position for an adult consultant psychiatrist.

Our service structure has enabled a strong focus on PSI, and countywide structures for support and supervision have helped our team retain focus and prevent burnout. Unlike generic CMHT models of EI work, our 'hub-and-spoke' structure has enabled team members to hone specialized skills and not be diverted into working with other client groups.

Although we initially envisaged that the spoke teams would be sited in non-statutory youth agencies, we had to base ourselves in offices alongside our existing mental health teams to allow effective liaison and use of Trust data systems. However, we have avoided the risk of stigmatization by working almost exclusively in community settings, such as clients' homes or local cafés.

Our structure has also enabled us to work closely with the existing four FI teams, which has enhanced

the family-inclusive approach within the EI service. This has also led to careful consideration of the interface between the services and the development of protocols for referral into the specialized FI service.¹⁴

The data appear to indicate that our service model is meeting the needs of people with FEP and their families. Although it reflects the inevitable difficulties faced by services as they are developing (e.g. initial inappropriate referrals), preliminary results indicate that DUP and relapse rates are low, and we look forward to develop from this promising start.

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VI

Service Related Issues

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4 **Setting Up a Family Interventions (FI)**
5 **Service – A UK Case Study**
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8 Frank Burbach and Roger Stanbridge
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12 *It was an invaluable service.*

13 *Without the help I don't think we'd have been in business. I don't think*
14 *we'd have been able to carry on normally.*

15
16 *They gave you hope and another view of the situation.*

17 *It is a must to have a service like this . . . there must be a support service*
18 *for families.*
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22 **1. Background**
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25 Although evidence for the efficacy of family interventions (FI) when a
26 family member experiences psychosis/schizophrenia is robust (see reviews
27 of randomised controlled trials by Bustillo *et al.*, 2001; Dixon, Adam and
28 Lucksted, 2000; Mari and Streiner, 1996; Pharoah, Mari and Streiner, 2002;
29 Pitschel-Walz *et al.*, 2001), and FI has been included in national policy
30 (e.g. National Institute for Clinical Excellence (NICE) Guidelines, 2002;
31 Department of Health (DoH), 1999), it has not led to the widespread
32 establishment of family intervention services in routine clinical settings
33 (Brooker, 2001; Dixon *et al.*, 2001; Fadden, 1998).

34 A comprehensive review of the literature by Brooker and Brabban (2004)
35 concluded that there has been a 'measured success' in implementing
36 psychosocial interventions (PSI), such as family work for people with
37

1 psychosis. This review highlighted a number of well-designed studies ‘which
2 reported similar barriers to the implementation of FI training (p. 8)’, par-
3 ticularly difficulties relating to clinicians’ inability to prioritise family work
4 due to the service environment. Specific issues included not having suffi-
5 cient time for FI, difficulties in integrating it with other responsibilities,
6 lack of support from colleagues and a lack of appropriate supervision. In
7 addition, many studies identified a difficulty in finding and engaging with
8 ‘appropriate families’, which appears to have implications for the type of
9 training provided.

10 It was against this background that, rather than consider sending staff
11 members on external FI training courses, we decided to develop FI ser-
12 vices by means of an in-house whole-team training approach (Burbach and
13 Stanbridge, 1998, 2006).

14 15 16 **2. Aims** 17

18 In this chapter, we aim to describe how we set up an FI service in the light
19 of the research into the barriers to implementation of FI training. We will
20 explore the strategies used in Somerset with a particular reference to the
21 three factors highlighted in the Brooker and Brabban (2004) review – team
22 training, supervision and organisational ownership/support. In addition,
23 we would add to this list the need to address the prevailing individually –
24 focussed service culture and the importance of developing more family
25 sensitive mainstream clinical practice.

26 We will describe how we have developed the FI services in Somerset by
27 means of accredited *in situ* whole-team training. Our 1-year training course
28 teaches a range of skills which have enabled our trainees to successfully
29 engage and work with a wide range of families. We will evaluate the service
30 development approach we have used and reflect on key issues relevant to
31 establishing FI Services.
32

33 34 35 **3. Context** 36

37 Somerset is a rural county in the South West of England with a population
38 of half a million. In the mid 1990s, as in other areas of the United Kingdom,
39 large Victorian hospitals were replaced by community care teams and locally

1 accessible units. In this context, the needs of families where a member has
2 severe mental health problems was beginning to be recognised. However,
3 mental health services retained their focus on individually based treatment.
4 Fortunately, in Somerset there were a number of family therapy clinics in
5 operation and there were people who had developed skills in working with
6 families with a wide range of mental health problems, including psychosis
7 (Brennan and Challenger, 1996; Procter, 1985, 1986; Procter and Pieczora,
8 1992; Procter and Stephens, 1984). As with other forms of psychological
9 therapy, however, the availability of these specialist services was limited and
10 dependent on the enthusiasm of particular clinicians.

11 At the same time, our mental health trust had become aware of FI in psy-
12 chosis training initiatives (Thorne; behavioural family therapy) which had
13 been developed following the randomised controlled trials which demon-
14 strated the efficiency of FI (for a summary of the evidence base at this time
15 see Mari and Streiner, 1996). A small number of staff had attended these
16 courses but this had not led to families being seen.

17 In 1994, following publication of Department of Health's Mental Illness
18 Key Area Handbook (Department of Health, 1994), our trust manage-
19 ment consulted senior family therapists including the authors regarding
20 the provision of family work for psychosis. Having recently researched
21 this area (Burbach, 1995, 1996) and having successfully implemented a
22 short (2½ day) whole-team training programme in 'behavioural princi-
23 ples' across the six rehabilitation units in Somerset (Quarry and Burbach,
24 1998), we put forward proposals to develop a new in-house FI in psychosis
25 training programme – the FI (research, skills, theory) in psychosis course
26 (FIRST).

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of Health,
1994" here.**

27 Our initial idea was to develop a local service with a multi-disciplinary
28 group of colleagues drawn from different parts of the mental health services.
29 The authors began to work together seeing families where someone was
30 experiencing psychotic symptoms but found it difficult to involve others
31 due to the constraints of their existing roles. The solution to this was to
32 propose a more formal 1-year training programme but to design this in a
33 way which would lead to the establishment of a service. The key to this was
34 the plan to begin work with local families halfway during the course.

35 We argued that this proposal made use of existing skills and that an in-
36 house whole-team training package would overcome the implementation
37 difficulties experienced subsequent to other FI training courses. Managers
38 investigated other training options and then decided to support our pro-
39 posal. The cost of putting on the course was largely absorbed within the

1 existing trust budgets – besides a small amount of start up money to facilitate
2 the development of course materials. We have not received any additional
3 funding to cover staff time (tutors and trainees) to establish the service. In
4 further meetings with trust management we developed these local proposals
5 into a trustwide 5-year development strategy and went on to gain accredi-
6 tation with our local university (60 credits at degree or diploma level) and
7 the Association of Family Therapy.

8 Over a period of 5 years we consecutively took the course to the four
9 service areas in Somerset. Teaching sessions were delivered by two tutors
10 drawn from successive course teams, each consisting of the authors and two
11 others. In order to maintain the service we have provided a series of ‘top-up’
12 courses in subsequent years. Our most recent courses have included staff
13 from the child and adolescent mental health services which has enabled
14 teams to intervene early with a younger age group (i.e. age 14 and over).

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22 **4. Key Features of the *In Situ* Whole-Team Training** 23 **Approach and Family Interventions Service**

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22 We invite applications from interested members of staff in the relevant local-
23 ity and then consider the applications in conjunction with the appropriate
24 line manager. We select staff only with the clear agreement of their line
25 manager that they will be able to devote a minimum of half a day per week
26 to providing the service when the course finishes. In essence this is a process
27 of selecting a team and we therefore carefully consider team composition.
28 We seek to have a range of professions (which have included art therapists,
29 family therapists, nurses, occupational therapists, psychiatrists, psycholo-
30 gists, social workers and support workers) and also seek to recruit staff from
31 each part of the local mental health service (e.g. inpatient unit; Community
32 Mental Health Teams; assertive outreach team).

33 The 1-year course comprises three modules, and approximates to a half
34 day per week. This establishes a level of commitment which is required
35 to provide the service subsequent to the course. Having this structure is
36 particularly important for staff who work according to staff rotas (e.g.
37 inpatient units) but this level of clarity also assists community staff who are
38 able to adjust their workload in order to participate in the FI service. The
39 *in situ* whole-team training approach allows us to accept referrals from the

1 local services and trainees begin to see families half way through the course
2 (using live supervision from course tutors). In addition, the local 'Family
3 Support Service' (this is the name we have adopted for our FI service)
4 becomes established part way through the course.

5 The three modules focus on systemic practice, FI and cognitive ap-
6 proaches with psychosis. The first module covers systemic theory, research
7 and basic practice skills. Systems thinking, the importance of context,
8 and the way in which problems arise/are maintained and are introduced
9 from a 'cognitive-interactional' perspective. The family lifecycle, family be-
10 liefs/narratives, the individual's/caregivers' experience of psychosis and the
11 stress-vulnerability model are introduced. Clinical skills relevant to the
12 various stages of therapy are developed by means of role-play. The second
13 module critically examines the systemic family therapy and psychoeduca-
14 tional FI approaches to psychosis and further develops their integration.
15 Theory and research about early intervention, ethical issues and risk are
16 also examined. Behavioural family therapy skills and systemic interviewing
17 skills are developed in role-play and in supervised work with families. The
18 third module further develops clinical skills through direct supervision and
19 considers their application in the service context. The focus is on cognitive
20 behaviour therapy techniques for psychosis and relapse prevention strate-
21 gies. In addition, solution focused/narrative approaches to working with
22 families are further developed.

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25 *4.1 Evaluation of the training approach*

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28 Although the most important measure of the efficacy of our training ap-
29 proach is the fact that we have successfully established four FI teams, we have
30 also conducted a study into the ability of FIRST trained staff to implement
31 the approach. This is significant in the light of previous studies (Brennan
32 and Gamble, 1997; Fadden, 1997; Kavanagh *et al.*, 1993) which found that
33 staff trained in FI had great difficulties in implementing the approach in
34 routine clinical practice and saw few families post-training (e.g. 1.7 families
35 (9–42 months post-training) and 1.4 (6–26 months) seen in the Fadden and
36 Kavanagh studies, respectively). Fifteen therapists who had completed the
37 FIRST course participated in the study which involved questionnaires used
38 in previous studies and focus groups (Bailey, Burbach and Lea, 2003). All
39 reported working with families using the Family Support Service approach
since completing the FIRST course. The average number of families seen

1 since completion of training (an average of 26 months, range 3–35 months)
2 was 3.5. Eighty per cent of the graduates reported ‘little or no difficulties’
3 in implementing the approach, and no one found they were unable to offer
4 the intervention following training. These findings compare very favourably
5 with the findings of other reported studies of post-training implementation
6 (Fadden, 1997; Kavanagh *et al.*, 1993).

7 In common with previous studies the two main areas of difficulty reported
8 were having sufficient time to do the work and its integration with caseload
9 and other responsibilities at work. However, in contrast with the previous
10 studies the Somerset staff did not experience any difficulty in tailoring their
11 approach to the needs of individual clients and families, nor in accessing
12 consultation and supervision.

13 In the focus groups, staff identified a number of specific aspects of the
14 service which enabled successful work with families. In particular, they
15 highlighted the flexible nature of the service, the multi-disciplinary nature of
16 the teams, the use of co-working and regular supervision as being beneficial.

17 18 19 4.2 *The Somerset family interventions service*

20
21 The Family Support Service uses a competency-based approach which inte-
22 grates psychoeducational/cognitive behavioural and systemic approaches.
23 The service is available to people who are in regular contact/living with their
24 family members or significant others (e.g. carers) who are experiencing psy-
25 chotic symptoms (including prodromal symptoms). We aim to intervene as
26 early as possible and encourage early referral which may be during the acute
27 phase and before a diagnosis has been made. Although the evidence base for
28 FI was originally developed with people with enduring symptoms who were
29 vulnerable to relapse, our service works with a wider spectrum of people with
30 psychosis. This is in line with national initiatives to develop early interven-
31 tion in psychosis services (DoH, 1999; IRIS, 2001) and our FI service works
32 closely with the recently established early interventions in psychosis service,
33 prioritising those with first and second episode psychosis (Burbach, Fadden
34 and Smith, 2008). The procedure is for two therapists to meet with individ-
35 ual families in the location most conducive to engagement. The aim is to col-
36 laboratively negotiate with each family a therapeutic contract which reflects
37 their particular needs and to continue supporting them as long as required.

38 Whilst the main focus of the work is often described as seeking to improve
39 outcome and quality of life for the person experiencing psychotic symptoms,

1 our systemic thinking leads us to place emphasis on relationships and there-
2 fore the needs of all family members (Pearson, Burbach and Stanbridge,
3 2007). Our aim is to improve quality of life and well-being for the whole
4 family. A range of interventions may be used such as those aiming to increase
5 competency in problem solving and communication within the family, and
6 developing more realistic expectations of the person's functioning. Whereas
7 information sharing may be helpful in this, in itself it has not been shown
8 to be sufficient to significantly effect clinical outcome (Lam, 1991; NICE,
9 2003). In most cases, an exploration of feelings (e.g. guilt, loss) and inter-
10 actional patterns and beliefs which maintain problems is required in order
11 to effect change in attitudes and behaviour. For further details regarding
12 the Family Support Service, see Burbach and Stanbridge (1998, 2006).

4.3 *Evaluation of the service*

13
14
15
16
17 Whereas the efficacy of FI is now evident, relatively few services have been
18 established in routine clinical settings and evaluation of the approach is
19 particularly difficult in such circumstances. Nonetheless in Somerset we
20 have evaluated the Family Support Service in a number of ways in order to
21 improve the service we offer.

22 We routinely collect data on all cases, which enable us to monitor our
23 service and provide feedback and thereby influence the wider mental health
24 system. This includes the following: referral rates, demographics of fami-
25 lies referred, information about diagnosis and onset/episode of psychosis,
26 attendance figures, dropout rates, details of which family members attend
27 sessions, feedback from families and caseloads of therapists. We have also
28 conducted an in-depth study of families' satisfaction with the first Family
29 Support Service to be established (Stanbridge *et al.*, 2003). Fifteen of the
30 first 22 referrals to the service agreed to take part in semi-structured in-
31 terviews regarding family satisfaction, clinical outcome and the therapeutic
32 alliance. All family members expressed satisfaction with the service overall,
33 10 families rated themselves as 'very satisfied' and 3 families as 'partially sat-
34 isfied'. The other two families were unable to evaluate the service as they felt
35 they had been referred 'too late' (i.e. on their son's discharge from hospital
36 when their situation had already improved) but reported that they would
37 have welcomed the service if it had been offered earlier. These high levels of
38 satisfaction are the more reassuring given that 73% of the sample reported
39 feeling apprehension prior to being seen in the Family Support Service.

1 This study highlighted some of the ingredients which may be associ-
2 ated with successful outcome. Satisfaction was related to families' needs
3 being met (e.g. coping with symptoms, problem solving, improved com-
4 munication in the family, better liaison with the services), family members
5 developing new perspectives, as well as feeling listened to in the context of an
6 empathic, non-judgemental therapeutic relationship. A number of factors
7 specifically emphasised in the Somerset Family Support Service appeared to
8 contribute to the establishment of a positive therapeutic relationship and be
9 particularly valued by families, namely mutually agreed therapeutic aims,
10 regular evaluation of the usefulness of sessions and the opportunity for open
11 discussion. These factors reflect the service's broad, flexible therapeutic ap-
12 proach which enables clinicians to offer a range of interventions suited to
13 different families' specific needs. These findings are perhaps best summed
14 up by one family members' response to the question regarding their overall
15 satisfaction with the service:

16
17 Surprised and satisfied. The most important thing was that they listened and
18 responded to the family's needs, not followed their own agenda, and that
19 happened.
20

21 22 **5. The Importance of Supervision** 23

24
25 Supervision is crucial in the maintenance of the service and also in ensuring
26 its quality. Besides Somerset-wide 'study days' and local team supervision
27 sessions, each pair of therapists also reflect on their clinical work before,
28 during and after each family session. Whilst one of the functions of this
29 range of approaches to clinical supervision is to ensure safe and ethical
30 practice, the prime function is to facilitate reflective practice (Schön, 1983)
31 and thereby enhance the effectiveness of therapy. We have found that the
32 range of supervision processes is important to support staff carrying out
33 this at times complex and demanding work.
34

35 36 *5.1 Trustwide study days* 37

38 Our quarterly study days bring together all members of our trustwide
39 service. These days have a number of functions including continuing

1 professional development, clinical governance and service development/
2 maintenance. The study days include case presentations and a consultation
3 slot for difficult clinical situations.

4 The format of the days varies, covering a range of topics and speakers, but
5 they all focus on service improvement and clinical reflection. For example,
6 a mother spoke to the group about her son's emerging psychosis and the
7 family's experience of services. In addition to increasing our understanding
8 of such traumatic experiences, a number of difficulties were highlighted
9 which resulted in further discussion. Initially, care was provided by the
10 mental health services in another part of Somerset to which her son had
11 only recently moved. The family struggled to transfer his care to a team
12 in the area where the family lived. As a result they experienced difficulty
13 in accessing appropriate information and support. The Family Support
14 Service clinicians were concerned to hear about these difficulties and, in
15 addition to doing what they could to ensure that the family received a better
16 service, highlighted issues with colleagues and managers and emphasised
17 the importance of early referral to the FI service.

18

19

20

5.2 *Team supervision meetings*

21

22 The monthly team peer supervision meetings contain an organisational
23 element (e.g. referral/allocation process) but reflecting on cases/clinical
24 issues is the main focus. In particular, clinicians are expected to report back
25 on the assessment phase and to refine a case formulation in consultation
26 with the group (e.g. see Table 1). Another key function of these group
27 supervision meetings is to help the therapists to generate new ideas.

28 Complex situations are often usefully discussed on a case-by-case basis
29 in the supervision group. For example, deciding whom to involve in family
30 sessions if a young person's parents have separated acrimoniously. In some
31 cases it is helpful to meet with different combinations of family members
32 (e.g. client and mother; client and father), whereas in others it may be
33 more appropriate to bring together all of the family members. Supervision
34 meetings can help the therapists to explore the implications of intervening
35 in the family structure and to develop appropriate therapeutic strategies.

36 Although some issues regarding the therapeutic process/therapeutic al-
37 liance can be addressed within family sessions by the co-therapists, other
38 more complex/personal issues for the therapist are best explored within
39 post-session discussions or team supervision meetings. For example, a

1 **Table 1** Example of Case Formulation
2

3 A 34-year-old man with bipolar disorder was referred to the Family Support
4 Service at the point at which he was being discharged from an inpatient unit to live
5 with his parents. The following formulation was agreed with him and his family:
6

7 James' present episode of illness and hospitalisation has interrupted his
8 sense of direction and achievements in life and he now find himself
9 temporarily living with his parents and having lost his job and girlfriend.
10 This has left James feeling demoralised, frustrated and angry. James is a
11 sensitive, articulate, energetic person with a lot to offer, who is vulnerable to
12 believing that he cannot meet societal and family expectations. It is good
13 that James is part of such a close supportive family who are able to talk
14 about issues and support him during this transition period. This situation
15 puts understandable strain on all family members but it is positive that all
16 are aware of unhelpful patterns and want to change them.
17

18
19
20 recently qualified female therapist who had grown up in a farming fam-
21 ily with rigid gender-based roles did not realise that she was taking sides
22 with a mother in the family sessions. She struggled to understand the posi-
23 tions of the young man with psychosis and his father, found it difficult to
24 develop a systemic formulation, and did not realise that the male members
25 of the family were beginning to disengage from therapy. Reflecting on this
26 in supervision enabled her to subsequently explore, in a non-judgemental
27 way, how the various roles (especially the husband's socially defined role)
28 had developed in this family, enabling them to make some adjustments.
29 This also allowed further helpful conversations about the son's future role
30 within the family business.
31

32
33
34 *5.3 Pre-session discussion*
35

36 Our practice is for the two therapists to meet before and after their session
37 with a family. The pre-session meeting (± 15 minutes) enables the therapists
38 to orient themselves – they review the previous session, assimilate any new
39 information entered in the clinical notes, and plan for the session. This
plan would involve the identification of potential themes and hypotheses

1 to explore, as well as following up agreed goals and tasks. In addition, the
2 therapist would consider process issues, both in terms of how the family
3 operates and respective therapist roles (e.g. who will take the lead or explore
4 particular topics). This is an opportunity to consider family dynamics and
5 the nature of the therapeutic alliance between the therapists and the family
6 members. This would of course be elaborated in other supervisory contexts,
7 where issues such as the therapist's use of personal experience as well as wider
8 contexts such as gender, race and culture are considered in greater depth.

9
10
11 *5.4 Post-session discussion*

12
13 Post-session there are a number of practical tasks to complete (e.g. writing
14 up notes, communicating with colleagues) as well as spending some time
15 reflecting on how the session has gone and noting issues to pick up on at
16 the next family meeting.

17 We often find that it is difficult for busy clinicians to safeguard the time
18 for pre- and post-session discussions; however, this is an essential part of
19 effective family work. It enables therapists to compare views on signifi-
20 cant moments in therapy and the effectiveness of particular therapeutic
21 interventions, and to remain focused on the goals of therapy. It also allows
22 therapists to debrief after sessions and to deal with any difficult feelings
23 which the session may have evoked in them. Of course many therapists are
24 also parents and therefore particularly affected by, for example traumatic
25 accounts of the effects of psychosis in young people.

26
27
28 *5.5 Reflection between therapists during sessions*

29
30 Besides reflecting on therapy sessions in supervision groups as well as be-
31 fore and after each session, reflection between the therapists during family
32 meetings is an important part of our way of working. An advantage of the
33 co-therapy model is that in part it is like having a supervisor in the room.
34 Whilst one therapist is engaged in talking with the family the other ther-
35 apist is able to observe the process and intervene where appropriate. The
36 co-therapist can help to keep the therapy on track, introduce new ideas and
37 help their colleague should they feel 'stuck'.

38 At times during the meeting it may be helpful for the therapists to have
39 a brief reflective conversation with each other in which they may comment
on the way in which the meeting has progressed and options for the rest of

1 the session, share observations and tentatively offer alternative perspectives.
2 For example, in a session with a young man (James¹) experiencing psychosis
3 and his parents, the therapists had the following conversation after concerns
4 were raised about possible relapse and evidence that James was exhibiting
5 pressure of speech and tending to dominate the session:

6 CO-THERAPIST: Hearing James talk when he feels passionate about something
7 makes me wonder how Anne and Charles respond when
8 James talks late into the night.

9 THERAPIST: Yes, it must be difficult for Anne and Charles to know how
10 best to respond. On the one hand they are interested in
11 James' views but on the other they may be concerned that if
12 he doesn't get enough sleep he may become unwell again.

13 CO-THERAPIST: Perhaps we could ask James how he would like his parents
14 to respond when he is in full flow late at night.

15 Whilst this is in keeping with our aim of wishing to work in a manner
16 which is as transparent as possible, it is also an effective way of influencing the
17 process of sessions. It is an unusual experience for families to hear themselves
18 being talked about and this can effectively interrupt unhelpful interactions
19 as they stop to listen. In addition, families value these opportunities to
20 reflect upon themselves and consider new perspectives. These reflective
21 conversations are not instructive or directive in nature but are conducted
22 in a tentative manner, where a range of ideas is offered for the family to
23 consider, comment on and incorporate where they seem appropriate. These
24 conversations need to be brief, genuine and positive in nature, use language
25 which is easily understood by the family, emphasise solutions rather than
26 problems, and be respectful and valuing of the family. These conversations
27 can be highly effective if conducted sensitively (Andersen, 1995; Lax, 1995)
28 but this approach does not suit all families (Jenkins, 1996) and it is important
29 to seek the family's feedback as to its value.
30

31 32 33 **6. Reflections on Establishing a Service**

34
35 This chapter has outlined the way in which we have equipped staff with a
36 range of knowledge and skills to successfully engage and work with fami-
37

38
39 ¹All names have been changed to ensure anonymity.

1 lies. We have done this by developing a new training paradigm (Burbach,
2 Donnelly and Stanbridge, 2002) in which an *in situ* whole-team training
3 approach is used to establish trustwide services consisting of local teams.

4 As with any model, there are benefits and drawbacks. In this section, we
5 will consider these as well as wider organisational issues which are essential
6 in the establishment of FI services. In addition, we will consider the impor-
7 tance of developing more family sensitive mainstream clinical practice.

8
9
10 *6.1 Benefits and drawbacks of our service development approach*

11
12 Trainees find it far less stressful to attend a local course with their colleagues,
13 with no additional time lost due to travel. This leads to high levels of
14 attendance and a low course dropout rate. Working together throughout
15 the year also helps to develop a strong team spirit which continues as the
16 course becomes the service.

17 Unlike other trainees who have to return to their workplace and set up
18 a service, our trainees establish the service during the course. They are
19 able to use their local knowledge to develop referral pathways, educate
20 other colleagues and problem-solve any operational difficulties. In addi-
21 tion, the fact that there is ongoing clinical work with families at the point
22 at which the course ends means that the newly trained team is already
23 operational.

24 The team training approach conveys additional benefits for the ongoing
25 service. Having a group of eight trained staff in each locality provides the
26 necessary critical mass to influence the local culture. We would agree with
27 Fadden (1997) on the importance of achieving a critical mass of trained
28 staff in order to enable the implementation of FI. In our services the team
29 of like-minded colleagues is able to provide the necessary initial support
30 and encouragement to sustain this demanding work. The establishment of a
31 team also enables the maintenance of service quality through the establish-
32 ment of clinical supervision, audit procedures and continuing professional
33 development.

34 Focusing training on service development conveys a number of advan-
35 tages in that the knowledge and skills taught are clinically relevant. Providing
36 this training in-house to whole teams is clearly a robust way of ensuring the
37 transference of these skills into an effective service. That this was achieved in
38 Somerset without significant additional funding may be seen as an advan-
39 tage, however, in an ideal world this would have been a funded plan rather

1 than a 'reconfiguration' dependent on goodwill. A related drawback is that
2 our staff will have a limited time devoted to FI as opposed to having people
3 employed specifically to provide FI. Although we would strongly argue the
4 benefits of having FI team members integrated into other teams/services we
5 would advocate that some dedicated FI time should be funded (e.g. trainers
6 and coordinators of the FI teams). This has been the approach adopted in
7 another Trust in our region where they have also established area-based
8 teams using our training course and model. Here, they have established
9 half-time FI team coordinator posts and a research assistant post, and have
10 funded some of the trainer/trainee backfill costs. Whereas we have found
11 that our training approach and flexible collaborative family-needs led model
12 has resulted in good engagement rates and high levels of satisfaction with
13 the service, we are aware that some managers in other areas may balk at
14 the extensive 1-year training course. Another potential disadvantage of the
15 more extensive range of approaches/skills taught on our course is that it is
16 more difficult to measure fidelity subsequent to training.

17 18 19 6.2 *Wider organisational issues*

20
21 The establishment of FI services has required both the championing of FI as
22 well as achieving support and ownership throughout the organisation. We
23 approached this by establishing partnerships across the organisation. It was
24 essential to have the formal endorsement of the trust board and to have the
25 establishment of the service included in the Trust's business plan. However,
26 it was also vital to collaborate with local team and service managers as their
27 support enabled the reconfiguration of services to allow staff to devote a
28 portion of their working week to the training and subsequent service. We
29 promoted the project through a range of presentations in order to raise
30 awareness at a senior management level as well as to motivate staff to
31 consider embarking on the training. Achieving accreditation for the course
32 with Plymouth University and the Association for Family Therapy provided
33 additional incentives for staff to undertake the training.

34 It has also been essential to consider the maintenance of the service from
35 the start of the project. Besides maintaining organisational support (e.g. via
36 annual reports, audits, presentations) we have been aware of the need to
37 maintain staff motivation and to ensure the quality of the service. The whole-
38 team training naturally facilitates mutual support, which is formalised in
39 team clinical supervision on a monthly basis. The co-therapy model also

1 enables supervision and support in the clinical situation. We have also found
2 that quarterly trustwide study days have enabled mutual support and the
3 updating of knowledge and skills.

6.3 *Influencing mainstream clinical practice*

4
5
6
7
8 When setting up a specialist FI service it is important to take into account
9 the baseline level of experience of staff in working with families. We have
10 found that the majority of staff have low levels of experience and confi-
11 dence in working with families as this did not form part of their initial
12 professional training. Working with the workforce as a whole to increase
13 their levels of knowledge and skills in engaging and working with fami-
14 lies as part of their routine clinical practice can provide a helpful platform
15 for developing specialist family services. A family sensitive workforce is
16 likely to be more supportive of specialist FI and to make more appropriate
17 referrals.

18 In Somerset we have developed a strategy to enhance working partner-
19 ships with families and carers in order to raise the general awareness of
20 family sensitive practice (Stanbridge and Burbach, 2004). This has involved
21 the development of a multi-professional, multi-agency steering group which
22 includes service user and carer representatives in order to guide the imple-
23 mentation of the strategy. This group has developed best practice guidelines
24 regarding confidentiality and information sharing, reviewed trust policies
25 and facilitated the provision of information and support for carers. In addi-
26 tion, we have provided a trustwide staff training programme for inpatient
27 and community staff which explores how clinical services might develop
28 working partnerships with families and enhances skills to enable the rou-
29 tine inclusion of families/carers in the assessment and treatment processes
30 as part of the care programme approach (Stanbridge and Burbach, 2007a;
31 Stanbridge, Burbach and Leftwich, 2008).

32 Whereas clinical practice in mental health services still predominantly
33 focuses on the individual, recent national policy guidance (Department of
34 Health, 2002; NICE Guidelines for schizophrenia, 2002b; NSF, 1999) has
35 signalled a shift towards increased partnership working with family and
36 carers (Simpson and Benn, 2007). We have found that the combination
37 of both the specialist FI and the general working with families training
38 programme has helped to begin to shift the organisational culture to a
39 more family inclusive way of working (Burbach and Stanbridge, 2008). An

Au: Please can you verify the reference “NICE Guidelines for Schizophrenia, 2000 (as per your response to our previous query)”. There is no such reference, instead do you mean “National Institute of Clinical Excellence, 2002” which is there in the reference list to be inserted here in place of “NICE Guidelines for schizophrenia, 2002b”.

1 important element of this has been the involvement of carers in delivering
2 the training (Stanbridge and Burbach, 2007b).

7. Conclusions

3
4
5
6
7
8 This chapter has described our experience of setting up an FI service. Our
9 service was developed in a particular context – a small specialist Health
10 and Social Care Mental Health Trust serving a population of 500 000 in
11 a rural setting. There are some advantages to working in an organisation
12 of this scale. Senior clinicians are perhaps able to have a greater influence
13 throughout the organisation through closer links with trust management.
14 The disadvantages have largely concerned the lack of availability of funding.
15 The rural nature of the area has necessitated the development of four smaller
16 FI teams, rather than a larger, central team. This could have the potential
17 vulnerability to fragmentation, gradual loss of staff and deterioration in
18 quality. We have, however, taken these issues into account and developed
19 a network of services by means of our training approach and subsequent
20 focus on service maintenance.

21 Although we developed our approach in Somerset, we have found that it
22 is also possible to implement this whole-team training approach to service
23 development in other trusts. Another rural trust in the South West of
24 England has used our package to develop a trustwide FI service consisting
25 of three area teams, suggesting that the approach is transferable and may
26 have wider applicability.

27 Other FI services in the United Kingdom have been developed using
28 somewhat different models. At a recent conference (NIMHE Imple-
29 mentation of PSI Conference, 2004) four FI services were described –
30 West Midlands, Avon and Wiltshire, Dorset and Somerset. The Meriden
31 programme in the West Midlands (Fadden, 2000) employed a strategic
32 approach with trusts in the region to deliver training and develop sup-
33 portive supervision structures post-training. This project provides a short
34 (5 day) training for a large number of mental health professionals, lead-
35 ing to widespread raising of skills and awareness regarding the needs of
36 families with psychosis, although the number of families seen per thera-
37 pist post-training is proportionally lower than in our service. In Avon and
38 Wiltshire (Smith and Velleman, 2002) the employment of local ‘champions’
39

1 has enabled co-working, supervision and the coordination of staff trained
2 in FI. In Dorset (Kelly and Newstead, 2004) strong links have been cre-
3 ated between the local University Thorn programme and the mental health
4 services, involving regular meetings between course graduates, their line
5 managers and the trainers. Whilst there are other FI services in the United
6 Kingdom, these examples reflect the range of solutions which have been
7 employed.

8 Anyone who wished to set up an FI service would have a range of examples
9 to draw on, but the key to success will be to identify an approach which
10 is appropriate to the local service setting and which emphasises the link
11 between training and service provision. Once established, the service will
12 have to focus on maintenance and ensuring that it remains well embedded
13 in the management and clinical structures.

14 We would hope that an enthusiastic clinician reading this chapter would
15 not be daunted by the scale of the task. Our experience is that develop-
16 ing partnerships between clinicians, managers and families can create a
17 momentum towards the development of FI services. Anyone wishing to
18 develop FI services today would benefit from the presence of supportive
19 national policy and increasingly well-developed carer/family organisations.
20 Listening to the experiences of families struggling with the influence of
21 psychosis it is clear that appropriate help for families should be routinely
22 available. The quotes at the beginning of this chapter demonstrate that fam-
23 ilies who have experienced FI are particularly compelling advocates for these
24 services.

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Establishing family inclusive acute inpatient mental health services: a staff training programme in Somerset

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In spite of policies advocating the involvement of families in the care of mental health service users in the UK there are few examples of training initiatives to bring this about. This article describes the delivery of a whole-team training initiative to promote family inclusive working in all acute inpatient units in Somerset. The three-day staff-training programme is described and training outcomes are reported. Staff reported a significant increase in confidence in their skills for working with families, and a pre- and post-training case note audit showed an increased consideration of the needs of families. This was accompanied by a modest increase in the average number of family meetings. Obstacles to family inclusive ways of working on inpatient units are described, and strategies to overcome these are discussed.

Introduction

The need to reshape and modernize acute inpatient mental health units has been the focus of national policy in the United Kingdom for a number of years, and progress is currently under review by the Healthcare Commission (2008). Working in partnership with families and carers has been a recurring theme within this process. This new emphasis was set on a firm foundation in Standard Six of the National Service Framework (NSF) (DoH, 1999) which outlined for the first time rights to their own annual assessment and written care-plan for carers who provide 'regular and substantial care'. This was supported by guidance on developing services for carers and families (DoH, 2002a). The Mental Health Policy Implementation Guide for Adult Acute Units (DoH, 2004a) and the Mental Health Implementation

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Guide: National Minimum Standards for General Adult Services in Psychiatric Intensive Care Units (PICUs) and Low Secure Environments (DoH, 2002b) further elaborated the need to work in partnership with families and carers and to involve carers in staff training. From another perspective, the Social Exclusion Task Force in their strategy document *Think Family: Improving the Life Chances of Families at Risk* (Cabinet Office, 2008) advocate a family focus to assessments in adult mental health services. However, the training implications to enable this cultural shift in service direction have not been addressed, and the difficulties associated with providing substantial training for acute inpatient staff have been well documented (Clarke, 2004).

Needs of families and carers

UK national policy has been developed in the context of families and carers consistently reporting that they have felt excluded by services from their relatives' care. Carers' initiatives (eg. IRIS, 2001; NIMHE/West Midland 'Carers in Partnership', 2003) and research studies (e.g. Shepherd *et al.*, 1994; Leavey *et al.*, 1997, Pinfold *et al.*, 2004) have recommended ways in which mental health services can more effectively meet the needs of informal carers and families. What they would like from services includes: to be listened to, emotional support, and to be involved in planning their relative's care. In addition, they require information about diagnosis, treatment, services and whom to contact in an emergency. They also request advice on ways to respond to their relative and wish to develop additional coping skills.

Part of this context is also our increasing knowledge of the stress involved (the term 'burden' is used in the literature) for carers in looking after someone with mental health problems. We know that carers are much more likely to experience mental and physical health problems themselves than the average population (Singleton *et al.*, 2002), and that caring has a pervasive effect both in terms of subjective stress and objectively in terms of its impact on work, leisure, health and finances. See Simpson and Benn (2007) for a summary regarding the impact of caring.

Current position

In spite of this strong national policy direction informed by the needs of families and carers, it would seem that for many carers and families

working in partnership remains an aspiration rather than a reality. In reviewing Standard Six in *The NSF– Five Years On* (DoH, 2004b), Louis Appleby reported that ‘we have too little to report on improving the support provided to carers’ (p. 74). Further reports have also identified the need for more progress in this area (Clarke, 2004; Sainsbury Centre for Mental Health, 2006; CSIP, 2007).

It is against this background that, in 2002, the Somerset Partnership NHS Foundation Trust, which provides mental health and social care in the rural county of Somerset (pop. 520,000), developed a strategy to enhance working partnerships with carers and families (Stanbridge and Burbach, 2004). This paper outlines a staff training programme delivered by the authors as part of the implementation of this strategy.

Why is there a need for a staff training programme?

The need for training is twofold. First, we inherit a mental health service that has traditionally tended to be individually focused, seeing pathology lying within the individual. This way of formulating problems has led to assessment and treatment processes that target the individual and often see the family/social network of the client as adjunctive. Whereas there have been some recent moves towards seeing the person in the context of their family and social network, embracing a bio-psycho-social model, this has not always extended to staff developing skills in engaging with families as part of their routine clinical practice.

Second, most mental health professionals still complete their pre-registration training without specific skills training in working with families (Stacey and Rayner, 2008). This leaves staff ill equipped and lacking in confidence to engage with families on the routine basis envisaged by national policy. If the partnership working defined in national policy and the raising of staff skills and capabilities in this area is to be achieved, then, in addition to providing resources to support carers, this will require a comprehensive staff training programme (Burbach and Stanbridge, 2008). For a review of this area see Simpson and Benn (2007).

Examples of inpatient staff training in working with families

An extensive literature search reveals only three examples of training programmes directed specifically towards developing family inclusive

ways of working among acute inpatient staff. It is important here to distinguish these initiatives from training programmes that are designed to set up 'specialist' family services, such as family interventions for psychosis. These training courses tend to train small numbers of staff, to a specialist level, for specific client groups, rather than training all staff in the basic skills for family inclusive ways of working in routine practice.

An extensive regional training programme promoting family inclusive working has been implemented by The Bouverie Centre, La Trobe University in the state of Victoria, Australia. This has included a number of projects promoting 'family-sensitive practice' (O'Hanlon, 2004) based on an earlier training programme delivered collaboratively by family caregivers and professionals (Farhall *et al.*, 1998). The largest and most rigorously evaluated was called the Get Together E.a.S.T. initiative. This project involved forty-four training programmes and included 880 staff from adult, older adult and child and adolescent services across Victoria. In the adult stream 410 staff attended, including forty-six (11.2 per cent) acute inpatient staff. The evaluation of the training demonstrated significant impacts, including improvement in the attitudes of staff towards families and a large number of projects being developed that improved access, information and/or support to family members and other carers (Farhall, 2000). However, they reported that major challenges remained in translating the increased awareness of family members' needs to changes in core clinical practice and service-wide policy and procedures.

Also in Australia, the Sunderland Adult Mental Health Services in Sydney have developed a family engagement and support project (Mottaghipour and Bickerton, 2005; Mottaghipour *et al.*, 2006). This project included an in-service training component of four sessions with follow-up meetings for all eighty hospital- and community-based staff. The emphasis was on encouraging engagement, assessment and general education as a minimum level of standard care. They argued that this was also a necessary prerequisite for the successful engagement of the fewer number of families who might require more specialist level interventions such as psycho-education, consultation and family therapy. They felt that the tasks of engaging, providing education and collaborating with most families fell within the scope of most staff with some additional training, and reported a doubling of clinician contact with families over a two-year period.

In Germany, Schweitzer *et al.* (2007) have developed a comprehensive eighteen-day systemic training as part of the SYMPA project

(systems therapy in acute psychiatry) which they have delivered to six ward teams from three separate hospitals. The multidisciplinary whole team training was delivered to one hundred staff, seventy of whom were nurses. The aim of the programme was 'to establish systemic case conceptualisations and interventions as routine practice' (p. 3). Translating theory into practice was a focus of the training, which led to an increase in single patient contacts and network conversations, together with a general increase in the use of systemic techniques by staff post-training. However, they report that more training would be required for staff to feel confident enough to conduct family meetings or take a leading role in systemic case discussion.

Somerset's inpatient staff training programme

In Somerset we have taken a two-phased approach to training (Stanbridge and Burbach, 2004, 2007a). In Phase 1 we provided a number of awareness-raising sessions to teams across the Trust, including a staff survey. The results of this survey highlighted a lack of confidence and prior training of staff in working with families, together with a wish for further training. In addition, a three-day package of education, awareness and skills training was piloted with new Assertive Outreach, Home Treatment/Crisis Resolution and Eating Disorders teams.

The second phase consists of the systematic implementation of the training programme throughout the mental health service by means of a whole-team training approach, beginning with the acute inpatient units. The three-day training was provided to inpatient nursing staff in all five of the acute inpatient units in the Somerset Partnership NHS Foundation Trust. From an establishment of eighty-one trained staff, seventy-two (89 per cent) attended the training with sixty-six (82 per cent) attending days 1 and 2. Fifty-seven (70 per cent) attended day 3 and fifty-two (64 per cent) attended all three days. In order for staff to attend without closing the unit the course was run twice on each unit with half the staff attending each time. Days 1 and 2 were provided consecutively to each group with Day 3 taking place after a planned gap of a minimum of one month. Staff attending the three-day course were all trained nursing staff including the deputy and ward managers. The involvement of managers was significant, both in supporting the process and in operationalizing the action plans developed during the training. In addition, the active support of

the service manager for acute services and the Trust Director of Operations provided a positive trust-wide context for the training. In addition, a modified one-day course was provided to inpatient nursing assistants and reception staff. This was delivered on five occasions and attended by a total of fifty-four (83 per cent) staff. Medical staff and other mental health professionals have been involved in a number of initial training sessions as well as the three-day training packages. However, they were not included in the inpatient training programme which focused on the nursing teams.

Training approach

The general aims of the training are to raise awareness of the roles families/carers play and to develop staff skills and confidence to work in partnership with families (the learning outcomes are listed in Table 1).

The balance of education/theory and practice provided within our three-day courses depends upon the needs of the particular part of the service. For inpatient staff, this included increased awareness of issues facing families and carers, how to access further help and resources, and developing skills in conducting family meetings.

TABLE 1 *Learning outcomes*

Attitude and awareness

- To have an awareness of family/carer views on mental health services.
- To have an awareness of research findings on the family burden associated with caring for someone with severe mental illness.
- To have an awareness of the benefits of involving families in treatment including the theory and evidence base for family work.
- To have an awareness of thinking systemically and to be able to consider the person in the context of their relationships and social network.
- To have considered their therapeutic stance in relation to working with families.
- To have considered best practice in relation to confidentiality and information sharing.

Skills

To have practised the following skills in family interviewing:

- engaging with families
 - conducting an initial family meeting
 - balancing the needs of individual family members
 - information sharing and developing a collaborative relationship
 - genograms and additional skills
-

The three-day training package has been specifically designed to address staff attitudes. While some staff welcome the shift to more family-oriented services, it is still the case that some others view family members either as a cause of the client's difficulties or as interfering, and thus resist contact with families, while many others might not see a need to involve families in the client's care. There is thus a need to inform staff members about the benefits of involving families and carers and to explore their attitudes and beliefs. We have found that involving carers in the provision of training is an effective way of addressing the required shift in attitudes (Stanbridge and Burbach, 2007b). Each training course starts with a presentation by a carer. This takes the form of the family member (or sometimes this is two parents) telling their story. We encourage people to talk about both good and bad experiences of services but specifically ask them to comment on the following areas:

- events leading up to contact with services;
- first experiences/impressions of services/inpatient unit;
- subsequent impressions/experiences;
- whether they felt included by staff;
- quality of the communication with staff;
- any recommendations they might have.

The training also focuses on helping staff extend their commonly held client-centred values and therapeutic skills in working with families. The qualities of empathy, warmth, genuineness and a non-judgemental approach also make up the therapeutic stance required to develop collaborative working partnerships with families and carers. In addition, the training explores the challenging practical and theoretical implications involved in making services truly family/carer friendly. We have found that a useful exercise is to ask staff to consider (individually and in groups) what personal and organizational obstacles stand in the way of family inclusive practice. This allows the trainers to empathize with their difficulties and then facilitate the group to find solutions. In addition, the course specifically addresses the subtleties concerning confidentiality and information sharing as this is often raised as an impediment to working in partnership with families.

The three-day training includes a combination of brief didactic presentations and group exercises (see Table 2 for content of inpatient training programme).

TABLE 2 *Three-day inpatient staff training programme*

Day 1

- Carer's story and discussion.
- Introduction to National Policy and Trust Strategy for Partnership Working with Families and Carers, including exercises discussing current practice and personal/organizational obstacles.
- Focus on information sharing and confidentiality using best practice guidelines and case examples.

Day 2

- Introduction to systemic thinking and interaction cycles (including case scenarios).
- Presentation by the carer's assessment worker: assessments and resources for carers and electronic patient records demonstration.
- The initial family meeting (introduce format and role-play).
- Development of a unit action plan.

Day 3

- Discussion of team progress and implementation of action plan.
 - Constructing a genogram (family tree).
 - Young carers' video and discussion about services for young carers.
 - Clinical discussion with examples from the group.
 - Evaluation of the training.
-

Although a focus on attitudes is necessary, it is not in itself sufficient for behavioural change, and we therefore emphasize the development of team action plans (which are followed up on Day 3) together with some skills training. The afternoon on Day 2 is largely devoted to an extended role-play of an initial meeting with a family. We encourage all staff to take turns in interviewing the role-play family, using an agreed format and with intensive support from the trainers (see Table 3 for meeting format). In addition, staff practise constructing a genogram (family tree).

Results

The training programme was evaluated in a number of ways.

Pre- and post-training case note audit

The audit examined the current practice of inpatient unit staff in seven specific areas relating to their work with carers and families. The first audit was undertaken immediately before the first two-day element of the training and was repeated prior to the third-day follow-

TABLE 3 *Initial family meeting**Aims*

- To create a rapport with the family.
- To identify and value the role of the family, and to encourage the maintenance of family relationships.
- To create a platform for future collaboration (three-way partnership); including discussions around confidentiality.
- To develop a shared understanding/aims.
- To understand the context of the individual's problems.
- To provide information on services, support networks (including carers' assessment) and services.

Content

1. Contact details; small talk (e.g. did you have to take time off work; occupations); rationale for meeting (working together; value family's expertise/knowledge); who is in the household/ family/friends? Plan for session.
2. Family's account of development of client's problems:
 - ~ initial onset of problems (what, when, triggers)
 - ~ how did family members respond (what helped/didn't help)
 - ~ experience of (accessing) services
 - ~ who else has been involved
 - ~ how things have developed
 - ~ how they have made sense of what has happened.
3. Impact of the problem on the family/family members.
4. Expectations regarding treatment, including family's goals.
5. Family members' attitudes to working collaboratively:
 - ~ discussion around confidentiality and information sharing
 - ~ involvement in care planning process.
6. Provide information about support and practical help for carers including the offer of a carer's assessment.
7. Genogram (elaborate in later session):
 - ~ who is in the family/what they do/how they get on
 - ~ any family history of mental health problems.

up training. In each case ten current electronic case records were randomly selected by the Trust's audit department. The objective was to identify any changes in practice relating to working with families and carers since the initial two-day training. This methodology also enabled us to report the results to each staff team and prompted useful discussion regarding service improvement. A follow-up audit, using the same criteria, was completed for four of the units (one having closed) at approximately one year following the third day of training.

TABLE 4 Overview of four inpatient unit audits pre-, post- and one-year follow-up from training (%)

	Pre	Post	One year
1. Carer registered on electronic patient record (EPR)?	22.5	42.5	42.5
2. Family or friends recorded in 'Contacts' on EPR?	90.0	95.0	97.5
3. Reference in integrated care programme approach to carer need, roles or contribution to care (including: family history, support network, carer's views)?	37.5	82.5	77.5
4. Carer involvement in relapse prevention plan?	5.0	17.5	15.0
5. Any carer responsibility for issues identified as problems within care plan?	12.5	15.0	25.0
6. Systemic issues identified and referral to specialist services:			
• Carer's assessment	15.0	42.5	37.5
• Carer's support/education group	5.0	32.5	22.5
• Family therapy/family interventions in psychosis	7.5	10.0	5.0
7. Carer need identified in progress notes in EPR?	67.5	75.0	95.0

The areas of practice examined for the audits included: registration of carers, recording of family-related information in various sections of case notes, and referrals to family services (See Table 4).

Comparing the first audit with the one-year follow-up audit one can identify marked improvements in practice in the majority of areas. For example, electronic registration of carers nearly doubled, and carers' assessments, designed to open pathways to support services for carers, increased by almost threefold.

Staff survey

A survey was undertaken at the outset of the training to gain baseline knowledge of staff training, experience and confidence in working with families.

The majority of inpatient staff (82 per cent) reported that they had not received any training in working with families; only a few staff (10 per cent) rated themselves 'confident' (rating of 4 or 5 on the 5-point rating scale) in their skills in working with families; staff almost universally (98 per cent) said they wanted further training in this

area. The survey also recorded numbers of times staff had met with families/carers in the past month. The survey was repeated for all staff attending the third-day follow-up training. Confidence in skills in working with families had increased – those rating themselves as ‘confident’ increased from 10 per cent to 57 per cent and the mean rating increased from 2.6 (range 1–4) to 3.6 (range 2–5) post-training. Although the majority of staff surveyed now felt confident in these skills, this was only associated with a modest increase in the number of meetings with families (one to three families seen: pre 61 per cent, post 43 per cent; four or more families: pre 21 per cent, post 34 per cent. Mean number of meetings: pre 2.35, post 2.90).

Most nursing assistants had not received any formal training (96 per cent) and only 16 per cent rated themselves as ‘confident’ in their skills in working with families. Thirty-six per cent reported that they had not met with a family in the past month; however, when asked to describe meetings that had been held, the major theme identified by 42 per cent of respondents was ‘*giving and receiving information from families and carers*’.

Action plans

At the end of Day 2 staff were asked to develop an action plan to take back to their units from ideas that had been generated during the training. A thematic analysis of all the plans showed the following main themes in order:

- To conduct planned meetings with carers/families within seven days of admission.
- To adopt a ‘meet and greet’ policy for families/carers visiting units.
- To develop a suitable child-friendly, bookable room for families/carers visiting their relatives.
- To record more detailed information about families/carers in patient records.
- To routinely invite families/carers to reviews/ward meetings.
- To ensure families/carers are registered on the electronic records system and, where appropriate, refer for carers’ assessment.
- To consider confidentiality issues/policy relating to families/carers.
- To provide easily accessible leaflets/information about units for carers/families and children.

Nursing assistants' action plans also included trying to meet with families and carers at the 'earliest possible time', and to be more confident to talk with trained staff about families' needs and issues.

In reviewing the action plans on Day 3 it was evident that progress had been made; for example, new policies around children visiting were being developed which included the provision of bookable family visiting rooms with toys and books. The provision of accessible information for families and carers including guidance on available support had also improved. In some areas, for example, holding initial family meetings, progress was more limited and this is where we have developed further initiatives (see Discussion below).

Evaluation of the training

Staff completed an evaluation at the end of the first two-day element of the training. Ninety per cent rated the teaching methods appropriate and stimulating; 95 per cent rated the training as appropriate to their needs; 93 per cent said they would recommend the course to their colleagues. A further evaluation was completed at the end of the third-day follow-up training: 98 per cent rated the three-day training as overall 'very useful'.

The large majority (85 per cent) of nursing assistants evaluated the teaching methods as 'appropriate' and 'stimulating'. All rated the training material appropriate to their needs and 87 per cent said they would recommend the course to their colleagues.

Discussion

Our experience has been that this kind of training programme is required on acute units and that it is possible to achieve the learning outcomes (see Table 1) in terms of attitude change, awareness raising and basic skills development. It is encouraging to note that the audit identified significant improvements in the registration of carers, in family information recorded under the care programme approach and the referral of families for carers' assessments and carer support groups. In addition, the recording of increased carer involvement in relapse prevention and care plans appears to indicate more partnership working. However, the partnership working in this area was only apparent in a quarter of the case notes audited. The audit also appears to indicate that staff have an increased awareness of families' needs (up to 95 per cent of cases), and have been ensuring that families

receive support (around 40 per cent) and are more cognizant of the client's family context (around 80 per cent).

The training appears to have led to an increase in staff confidence in working with families – those rating themselves as 'confident' increased from 10 to 57 per cent. This was also reflected in the open-ended evaluation of the course where 14 per cent of trained and 29 per cent of untrained staff commented on an increase in confidence to work with families.

The team action plans also appear to illustrate an increase in confidence and a more positive attitude towards families. They included a range of changes in unit practices, which have led to an improved experience for families and carers.

Although conducting meetings with families/carers within seven days of admission was a key action for all units, they reported that they had found this difficult to achieve. This was reflected in the modest increase reported in the staff survey, where post-training the mean number of family meetings was 2.9 in the previous month. While it is difficult to compare projects, it is interesting to note that both the Bouverie Centre and the SYMPA training programmes report similar difficulty in effecting an increase in the number of clinical meetings with families. The Sunderland project appears to have had more success, although they have not reported their findings in sufficient detail to enable comparison.

Obstacles

Staff found it difficult to arrange family meetings due to work pressures and existing admission procedures (assessments on admission were usually carried out by doctors). Our training package includes an exercise on the first day when staff are asked to identify personal and organizational obstacles to family inclusive ways of working. The main themes ranked in order by trained staff were as follows.

- *Personally.* Lack of confidence, lack of time, lack of knowledge, lack of information and training. Also concerns about confidentiality and family expectations were expressed.
- *Organizationally.* Lack of time, lack of family-friendly facilities and resources. Confidentiality issues and lack of knowledge, lack of training and information were also again expressed.

Many similar themes were identified by nursing assistants and other support staff who also commented that they had a more limited and

supportive role and that they, and the families, often deferred to trained nursing staff who were seen as better placed to meet families' needs.

Reflections

The feedback we have received on this training programme has been overwhelmingly positive both within the organization from staff and management, and also from representatives of carer organizations. However, on reflection, the training might have benefited from the involvement of medical staff working on the units. Although the Royal College of Psychiatry has published guidelines for partnership working with families (Royal College of Psychiatry, 2004), integrating this approach can still present a considerable challenge. We recognize that the evaluation of the project might be criticized on a number of grounds – for example, parts of the survey may have been affected by a reliance on memory, and the audit only sampled 41 per cent of inpatient case notes, but we are encouraged to note that the range of measures all reflect the same trend to more family inclusive ways of working.

However, although there have been positive changes in practice we are aware that further progress will require ongoing training, consultation and organizational initiatives. To bring about more regular family meetings is a particular challenge. We are approaching this in a number of ways. Following consultation within the Trust we have established best practice guidelines (available from the first author) that specify that families should be involved in the assessment process within seven days of admission. Units have also agreed to identify unit 'champions' to promote family inclusive working and we have agreed a strategy to support staff in carrying out family assessments. In one acute unit a staff nurse with family therapy/interventions training has been employed for one day a week to join with key workers to conduct family assessments as part of the admission process. In the first six months of this pilot, family meetings have taken place with 42 per cent of admissions. (The figure rises to 64 per cent of admissions if cases are excluded when patients do not have contact with families, when families live out of the area and are unable to visit, patients are discharged within six days or family meetings were clinically inappropriate.) Seven out of eleven (64 per cent) of trained nursing staff have taken part in these meetings. In two other acute units family therapists are offering a similar level of support to enable staff to meet the practice guideline and to develop their skills and confidence in meeting with families.

We are also maintaining staff focus on these issues by providing 'top-up' training for new staff (to date we have held a further two-day course for sixteen new trained staff), regular presentations to unit training programmes, and also by conducting further annual case note audits and reporting results to teams. We would also hope to survey families' experiences of partnership working.

Conclusion

We are encouraged by the results of our acute inpatient training initiative and are now providing similar packages of training to community and specialist adult mental health teams as well as to older adults services.

Our experience has been that a team training approach is most effective in bringing about the cultural change required. In providing this training, it is important for trainers also to be aware of the current working context of mental health staff. Training needs to be carried out in a positive way. It needs to take into account the pressures and conditions in which both staff and carers work on a daily basis and provide support to staff through education and skills development to enable the setting of achievable personal and organizational goals.

This wider training will further expand the family inclusive culture within the mental health services in Somerset. In summary, change from a culture based on the individual to one that sees individuals in the context of their social networks requires a sustained and strategic approach.

Acknowledgements

We would like to thank the carers who were prepared to share their experiences with inpatient staff, and our colleagues for their willing participation in the training. We would also like to acknowledge the contribution of Trust management, in particular the unit managers Keith Fox (Service Manager) and Diana Rowe (Director of Operations and Deputy Chief Executive) whose support enabled this training to take place.

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Chapter 23 **Family interventions for first-episode psychosis**

Frank R. Burbach, Grainne Fadden and Jo Smith

Introduction

One of the fundamental objectives of the WHO Early Psychosis Declaration (EPD) Consensus Statement is to 'generate optimism and expectations of positive outcomes and recovery so that all young people with psychosis and their families achieve ordinary lives' (Bertolote & McGorry, 2005). The statement goes on to detail the 5-year outcomes that a comprehensive and effective programme would deliver to people with early psychosis and their families, and the interventions, both pharmacological and psychological, that would be required to attain these. In addition to advocating that services involve families, key supporters and communities as partners in care, the consensus statement recommends the routine availability of family interventions and practical psychosocial support. Families' needs in terms of 'better access to information and education, social, economic, practical and emotional support' can be met in a variety of ways. These include self-help and support groups (see Chapter 26), provision of information about early psychosis, assessments and packages of care for key family members (see Chapter 24) and through single and multiple family intervention (FI) and therapy.

Although there is a substantial evidence base for family interventions, concerns have been raised about the ability of staff to implement family work following training. However, one might anticipate that issues in implementing family work in Early Intervention (EI) services would be less than in generic services, given that the UK Department of Health (DH) has stipulated small caseload size and a family-oriented approach in these services: 'Care must be taken to engage and support all those

important to the service user' (DH, 2001). In this context, EI services need to consider how best to facilitate access to a range of family-based services and, specifically, when to offer formal rather than routine family interventions.

This chapter examines the evidence base underpinning family interventions in first-episode psychosis (FEP), explores issues relating to the implementation of FI in the context of family-oriented EI services and provides examples of family interventions in two NHS EI service contexts.

Summary of the evidence

There is a clear rationale for working with families in early psychosis. Between 60% and 70% of young people live with or are in close contact with their parents, grandparents and family of origin (Addington & Burnett, 2004). Many have young brothers or sisters who are affected by their sibling's difficulties (Fisher *et al.*, 2004). Others are already in relationships and are parents of young children. Frequently, it is family members who initiate and sustain engagement with services, and EI services may engage with family members first, if individuals will not engage (De Haan *et al.*, 2002, 2004; Sin *et al.*, 2005; Boydell *et al.*, 2006; Singh & Grange, 2006).

The available literature on the impact of emerging psychosis on families highlights how traumatic this can be (Martens & Addington, 2001). High levels of distress are common, and are present whether or not the young person is living at home. High expressed emotion (EE) is reported as present in over 50% of families, but the evidence for its predictive value is equivocal, with the weight of evidence suggesting that high EE during the first 2 years is probably



not predictive of relapse (Huguelet *et al.*, 1995; Patterson *et al.*, 2000; Bachmann *et al.*, 2002; Heikkila *et al.*, 2002). 'Illness' factors such as symptom type and severity, age of onset, diagnosis or length of illness are not associated with EE or distress (Heikkila *et al.*, 2002), which appears to be linked more with functional difficulties such as disorganisation, impaired interpersonal functioning, difficult behaviour and social withdrawal (Tennakoon *et al.*, 2000). The family's perceptions of behaviour and their psychological appraisal of the impact of the mental health difficulties on them have also been identified as significant predictors of distress and poor psychological well-being for relatives (Addington *et al.*, 2003, 2005a; Raune *et al.*, 2004). For some families, the trauma and shock is so great that, initially, they are in denial (Slade *et al.*, 2003), and issues of grief and loss are common (Gleeson *et al.*, 1999). Families struggle to understand how health systems work, and identify finding a way through the 'service maze' as one of their primary needs (White, 2002).

Family interventions for people with FEP have been developed against a background of substantial evidence of the efficacy of FI for people with multiple episodes of psychosis. A number of randomised controlled trials indicated that the inclusion of family work with standard care, including medication, significantly reduces relapse rates, improves social functioning, reduces 'family burden' and reduces overall treatment costs (see Pharoah *et al.*, 2002; Pilling *et al.*, 2002; Pitschel-Waltz *et al.*, 2001). To date, the evidence base for family work in early psychosis is rather limited and although detail on the content of what should be offered requires further study (Penn *et al.*, 2005; Askey *et al.*, 2007), family approaches appear to be beneficial (Haddock & Lewis, 2005). Brief family psychoeducational approaches that typically consist of stress management, problem solving, the provision of information and relapse prevention strategies result in positive outcomes or changes from high to low EE (Goldstein *et al.*, 1978; Zhang *et al.*, 1994; Rund *et al.*, 1995; White, 2002). There is also evidence that systemic family therapy and a crisis management approach can result in lower readmission rates (Lehtinen,

1993; Seikkula *et al.*, 2006). Results from the Calgary Early Psychosis Program have consistently shown positive effects for family members in terms of improvements in psychological well-being and reductions in levels of distress and negative aspects of caring (Addington *et al.*, 2002, 2005b). The other theme that emerges from the literature is that families may benefit from different types of help being offered at different phases of psychosis (Gleeson *et al.*, 1999; Shannon *et al.*, 1997). This phased approach is summarised in Table 23.1. See also other chapters in this section for a fuller discussion of other interventions (Chapters 24–26).

While there are issues with the quality of family studies in early psychosis (Askey *et al.*, 2007), there is sufficient evidence that working with the family is critical for effective EI services. In addition, leading practitioner-researchers from IRIS (2000) in the UK (see Table 23.2) and EPPIC in Australia (Shannon *et al.*, 1997) have produced comprehensive guidelines for practice.

Implementation into practice

Family needs and service delivery

As the development of EI-specific services is relatively new, there have been few studies to date looking at the delivery of family work in practice. Slade *et al.* (2003) compared a specialist EI service with generic Community Mental Health Teams and found that while all staff acknowledged the importance of family work in psychosis, the EI staff, who had smaller caseloads and who had access to supervision, engaged in significantly more family work. The EI staff 'described their work as largely supportive and psycho-educational, with formal family therapy sessions being quite rarely undertaken'. The idea that FEP families do not necessarily require the detailed family intervention developed for families coping with recurrent or long-standing problems presents a challenge in terms of service design and delivery. The majority of families will benefit from some psychoeducation and support, while a small number may still require specialist family work. Staff in EI teams tend to come from generic services and are therefore not necessarily experienced in family work. The challenge is how EI services



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Table 23.1 The needs of first-episode families: the stage model

Focus 1	Focus 2	Focus 3
The impact of the psychosis on the life of the 'family system' as a whole.	The impact of the psychosis on individual family members.	Interaction between the family and the course of psychosis.
Stage 1: Before detection: Perceptions and explanations		
The need to access appropriate treatment as soon as possible.	The need to feel safe, and to feel that the young person is safe.	The need for accurate information about the early warning signs of psychosis.
The need for consensus regarding the explanation for the change in behaviour.	The need to access appropriate treatment.	The need for information about appropriate sources of help.
		The need to minimise conflict regarding the young person's behaviour.
Stage 2: After detection: Grief and stress		
The need for effective treatment for symptoms of psychosis.	The need for effective treatment for symptoms of psychosis.	Education about the role of the family in treatment, especially for home-based acute phase management.
The need for information which minimises potential for conflict regarding treatment.	The need for practical and emotional support to minimise the impact of trauma.	
	The need to understand what has happened to their relative.	
	The need for repeated, clear messages about psychosis and its treatment.	
Stage 3: Towards recovery: Coping, competence and adaptive functioning		
The need for early identification and more aggressive treatment for treatment-resistant psychosis.	The need for early identification and more aggressive treatment for treatment-resistant psychosis.	The need for ongoing information regarding treatment during recovery phase (e.g. prophylactic role of medication).
The need for identification and intervention for more complex family issues (e.g. severe marital conflict, abuse).	The need for early identification and treatment of 'at-risk' family members (e.g. depression, acute stress).	The need for information regarding appropriate level of care as recovery progresses.
		The need for information regarding early warning signs of relapse.
		The need to encourage positive, low EE behaviours.
		The need to improve communication and problem-solving skills.

Table 23.1 (Continued)**Stage 4: First relapse and prolonged recovery: A view into the future**

Need for effective acute-phase treatment for relapse. Need to reach consensus regarding longer-term prognosis.	Need for effective acute-phase treatment for relapse.	Need for psychoeducation and communication training for ongoing 'high EE'.
Need for assistance (e.g. family therapy) for complex, ongoing systemic problems such as enmeshment.	Need for access to ongoing community supports (e.g. Schizophrenia Fellowship). Need for treatment for depression and chronic stress problems.	

Table 23.2 IRIS guidelines**General aims of family work:**

- To provide an effective treatment for the client.
- To address the needs of all family members who are affected by their relative's psychosis.

The main aims of the involvement of family in the early phase:

- To provide a complete picture of the build-up to psychosis.
- To engage them in a collaborative therapeutic process.
- To deal with the crisis of psychotic illness in the family.
- To identify and respond to the needs of individual families.

Guiding principles of family work:

- A collaborative working relationship is established between the client, family members and the professionals who are working with them.
- The difficulties faced are seen in an objective way and the combined efforts of all three – client, family and professionals – are seen as the best way of addressing issues.
- The value base underlying the approach is non-judgemental towards family members. Their past or current attempts to deal with the psychosis are valued and are seen as their best efforts to cope with a complex and unfamiliar situation within the limits of their current resources.
- The focus of the work is here-and-now and towards the future. There is an emphasis on positive achievements, and difficulties are addressed in a constructive way, arriving at a range of potential solutions that can be tried out.
- There is an emphasis on the honest and open sharing of information with all family members including the client.

Key tasks in family work:

- To engage the family in a therapeutic working relationship with professionals.
- To provide family members with the time to talk about what has been happening, to normalise their reactions and provide them with empathic support.
- To interview family members individually in order to get a picture of how each understands their situation, is affected by what is happening and can contribute to getting family life back on to an even keel again.
- To assess how family members relate to each other and how they as a unit address the issues with which they are faced.
- To provide the family with knowledge and to help them to deal with the situations they face as a result of psychosis.
- To help them to make contact with other people in similar situations to reduce feelings of isolation and stigma.

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can meet DH guidance and provide a comprehensive service to young people and those who are important in their social networks. How can services best meet families' basic needs as part of routine care within EIS, as well as flexibly responding to the more complex needs of particular families?

A helpful heuristic may be to consider families' needs in terms of a hierarchy (Mottaghipour & Bickerton, 2005; Pearson *et al.*, 2007), although families' needs will not necessarily present in single categories and will not necessarily develop in a step-wise manner. When first involved with services, families tend to require information (about mental health issues, treatment options, how services work etc.) and the opportunity to talk about their traumatic experiences. This commonly includes a need to discuss their experiences related to the development of psychosis, their difficulties in accessing appropriate help and feelings of fear, anger, loss and grief. Many will also welcome further help with solving problems (e.g. about roles, chores or achieving goals) and improving communication (e.g. when misattributions result in patterns consisting of criticism and withdrawal), and some will seek more in-depth exploration of issues. In our experience, some families engage more with

psychoeducational interventions, while others are more interested in reflecting on family relationships and interactions in the context of family history and cultural issues. A detailed discussion regarding family needs by Pearson *et al.* (2007) is summarised in Figure 23.1.

Mottaghipour & Bickerton's (2005) 'pyramid of family care' model similarly proposes a minimum level of care to meet families' basic needs for information regarding illness and orientation to the mental health service, and in a hierarchical fashion builds more specialist interventions to meet more complex family needs. This has implications for the training of staff and the provision of services. All staff will need to possess an ability to form supportive therapeutic relationships with families, be able to provide relevant information in a manner which takes into account the families' current knowledge and beliefs, and have some ability to enable families to reduce stress levels by improving communications, and developing coping strategies and problem-solving skills. In some circumstances, families may require more complex psychotherapeutic intervention, for example where pre-existing relationship problems are impacting on the person with FEP or in situations of pre-existing trauma or abuse. The traumatising effect of the onset of psychosis and the guilt,

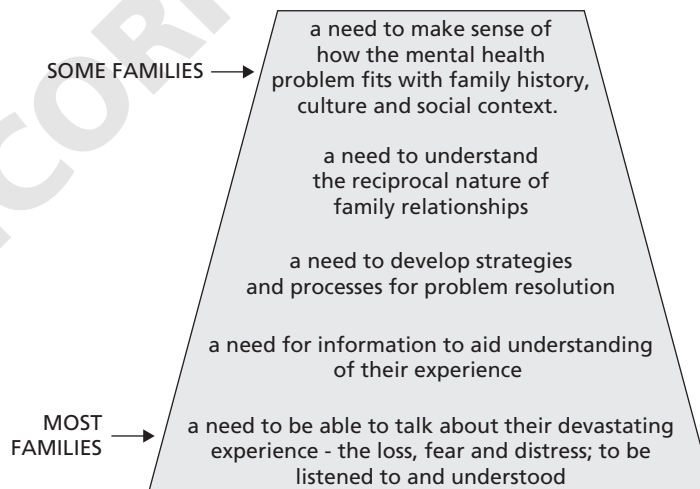


Figure 23.1 Family needs – The relationship between 'Breadth' and 'Depth' (Pearson *et al.*, 2007).

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denial, anger or hopelessness that frequently accompany this may also require the more skilled input of an experienced therapist. Although the ideal scenario may be for all EIS staff to be sufficiently well trained to respond flexibly to the full range of family needs, in reality, these more complex needs are often best met either by having some staff on the team who have received more specialist training and therefore have a more developed level of therapeutic skill, or through co-work with a more experienced family therapist, or referral to specialist psycho-therapeutic services.

Service examples

In essence, what we are recommending is the incremental establishment of a range of local services for family members/significant others affected by FEP. Whilst we recognise that specialised services develop in the context of pre-existing local services and in response to local needs, it may be helpful to consider the implementation of family work in two NHS EI service settings.

Worcestershire EI Service

The Worcestershire EI Service, established in 2002–2003, provides an example of a family-centred service with a range of services appropriate to families' needs at different points in time during their contact with the service (Figure 23.2). Families are routinely engaged in the services from the point of initial assessment and the team adopts a collaborative approach to clinical care decisions, involving the client and their family members. The majority of families (89%) meet regularly with members of their relatives' care team and in a recent service review, two-thirds had been actively involved in the production of their relative's care plans. Besides involvement in the clinical care process, 'routine family support' also includes crisis counselling and informal psychoeducation.

All members of the Worcestershire EI team are trained in Behavioural Family Therapy (BFT) and all families are made aware of and offered formal family intervention at some point in their

contact with the EIS. BFT usually involves a number of assessment meetings with individual family members and the family unit followed, where agreed, by a series of (weekly) family sessions focusing on family psychoeducation and enhancing communication and problem-solving skills. However, only 20–25% of the caseload will be in receipt of formal FI at any one time related to both family need and team capacity limitations. As the sessions take place in the evenings, each case manager typically is able to offer formal family intervention to a maximum of two families.

Some families' needs are met through the other aspects of the service (e.g. routine family support and group psychoeducational sessions) but when families are clearly not coping, structured family sessions will be recommended. Typically, all families will receive routine family support from their case manager from the outset unless the individual does not consent to family contact, which is rare. Family members will also be encouraged to attend a relative's psychoeducation group during their first 12 months with the service (see Chapter 26 for more information on group-based interventions). Family intervention may be offered at any point during their 3 years with EI. Owing to families' ongoing relationship with the service as part of routine care, they are usually happy to take the advice of the team regarding the form of FI which might be of most help. Although, on occasions, families do prematurely discontinue family work when the clinicians involved feel that it would still be helpful. The take-up of formal FI is, thus, affected by a range of issues including the particular needs of families, the individual case manager's clinical judgement as well as the way in which case managers introduce the idea of BFT and its potential benefits.

We would suggest that it is the range of family-based services provided by the Worcestershire EI Service that enables an effective response to families' varying needs. In addition, it should be noted that, ideally, any family group interventions should be specific to EI families as relatives tend not to attend groups where families have more long-standing difficulties.



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Worcestershire Early Intervention Service Developing a Family Centred EI Service																									
<p>Service background</p> <ul style="list-style-type: none"> • Service opened Jan 2003 (South), November 2004 (North) • 560,000 catchment population • Mixed urban/rural geography • Anticipated incidence rate of 15–20 new cases per 100,000 per year countywide (based on local audit figures) • Based in Worcester city • Outreach to market towns of Malvern, Droitwich, Pershore, Evesham, Redditch, Bromsgrove, Kidderminster and surrounding rural areas (70–100k per town) 	<p>Group family psychoeducation sessions</p> <ul style="list-style-type: none"> • An opportunity for family members (including siblings) to meet with other families involved with the EI service • Eight weekly 2-hour sessions focus on learning more about psychosis amongst others with similar experiences • Opportunity to share experiences and discuss the impact of having a relative who has experienced psychosis • Recent pre–post-group evaluation measured: <ul style="list-style-type: none"> – Knowledge about psychosis – Distress about their relative’s difficulties – Perceived control over their relative’s illness – Perceived support and ability to cope with their relative’s illness – Optimism about their relative’s future 																								
<p>Family work as part of routine case management</p> <ul style="list-style-type: none"> • Families engaged in the service from the initial assessment • Informal psycho-education for family members • Collaborative approach to clinical care decisions involving the client and their family members • Crisis counselling and help for family members • Service satisfaction data has measured family satisfaction with the EI service: <ul style="list-style-type: none"> – 100% of families were aware of the content of their relative’s care plan and 66.7% had been actively involved in its production – 88.9% of families meet regularly with members of their relative’s care team – 71.4% of those who had received family intervention work felt it was helpful – 66.7% of families were “very happy” with the service their relative was receiving from the EI team. The remaining 33.3% were “quite happy” with the service • Quote from a family involved with the service: <i>‘the support, care, help, advice, guidance and counselling has been excellent for my son, my wife and myself in understanding and accepting this health condition’</i> <p>Formal family interventions</p> <ul style="list-style-type: none"> • All members of the EI team are trained in Behavioural Family Therapy (West Midlands Meriden Family Intervention Programme) • All EI families are offered family intervention • Formal family intervention is offered to address family needs not met by routine family support • Focus on family psycho-education and enhancing communication and problem solving skills within the family unit 	<p>Pre–post-group evaluation</p> <table border="1"> <caption>Pre–post-group evaluation scores</caption> <thead> <tr> <th>Category</th> <th>Mean pre-group score</th> <th>Mean post-group score</th> </tr> </thead> <tbody> <tr> <td>Knowledge</td> <td>4.0</td> <td>7.0</td> </tr> <tr> <td>Impact on life</td> <td>4.5</td> <td>5.0</td> </tr> <tr> <td>Distress</td> <td>6.0</td> <td>5.0</td> </tr> <tr> <td>Control</td> <td>3.0</td> <td>4.5</td> </tr> <tr> <td>Support</td> <td>5.0</td> <td>7.0</td> </tr> <tr> <td>Coping</td> <td>4.0</td> <td>5.5</td> </tr> <tr> <td>Optimism</td> <td>4.0</td> <td>5.0</td> </tr> </tbody> </table>	Category	Mean pre-group score	Mean post-group score	Knowledge	4.0	7.0	Impact on life	4.5	5.0	Distress	6.0	5.0	Control	3.0	4.5	Support	5.0	7.0	Coping	4.0	5.5	Optimism	4.0	5.0
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Support	5.0	7.0																							
Coping	4.0	5.5																							
Optimism	4.0	5.0																							
<p>Carers’ open evenings</p> <ul style="list-style-type: none"> • Quarterly meetings open to all family members of those involved with the EI service • Informal atmosphere and an opportunity to meet other families with similar experiences in a relaxed environment • Regular talks and presentations, along with time for attendees to meet each other and interact. • Recent topics have included the roles of the different professionals within the EI team and services provided by the local Carers Unit. 	<p>Support for siblings</p> <ul style="list-style-type: none"> • Specific information booklet developed for siblings, which was written with the help of 2 siblings involved in the service • Brothers and sisters routinely involved in family intervention work • Siblings are invited to attend the family psychoeducation group • The service has helped link siblings together for peer support through facilitating the exchange of email addresses • Quote from a service user’s brother about the value of attending an EI family psychoeducation group: <ul style="list-style-type: none"> <i>‘There are a lot of people in the same boat as us, and in a way that’s reassuring. Good information which has helped me understand about my brother’s illness’</i> <p>Carer involvement in service development</p> <ul style="list-style-type: none"> • Service users and family members involved in rewriting, illustrating and launching the service’s promotional prospectus. • EI trust fund initiative is due to be led and coordinated by family members of EI service users. • EI families regularly contribute to local family intervention training courses 																								

Figure 23.2 Worcestershire EI service – Developing a family-centred EI service.

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Somerset EI and Family Intervention (FI) services

In Somerset, a smaller 'hub and spoke' EIS was established in 2006–2007, in the context of an existing county-wide FI service. The FI service had been created through the delivery of a 1-year multidisciplinary course in each of the four service areas, with management agreement that all staff trained in FI would be able to devote half a day a week to the delivery of FI (Burbach & Stanbridge, 1998, 2006). Half of the EIS staff were also part of the FI service and faced the challenge of deciding whether to work with particular families as part of routine care or to refer them to the FI service where they had the further option of being one of the co-therapists working with the family. In the early stages of the new EI service, the EI/FI worker in one of the service areas referred approximately half of the caseload to the specialist FI service at an early stage, whereas an EI/FI worker in another area made fewer referrals to the FI service but tended to find herself dealing with increasingly complex family issues after having engaged with her families as part of routine family support. As the EI service developed, especially following the increase in the potential families that could be referred to a relatively finite capacity FI service, guidelines concerning routine and formal family work were recently agreed (Figure 23.3). Although in many cases, routine family work was sufficient to meet families' needs, and best provided by the EI worker, for families that expressed more complex needs it seemed more appropriate for an FI team member to join the EI worker to deliver formal FI, or to refer the family on for formal FI. The possible permutations were discussed on a case-by-case basis in the regular EI team and FI team supervision meetings, and other options available to all families and carers in Somerset such as generic rather than psychosis-specific services were also considered, including a formal carer's assessment and carer's support, a carers' education programme and carers' support groups.

On the rare occasions that the individuals do not wish their families to be involved in their

care, it is explained that relatives are entitled to their own independent support and they are referred for a Carer's Assessment. On other occasions, the needs of the service user and other family members appear to be best met separately. In these situations, the family members may be seen in the FI service while the EI case coordinator focuses on the young person with psychosis. There are many permutations, for example, recently, the EI worker and an FI team colleague worked with a young woman with psychosis and her partner, while her parents were seen by two other therapists in the FI service. In our experience, however, the majority of young people with FEP can be engaged in FI with significant others. This is usually parents, but can also include siblings, partners, friends and professionals such as housing support staff. The key to successful engagement in the Somerset 'cognitive-systemic' FI approach appears to be the flexible, collaborative approach. The approach is to respond to families' expressed needs as well as trying to incorporate family needs as assessed by clinicians, agree therapeutic goals collaboratively, ascertain whether sessions have been useful and agree whether to have further family meetings on a session-by-session basis (Stanbridge *et al.*, 2003). It is interesting to note that in more clearly delineated approaches based on assessed needs such as BFT where family members' needs are assessed, and a series of family sessions are agreed, there is also a similar focus on flexibility and briefer interventions when working with people with FEP (Fadden & Smith, 2008).

The content of FI with FEP

The recommendations for meeting families' needs made by Gleeson *et al.* (1999) included a crisis-oriented approach with an initial focus on eliciting feelings from the often bewildered or traumatised family members, with techniques such as problem solving or communication training being introduced later. These have since been endorsed by other leading writers in the field (Addington & Burnett, 2004). We recommend an individualised approach



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<p>SOMERSET'S GUIDELINES FOR ROUTINE AND FORMAL FAMILY WORK ROUTINE FAMILY WORK (All families can expect an EI worker to offer the following:)</p>
<ul style="list-style-type: none"> • Exploration of distress and provision of emotional support • Exploration of contexts related to client's symptoms/problems • Initial Carers Assessment (and signposting on to carers services) • Involving the family in care planning and reviews • Provision of information about psychosis and other mental health issues, coping strategies and services • Encouraging realistic expectations and helping the family to maintain a sense of hope • Assessment of need for formal FI
<p>FORMAL FAMILY INTERVENTIONS (Family needs-led sessions convened by FI trained co-therapists)</p>
<ul style="list-style-type: none"> • Reducing stress/burden and encouraging realistic expectations • Enhancing family members' skills for coping with psychotic symptoms • Enhancing the ability to anticipate and solve problems • Helping the family to communicate more clearly • Identifying early warning of relapse and agreeing a plan of action • Liaison and advocacy with mental health and other services • Enabling change in the family interaction system • Helping the family to be reflective, explore options, reach a shared understanding, deal with strong feelings (e.g. anger, guilt) and encourage a sense of personal agency <p>It is recognised that in less complex presentations the first six of the above can also be met within Routine Family Work</p>
<p>INDICATORS FOR FAMILY SUPPORT SERVICE (FORMAL FI)</p>
<ul style="list-style-type: none"> • COMPLEX NEEDS <ul style="list-style-type: none"> - High level of family stress/distress/chaos - High risk of relapse - Concurrent (physical/mental health) problems in other family members - Relationship difficulties maintaining problems - Hopelessness or other strong feelings (e.g. guilt, denial)/poor coping strategies • Pre-existing client/family risk factors (e.g. history of abuse or violence; developmental issues) • Family unable to access other resources/services effectively • EI worker's relationship with the client might be jeopardised by routine family work
<p>PROCEDURE FOR REFERRAL FOR FORMAL FI</p>
<ul style="list-style-type: none"> • Discuss Family Support Service with family members (give leaflet) • Discuss reasons why formal FI is appropriate/agree basic goals

Figure 23.3 Somerset's guidelines for routine and formal family work.

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tailored to the specific needs of each family, with a range of family services being available to meet the family's needs at different points in time.

Training implications

It is interesting to note that in a recent national survey of psychosocial interventions (PSI) skills within EI teams (Brabban & Kelly, 2006), the

South West and West Midlands regions reported the highest numbers of EI staff with formal PSI and family work qualifications. Both of the services described in this chapter have systematically attempted to develop the workforce in this manner and are now able to draw on this somewhat larger pool of trained staff. However, training alone does not guarantee implementation of FI – this requires a strategic, whole-systems perspective as discussed below.

With regard to the content of training programmes, we would make the following recommendations. In order to provide flexible multifaceted family work, staff should be trained in psychoeducational family interventions such as those developed by Barrowclough and Tarrier (1992), Falloon *et al.* (2004) and Kuipers *et al.* (2002) and to have specific knowledge of issues relating to early psychosis. In particular, they will need to feel confident in discussing issues regarding diagnostic uncertainty and be competent in dealing with the feelings evoked by the onset of psychosis. Skills in crisis-oriented counselling and collaborative, competency-based therapy (Bertolino & O'Hanlon, 2002) will also be helpful in encouraging an increased sense of agency and hope for the future amongst family members. Staff also need skills in working with children. In Somerset, it has also proved useful to train staff to explore interactional patterns and to provide them with a working knowledge of the way in which families develop over time. This facilitates the exploration of family stress in a normalising, non-blaming manner.

It is undoubtedly helpful to be more extensively trained, and the recent UK report on training and skills in EI services recommends the development of EI-specific family intervention training such as that currently offered through the Meriden Programme in the West Midlands (Brabban & Kelly, 2006). However, the skills listed above should not be regarded as a prerequisite for working with families with FEP. Much of what is described as 'routine family work' can be provided following relatively brief packages of training such as Somerset's 3-day course in Family Oriented Practice (Stanbridge & Burbach, 2004, 2007), which is generic in nature. Courses focused on psychosis, such as

Behavioural Family Therapy, can introduce key specialist family intervention skills to staff in only 5 days. Successful implementation of these new skills on completion of the training, however, will depend upon the ready availability of high-quality ongoing supervision (Fadden *et al.*, 2004; Fadden, 2006) and the maintenance of a service context which facilitates family work. In Somerset, we have found that supervision is crucial in the maintenance of the service and also in ensuring its quality (Burbach & Stanbridge, 2008). This takes place in local monthly team supervision sessions, quarterly county-wide 'study days' and is built into our routine practice as each pair of therapists also reflect on their clinical work before, during and after each family session. Whilst one of the functions of this range of approaches to clinical supervision is to ensure safe and ethical practice, the prime function is to facilitate reflective practice (Schön, 1983) and thereby enhance the effectiveness of therapy. Building in a range of supervision processes is important to support staff carrying out this at times complex and demanding work.

Case study

This case study describing family work that took place over a 3-year period will illustrate the various forms of family work including psychoeducational intervention, informal carer support via a case manager and more formal family intervention (both behavioural family intervention and systemic family work).

Connor, aged 17, was referred to the Early Intervention Service after a 2-year period of alcohol and cannabis use. This had been associated with a decline in school performance, truanting, stealing from his parents and trouble with the police. Experimentation with amphetamine and cocaine triggered psychotic experiences. Relationships with his family deteriorated and there was some physical aggression between Connor and his father.

During an extended 6-month assessment period, the EI team provided family psychoeducation regarding substance abuse and psychosis, referred him to other agencies who helped him

to come off drugs and to secure employment in a local dog sanctuary and helped him to repair relationships with his family. The team concluded that Connor's problems were drug induced and he was transferred to 'monitoring' only.

However, 4 months later, Connor's parents contacted the EIS to report that his psychotic symptoms had returned, apparently linked to stress at work. His psychotic symptoms were treated with low-dose antipsychotic medication. His mood subsequently dropped and he became uncommunicative, spending long periods sleeping in his bedroom, neglecting his personal hygiene and failing to carry out even basic home care tasks (e.g. washing up, making his bed and keeping his room tidy). This was a source of major friction for his parents who saw him as lazy and 'wasting his life away' in bed.

The case manager held a number of joint sessions with Connor and his parents but behavioural family intervention had little impact. Connor's parents declined an invitation to join a local early intervention relatives group 'in case they met people who knew them'. They also felt they had sufficient information from an information booklet, Internet and discussions with the case manager. However, Connor had slipped back into substance misuse, accompanied by psychotic symptoms and incidents of aggression particularly directed at his father, which led to increased parental frustration and threats to make Connor homeless.

The case manager then sought the help of a psychology team colleague to work with Connor and his family to address their current difficulties and the family tensions these were creating. Connor failed to attend the first two family sessions and his parents vented their frustration at the lack of progress and the detrimental impact on 'family life'. They experienced constant tension on returning home from work (wondering what state the house or Connor might be in), reported problems with Connor borrowing and stealing money, aggression towards his dad and felt Connor was 'using' them. They noted increased marital tension and arguments between themselves and were split between natural parental concern and understandable anger at Connor's behaviour, particularly the drug and alcohol use, which they felt was within Connor's control.

They were encouraged, in Connor's absence, to use the sessions to consider the relationship between themselves and Connor and to what extent their own actions might be contributing to Connor's difficulties; e.g. doing too much for Connor, lending money to Connor, which may be funding his drug purchases, not setting clear limits and threatening consequences that they did not actually follow through. Although accepting that this might be a useful focus for sessions if Connor failed to attend, informal feedback via the case manager following the session suggested that they had felt judged and blamed for Connor's behaviour. This was broached directly at the next session and it was noted that all of their actions were understandable as caring parents and their intentions were clearly to support Connor. In spite of their frustrations and the damaging effect of Connor's behaviour on their relationship with him, there was clear evidence of their concern and caring. It was noted that their efforts at trying to manage and alter their situation appeared to have had little impact and that it may be valuable to use a dispassionate facilitator to develop a new perspective on their situation. There was discussion about how they would like things to be different and how this might be achieved.

At this point, Connor unexpectedly arrived at home and joined the session. He was briefed on the discussion to date and was asked in what ways he felt that his parents' lives had altered since his difficulties began. He observed that they rarely saw any friends now, rarely went out socially either independently or together, rowed constantly and were sleeping in separate bedrooms. He felt he could do nothing right, was treated like a child and felt bullied and intimidated by his dad. He observed 'from the moment I come up the drive and even before I come in Dad is already working himself up to have a go at me'. These observations were explored. His parents noted that the loss of contact with friends was through embarrassment at the situation with Connor, feeling that they could not compete with positive stories about their friends' offspring. They now felt too tired to do anything in the evenings and the rows reflected the general tension in the home and disagreement between them over the best way to handle their difficulties with Connor. They acknowledged Connor's comments about anticipatory tension but felt

this was understandable in view of the difficult behaviour they had previously had to deal with when he arrived home drunk/heavily drugged. They were surprised that Connor had registered these adverse changes to their lives as they had perceived him to be self-concerned and detached from family life.

Connor for the first time apologised for the difficulties that he had caused them and noted how difficult his life had been compared to his sister Amy whom he perceived as 'the favoured child' and 'lucky'. He said he had always felt that his dad did not like him and had dominated him with criticism. His parents acknowledged he had been bullied at school and he said this had left him feeling low in confidence and a failure in his parents' eyes. Several sessions were spent identifying goals for change, individually and collectively, and also how they might support one another in making small changes. On the basis of a previous shared interest in tennis, his parents were encouraged to take this up again for tension relief and to build social contacts. Mum took up an evening fitness class and dad renewed a former interest in animal husbandry and bought some poultry to help with stress management and to build a leisure interest. His parents were encouraged to have a weekend away and subsequently booked their first holiday together as a couple for a number of years. Connor joined an assertiveness course at the local college to help build his confidence and began exploring the possibility of moving to an independent flat with the help of his case manager.

Further work dealt with Connor's observations that he felt treated like 'an incapable child'. He was encouraged to look for opportunities to demonstrate his maturity and ways he could command his parents' respect. His parents were encouraged to try positive rather than negative monitoring, noting those occasions when Connor was acting responsibly. Feedback revealed that there were many occasions where Connor was active, for example washing up, tidying, vacuuming, which had been missed or taken for granted. The more these were acknowledged, the more frequently they occurred. Connor was encouraged to tackle tasks independently on his car, for example changing the oil and fitting a stereo. Connor's father was surprised at how able Connor actually was. He realised through family discussion how his

own high standards and abilities undermined confidence in both his wife and Connor. He realised that he set unrealistic expectations for his family which they all struggled to live up to and he began to hold back on advice giving, letting others do things in their way and learning to wait to be asked rather than offering unsolicited advice, which was perceived as implicit criticism, or doing things for his family which undermined confidence in their own abilities. He was able to observe a growing confidence in Connor, improvements in family tension and noted a relief of his own sense of responsibility for everything.

Over a series of fortnightly sessions for a 6-month period, family tensions gradually eased. Connor's parents began to go out more and to recontact friends. They played tennis together and independently several times during the week, and also enjoyed several short breaks and a week's holiday away. Connor's behaviour gradually improved. He stopped using drugs and alcohol and his paranoia eased. He started a part-time mechanic's course at a local college. Connor was eventually supported by his case manager, parents and sister to move to a flat nearby, which his family helped him to paint and furnish. He was able to invite his parents round for coffee and meals and sought their support with budgeting and domestic management tasks. The changes in family dynamics were summarised in a comment from Connor concerning his dad, noting: 'He treats me like an adult now. I feel now I have my own flat and am coping that he treats me with respect and as an equal. My dad even asked me to help him last week with a job he could not do on his own. I was made up!' The need for family sessions was subsequently reviewed and stopped after 9 months of formal family intervention. Further progress was reviewed in the course of routine contact by the case manager with Connor and his family.

Implications and conclusions

Working with the family and others who are important in the young person's social network ensures that their difficulties are understood in a social context. It facilitates the establishment of effective collaborative working relationships between the individual, family and health care

Table 23.3 Recommendations to maximise implementation of FI post-training**Recommendations to maximise implementation of FI post-training**

1. Ensure support for the training programme at the highest organisational level.
2. Ensure appropriate service context and sufficient resources are available to enable practice post-training (protected time, smaller caseloads, access to assessment materials).
3. Ensure post-training expert clinical supervision is available.
4. Use a team-training approach or ensure that there is a local 'critical mass' of trained practitioners.
5. Involve families/carers in the training programme and in the design and governance of the service.
6. Appoint local service leads/champions who are responsible for the development and maintenance of the service.

services. Offering help at this early stage supports the family's understanding, the way in which they relate to each other, and their adjustment to the major changes they face in their lives. It also helps to minimise the risk of problems developing for individuals and for the family as a whole. All of the well-established EI services such as those in Melbourne, Australia (Shannon *et al.*, 1997; Gleeson *et al.*, 1999; Crisp & Gleeson, 2008), Calgary, Canada (Addington & Burnett, 2004) and Birmingham, UK (Fadden *et al.*, 2004) as well as the two services described in this chapter identify family work as a core component of what should be delivered in order to maximise family functioning and to minimise risks of long-term difficulties. However, evidence from developing EI services in the UK suggests that while staff offer a minimum level of support and advice to families, they often feel ill-equipped to offer more structured types of help, and quote issues such as lack of materials and resources, and lack of confidence in dealing with children (Slade *et al.*, 2003). However, as a result of the substantial literature investigating difficulties involved in implementing family interventions following training (Fadden, 1997; Bailey *et al.*, 2003; Brooker *et al.*, 2003), there is now a growing consensus regarding the key requirements to maximise service delivery (see reviews by Brabban & Kelly, 2006; Brooker & Brabban, 2004) (Table 23.3).

This chapter has discussed some of the key ingredients – clear policy guidance, clinical guidelines, training programmes and guidance regarding implementation post-training – which are available to support the delivery of family interventions within EI services and we hope that the service examples and case study will encourage all EI services to develop the range of support available to families.

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Queries:

AQ1. The caption and the column heading of Table 23.3 both have the same sentence 'Recommendations to maximise implementation of FI post-training'. Please clarify if we need to retain the column heading as such or delete the same.

AQ2. Figures

Please confirm the captions for Figures 23.1, 23.2 and 23.3.

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‘A Different World’ Individuals’ experience of an integrated family intervention for psychosis and its contribution to recovery

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Objectives. The aim of this study is to explore the meaning and significance of family interventions (FI) for the individual who experiences psychosis, and its significance for recovery.

Design. A qualitative in-depth interview design was used to explore individuals’ experience of FI and its meaning to them.

Methods. Seven individuals recovering from psychosis attending integrated FI sessions were interviewed using a semi-structured interview schedule developed with service user input. Interviews were recorded, transcribed verbatim, and explored using Interpretative Phenomenological Analysis.

Results. Three central themes highlighted the participants’ experience: (1) They welcomed the shared experience with their families and felt contained and valued by the therapists; (2) They felt the sessions contributed to changed patterns of relating within the family and the creation of new meaning through the validation of multiple perspectives; and (3) They described how the family sessions supported a new positioning in the world, a sense of their own empowerment and personal responsibility, greater self-acceptance, an increased ability to manage emotions, and hope for the future.

Conclusions. Conditions in the family sessions provided an environment for changes in patterns of relating, personal meaning, and emotions to take place. Recovery, for these individuals, appeared to be about repositioning themselves in the world. The shared experience of sessions and the recognition of multiple perspectives within a containing environment may be related to recovery via the development of new perspectives and a more robust sense of self. This has clinical implications for the focus of FI sessions.

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Practitioner Points

- This study supports the use of various elements of integrated family interventions.
- Understanding service-users' experience of family interventions and recovery processes can support the development of responsive clinicians and produce therapies that best support recovery processes.

In this paper, we explore the different processes involved in a family intervention (FI) and how these processes impact on individuals' experience of recovery. Recovery has become an important concept in assessing outcomes in psychosis as research has revealed the idiosyncratic and all-encompassing nature of psychosis and thus recovery (Aggergaard Larsen, 2007; Killackey & Yung, 2007). Recovery is no longer just seen as an absence of symptoms. Finding hope, re-establishment of identity and relationships, finding meaning, and taking responsibility have all been identified as important for recovery (Andresen, Oades, & Caputi, 2003; Chadwick, 1997; Forchuk, Jewell, Tweedel, & Steinnagel, 2003; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007; Repper & Perkins, 2003). Developing a coherent sense of the self which integrates different elements of experience is seen as a key process in recovery (Davidson & Strauss, 1992). Psychosis is thought to have a profound impact on an individual's sense of self. In fact, researchers have hypothesized about a disintegration of the sense of self in psychosis (Lysaker & Lysaker, 2001), suggesting people with psychosis embrace a singular, all-incorporating self-position and lack integrated multiple self positions. It is these multiple self positions that are suggested to be important in the development of self acceptance and identity which are seen to be vital for normal functioning of the mind (Hermans, Kempen, & van Loon, 1992). Lysaker, Glynn, Wilkniss, and Silverstein (2010) emphasize the significance of supporting the development of a self-narrative in psychotherapy and a 'growth process in which the self is viewed as both more multifaceted and more integrated' (p. 6).

In a grounded theory exploration of recovery processes in psychosis Dilks, Tasker, and Wren (2010) highlighted the importance of 'conversational processes in therapy' (p. 102) in developing the self, through pointing towards the importance of dialogue and grounding the sense of self in the social world. The reciprocal nature of developing identity has long been acknowledged (Soddy, 2001). Deetz (2003) suggested we can only know ourselves in relation to others. It is therefore surprising the literature on the development of self does not attend to the role of systemic therapy or family work (Lysaker, Roe, & Yanos, 2007).

The conception of multiple self positions within the self could be construed as consistent with social constructionist approaches that emphasize the importance of the co-existence of multiple realities in the social world and the importance of language in the development of meaning (Yerby, 1995). However, more purist social constructionists minimize the significance of creating a boundary between the self and the social world, suggesting no processes operating at the individual level have any explanatory power because it is the discourses at a social level that influence the individual's development of identity (Burr, 2003). This may explain the lack of focus within recent systemic theory on the role of the self in change.

Boscolo and Bertrando (1996) theorized that the self is developed through the internalization of relationships, emphasizing the role of shared meaning in this process. They highlighted Bateson's conception that systemic communication connects elements of the individual's inner world with elements of the external world. Bertrando (2008) further explored the role of dialogue in systemic therapy in this process. More recently Karatza and Avdi (2011) explored shifts in narratives and the development of self

narratives in family work for psychosis, emphasizing the importance of dialogues and their relationship to a wider discourse. It is possible that family sessions provide for the person with psychosis an arena for the development of a new set of multiple dialogues or perspectives.

However for the most part, systemic therapists have focused on wider processes within family work rather than either specific changes or the recovery processes. Research has shown FI to have a positive impact on relapse and rehospitalization rates (Dixon & Lehman, 1995; Pharoah, Mari, Rathbone, & Wong, 2008; Pilling *et al.*, 2002; Pitschel-Walz, Leucht, Bäuml, Kissling, & Engel, 2001). However, these reveal little about the complexities of the change process, an important lacuna, given the wide variation in implementation of FI.

Systemic approaches to family work are underpinned by the notion that an emotional climate is created by interactions (Cecchin, 1987). Thus, the focus is on changing family patterns and the construction of shared narratives to support such changes (Dallos & Draper, 2010). Family management, as opposed to systemic, approaches are also employed with psychosis. Family management approaches do not focus on the role of family interactions in the manifestation of psychosis. Family management instead posits a disease model of 'schizophrenia', with a focus on education and developing coping strategies. These differences of emphasis raise the question: what are the important change processes for FI?

The literature in both types of family work indicates the importance of shifting meaning - particularly suggesting the role of shifts in perception, emotions, and/or communication patterns within the family (Addington, Coldham, Jones, & Addington 2003; Fortune, Smith, & Garvey, 2005; Kuipers *et al.*, 2006; Pote, Stratton, Cottrell, Shapiro, & Boston, 2003; Sexton & Schuster, 2008). However these studies have focused on family members' experience rather than the experience of the individual with psychosis. Moreover the question remains: just how do these shifts occur in therapy?

Systemic research has investigated conditions within the therapeutic space connected to change. Safety, fairness, normalization, hope, and 'pacing' have been isolated as key (Christensen, Russell, Miller, & Peterson, 1998). Normalization is defined as therapists giving families support for developing an understanding that their behaviour or emotional experience is 'normal', given the circumstances. The systemic therapeutic stance of neutrality, theorized as a strong element of the therapeutic relationship (Cecchin, 1987), was also found to be an important part of the change process (Stanbridge, Burbach, Lucas, & Carter, 2003). Indeed, studies have emphasized the significance of having a good therapeutic relationship for individual relapse rates (Smerud & Rosenfarb, 2008). Further research suggests that the systemic strategy, 'reframing', which can change the original meaning of an event (Jones & Asen, 2002), could effect positive shifts for relatives, in particular (Fortune, Smith, & Garvey, 2005).

Other research has investigated the role of expressed emotion (or 'EE') - that is, hostility, emotional over-involvement, and critical comments - in FI. Reductions in EE of family members have been shown to be related, for the service users, to decreased mental health problems (Butzlaff & Hooley, 1998; Kuipers *et al.*, 2006; Pharoah *et al.*, 2008). Kuipers (2006) suggested that working on problem-solving and coping strategies in family sessions allowed for a reduction in the negative emotional climate, which then has an impact on family members' ability to reappraise their difficulties.

Affect dysregulation has been found to be connected to the disintegration of the 'dialogical self-structure' in psychosis (Lysaker & Lysaker, 2001). From a systemic perspective this suggests that improving an individual's emotional climate, or context,

should facilitate emotional shifts to encourage positive, integrated self-image – and thus recovery. As individual therapy can improve self-reflexivity (Dilks, Tasker, & Wren, 2008), systemic work might widen such possibilities.

Qualitative methodologies, through examining family members' experience, have contributed to the literature on FI and outcomes, showing that families find helpful the opportunity for open discussion, developing perspectives and problem-solving (Stanbridge *et al.*, 2003). Families report reductions in stress and enhanced communication skills along with a sense of empowerment (Campbell, 2004).

Studies on individual therapy have shown the extent to which qualitative methodologies can support our understanding of how therapy supports changes in individuals' internal mental processes. Such work has underscored the central importance of the therapeutic relationship as well as highlighting that developing new understanding and an internal locus of control is particularly important (Bury, Ravel, & Lyon, 2007; Dilks *et al.*, 2008; Higginson & Mansell 2008; Newton, Larkin, Melhuish, & Wykes, 2007; Singer, 2005).

Interpretative Phenomenological Analysis (IPA) appears a particularly useful methodology if the research aim is to uncover in-depth individual processes in interventions. IPA is a structured method of exploring individuals' phenomenological experience within a framework that privileges accessing idiographic meaning as directly as possible. It has provided rich accounts of subjective experiences around therapeutic change (Higginson & Mansell, 2008; Newton *et al.*, 2007; O'Toole *et al.*, 2004). To explore in depth the individual's experience of change within family work, then, IPA would seem an appropriate methodology. IPA, with its emphasis on subjective lived experience, would also seem particularly useful in the study of psychosis and recovery, given the importance of individualized journeys in recovery (Borg & Davidson, 2003).

The current research reports on just this: how the individual with a diagnosis of psychosis experiences family work and how the experience of family sessions make an impact on their development, their sense of self, and on their recovery. The research was carried out in the Somerset Family Intervention Service which uses an integrated FI approach (Burbach & Stanbridge, 1998, 2006, 2009). This approach has been developed to be both collaborative and tailored to individual families' specific needs. The Integrative FI approach uses psycho-educational and cognitive behavioural therapy techniques, as well as systemic and solution-focused techniques. It is underpinned by a systemic perspective 'which locates an individual's difficulties in their family, cultural and socio-political context' (Burbach & Stanbridge, 1998, p. 319) Thus, it emphasizes interpersonal interactions that can sustain problems. The research was hoping to discover from service users' accounts what sorts of systemic practices, and which others – for example, psychoeducational ones – they found helpful.

Method

Using IPA (Eatough & Smith, 2008), seven individuals who had attended Integrated Family Intervention sessions were interviewed by the first author. Following IPA procedure (Smith & Osborn, 2003), the interviews were guided by the schedule rather than dictated by it. The interview schedule was developed in collaboration with a service-user consultant.

The seven participants were drawn from a pool of those service users who had both experienced psychosis and had been seen within the service for more than 6 months,

Table 1. Participant information^a

Participant	Gender	Age	Age of first onset	Time spent in FI service
Bob	Male	40s	20s	59 Sessions
Tim	Male	50 +	30s	17 Sessions
Peter	Male	20s	20s	20 Sessions
Emily	Female	50 +	Late teens	32 Sessions
Simon	Male	30s	20s	15 Sessions
Charlie	Female	Teens	Late teens	12 Sessions
Deborah	Female	20s	Late teens	29 Sessions

Note. FI, family interventions.

^aAll names have been changed.

(see Table 1). The number of sessions the participants received varied, depending on the length of time in the service. The participants included four men and three women, all British Caucasian. Diagnoses included schizophrenia, bi-polar disorder, and severe depression. Most participants attended family sessions with their parents, though some attended with partners and/or extended family.

Results

Three master themes emerged: the importance of a shared, containing space; changes that create new meanings; and the development of a new positioning in the world.

A shared, containing space

The experience of a shared, containing space in family sessions was centrally important, linked in their accounts to recovery. Indeed, those who either did not experience such sharing and containment – or who did not value it – did not report as much progress on their path to recovery.

'Going through the same': Shared experience

Most participants highlighted a general sense of shared experience with their relatives, or as Peter remarked they were '... going through the same'. In particular, they said they welcomed the opportunity to share therapy with their family. Deborah said 'I just thought that it would be a good opportunity to ... for all of us to sit down together in a neutral environment and kind of talk about our own worries and fears'. Emily, another participant, points to the interrelated nature of problems: 'I think Brian was depressed as well and I think we were both pulling each other down'. Her observation underscores the notion in systemic work of the feedback loop in maintaining and developing problems (Dallos & Draper, 2010), in which the problem and distress maintenance can be located anywhere. Emily recognized it is not just the member with psychosis who might be generating the distress in others, but also others who might be maintaining their own distress.

The participant called Charlie noted that 'we are both working at each other (...) knowing our best tactics to deal with each other's problems', indicating that, while not

denying her own problems, she recognized that sessions were places to discuss all the family's issues.

For most participants, this shared experience meant they noted similarities and differences in family members' perspectives. 'It got us all together (...) but once we were all there (...) the emphasis was not only like what I was going through (...) but how everybody else in the family was also going through the same (...) I think we all had very different experiences,' according to Peter. The shared space created an arena for reflections and comparisons in the family system.

All but one mentioned the 'shared space', although the group varied in terms of how much this may have made a difference to them. Even though Bob had been in the service the longest, his account did not refer to his shared experience with his family. Instead, his account contained little about the experience of his family members. Indeed, he implied a focus on them was irrelevant: 'Well no - because I mean the sessions are supposed to be about me - they are not supposed to be about my carers'.

'A different world': The therapeutic space

This sub-theme describes the 'therapeutic space' which was created; described by Charlie as 'a different world'. Simon said the sessions provided 'a helpful state of mind'. Consistent with earlier reports suggesting individuals felt tentative about commencing family therapy (Stanbridge *et al.*, 2003), Simon noted 'I was a bit nervous because I didn't want anyone to know what state I was in at the time, because it made me feel really vulnerable'. This extract suggests uncertainty about starting family therapy may be due to a fear of one's fragility being exposed.

The anxiety Simon and others noted apparently diminished over time, so that, instead, sessions became a place of safety, created by the experience of being heard, valued and their behaviour normalized. Bob reported 'there was a sympathetic ear and they were quite encouraging (...) it made my behaviour seem not abnormal under the circumstances'.

Participants also appreciated therapists engaging the family to develop a containing environment, as Deborah notes: 'they tried to take an interest in each person'.

Participants expanded on the theme of how therapists made things 'safe', pointing to their non-judgemental stance, noted earlier as central to systemic work, as per Peter's account: 'No-one was told "that is wrong or that is right" ... I think everyone was made to feel that their input was as important as the next person (...) it was really a nice atmosphere (...) to debate different issues'. Here Peter points to the importance of neutrality in being able to open up and discuss 'different' or even difficult issues.

Indeed, therapists' lack of neutrality could lead to negative feelings. Emily initially suggested 'The therapists backed me up which was really good'. However, later she noted frustration about an occasion when the therapist did not support her in a debate with her partner. 'They really encouraged him in what was really anti-social behaviour and I am really fed up, then I think that maybe it *is* me and it goes on and on', indicating Emily's apparently fragile sense of self being buffeted by such perceived partiality.

Changes that create new meaning

This second theme pools together disparate elements of the *process* of change. Each participant described changes in their pattern of relating that adjusted their perspective

and provided new meanings around psychosis. However, there were differences in the reported experiences.

'Talking in ways we wouldn't normally': Changed patterns of relating

Participants felt that the sessions changed patterns of relating, as systemic theorizing would propose (Dallos & Draper 2010). Deborah described this as '... talking in ways that we wouldn't normally'. Simon reported 'there were some things that I was reluctant to approach because I thought it would lead to an argument but in the family sessions it didn't turn out to be that bad (...) it was just a relief to talk about it', describing a new level of openness. Participants reported that their fears and beliefs about the consequences of discussing problems had been successfully challenged, even in the face of their acknowledgement that psychosis had meant profound self-absorption. Indeed, openness meant problems were not, as Simon described 'bouncing around in my head'.

Simon noticed: 'Everyone had their turn to speak (...) it became more about giving as much as just sitting there and just blurting out what was on my mind'. This suggests that the sessions not only allowed them to open up but start to listen and develop an understanding of the shared and reciprocal nature of conversation.

'A whole new perspective'

Sessions also seemed to have engendered a cognitive shift that (as systemic theory would suggest) arose from encouraging multiple views of reality, bringing, as Simon described it, 'a whole new perspective'.

Simon explained the importance of this new view, saying '... the external perspective, which is really difficult when you are swept up in your mind all the time'. The phrase 'swept up in your mind' highlights the unilateral perspective held by most participants prior to the sessions. So sessions enabled one to '... stand back and see the big picture' (Bob). Exploring the 'big picture' appears to suggest the importance of exploring the wider context of the participants' difficulties.

All noted the therapist's role in providing information and enabling better coping strategies: 'They gave ideas on how to cope', in Deborah's words. They also opened up new perspectives: 'It was good to have an outside professional opinion (...) it's like an outward perspective looking at it (...). Tony [therapist] would come up with something completely different and that would add a whole new perspective on things' (Simon). This extract underlines the importance of someone new and less involved providing a novel view and supporting change in the system.

In contrast, Tim and Emily both mentioned having been upset by perceiving a loss of therapist neutrality: neither mentioned that their therapists had helped them gain new ways of perceiving things. However, they did value hearing their families' perspective, in common with all the others. Emily told how discussing her husband's difficult childhood helped: 'I think my perspective (...) changed as early as James talking about his background (...) I didn't think that things were hopeless', showing it was this that, for them, facilitated a shift in meaning and engendered hope.

Bob was different again. Along with not valuing the fact his family had shared his experience he was the one person who did not point to the importance of hearing his family's perspective. He did, however, join the others in noting the significance of developing a new understanding – but this only as a result of working with the therapists: 'It's ... reaching an understanding of your own issues ... which is why I've been talking

to Peter [therapist]’. However as we see here, the language he uses, for example, ‘own’ or ‘I’ve’ is singular, rather than communally focused.

Developing a new positioning in the world

This theme coalesces elements that reflect changes in the individual’s positioning in the world. Recovery was discussed in relational terms, both as a process and also as a phenomenon within their social context. This is consistent both with previous research that reports the significance of recovery as a social phenomenon (Bonney & Stickley, 2008), and with participants having been in a treatment that focused on social relating.

‘Be responsible’: Responsibility and empowerment

In line with previous research on the centrality of personal responsibility to recovery (Andresen *et al.*, 2003), participants emphasized both the development of personal responsibility and feeling empowered to change. Most referred, repeatedly, to the issue of ‘responsibility’. At some point before the family sessions, all had considered others responsible for their mental health problems, as this account from Deborah shows: ‘(I) . . . blamed them [her parents] for the fact that I was being bullied at school’.

However, as sessions unfolded, most began to focus on their own responsibilities regarding recovery. Charlie noted, ‘you get to that stage when you realize that something has got to change, I’ve got to kick myself out of it so a couple of months ago I changed my outlook’. Peter described this responsibility shift: ‘It made us see that it’s not just one person’s responsibility for doing X, Y, Z, it is a mixture of all of us taking on that responsibility rather than just saying, I made the effort’. The joint conversations in sessions allowed for such reflection – pointing to the importance of others also being involved in the change process.

Not all showed such a shift in perspective around responsibility: Tim, Emily, and Bob’s accounts, in contrast to the others, showed them taking a more passive approach when in sessions. This was alluded to by Emily: ‘I don’t rehearse what I am going to say beforehand, I just sort of think . . . I wonder (. . .) I wonder why we are going, and what we are going to discuss’. In contrast, others were more intentional and active in approach. It should be noted that these three participants showed less change or recovery – perhaps suggesting the relative importance of this theme.

Developing the self: Building confidence

Most participants talked about both building confidence in their own perspective and a stronger sense of self. This can be seen in the following quote from Simon: ‘Learning the importance of interacting with people and listening to what they say but not doing what people say (. . .) life’s not a rehearsal; it’s for real’. Here, we see the development of a sense of who he is, distinct from the narratives of others. He feels able to do what he, himself, ‘really’ feels.

There were indications of how the sessions impacted on the process of ‘developing the self’: ‘They reinforced (it) and gave you the confidence’ said Emily. While Deborah noted: ‘As you become more confident obviously you become less insecure and a lot of paranoia comes from insecurity’, demonstrating that increased confidence meant more security and fewer psychotic symptoms.

Changed emotional experience

Central to new positioning in the world was a 'changed emotional experience'. Illustrating the connection between self-identity and emotional experience, Charlie reported that, prior to the sessions, when she experienced heightened emotions she questioned her sanity: 'My emotions (...) they were all over the place ... I was extremely upset questioning myself ... thinking I'm going crazy'. Deborah said that sessions helped her 'get over the anger'. Emily pointed to the value of validation and normalization: 'they sort of cement emotions that you have as being all right ones to have'.

Balancing distance in relationships

This theme refers to the search for balance in their relationships between independence and support. For many, especially those living with parents at the time of psychosis, a normal developmental separation from parents had clearly been undermined by psychosis. Simon's account hints at this: 'I was quite close with my mum when I was younger but not so much later (...) she was trying to sort of comfort me and be a mum and I was trying to (...) break away from that'. Psychosis can interfere in the calibration of healthy measures of dependence and independence in a number of ways. For instance, as Simon reported, episodes of psychosis can bring about withdrawal: 'I just stopped going out, stopped talking to people and just found it really pained and I (...) went inside myself and stayed locked in my room'. This extract points to the importance of internal relations in psychosis and the difficulty of relating to others.

Sessions apparently enhanced families' ability to find a more comfortable balance between support and independence. As prior research suggests (Bonney & Stickley, 2008) this is key to recovery. Deborah eloquently described this when she said they were being '... supportive of each other and at the same time respect each other and the fact that I maybe need my space and the same with Mum and Dad'.

Tim, as we pointed out earlier, showed a different account of recovery. He reported continued withdrawal, (unlike the others, who reported this as characterizing their periods of psychosis): 'I've got more withdrawn, my health has deteriorated but I still enjoy life'. However, though less obviously advanced along the recovery path than others, Tim did report some measure of improvement.

'Looking at my future': Hope

This theme describes the beginning of hope, or, as Peter described it, 'looking at my future'. The experience of psychosis, as is common, either locked participants into their grim and painful present, or kept them stuck in unproductive circles of reflection on their past. Simon, recalling his period of psychosis, described being overwhelmed by his psychotic obsessions: 'It depended what the obsession was at that time ... it just sort of took over ... life just sort of got put back', highlighting the global impact of psychosis on their lives.

However, as Peter reported, over time, this changed: 'When I first came out of hospital I had no idea what was around the corner but now (...) I have built up a bit more confidence and (...) I don't feel as if I'm looking over my shoulder at my past (...) I'm not so worried about the place I'm in at the moment. It is really looking at my future and try and make a future for myself so just lately I have started a new job and I've started college'. Although fearful of looking too far into the future early on in

feeling better, participants described being able to look further ahead as confidence, acceptance, and a sense of their own responsibility increased.

Discussion

The three main themes identified through these service users' accounts have highlighted the value of certain aspects of a particular systemic approach, one that is blended with psychoeducation, in the recovery process for people with psychosis. These, broadly, encompass the following: the importance of sharing a containing space; of changing meanings through the vehicle of interactional conversations; and finally through these, of changing a sense of one's position in the world. The centrality of the interactional quality of the sessions is underscored.

The first theme, 'a shared containing space' shows the significance of bringing together family members in a safe environment. The second theme 'changes that create new meaning', points to the importance of interpersonal interactions in underscoring multiple viewpoints that can create a new individual perspective. The third theme, 'a new positioning within the world,' similarly implies recovery dependent on one's relationships with others and the wider context.

The 'shared contained space' theme included accounts of a strong therapeutic relationship and highlighted a sense of fairness and neutrality on the part of the therapist. This is consistent with prior research (Christensen *et al.*, 1998; Flaskas, Mason, & Perlesz, 2005); in addition, previous research has indicated the importance to family members of sharing the therapy experience (Campbell, 2004; Stanbridge *et al.*, 2003). Now this study expands this to show its value also to the service-user.

This study suggests support for elements of the FI approach employed in Somerset - with its use of both family management and family therapy techniques (Burbach, 1996). This could be seen by how they valued therapist neutrality, time spent developing an understanding of each other's perspective, or what we have named 'exploring multiple perspectives', as well as practical support and information sharing. In contrast to a study by Stanbridge *et al.* (2003) on family members' experience of FI, our participants placed less salience on receiving practical advice. Family members' needs might be different: that is, family members may feel particularly at sea in the face of managing psychosis. If so, gaining practical advice would be particularly important to them. In contrast, to those experiencing psychosis understanding themselves and gaining insight, knowledge, and social awareness would seem to be more pertinent.

Findings by Dilks *et al.* (2008) that the process of jointly 'building bridges to new observational perspectives' (p. 209) was the core of the therapy process underscores our present findings that achieving a new perspective - through the discussion of multiple ones - was critical. It also sits well with contemporary systemic theory, that is, that there are a plethora of 'truths', and self-understanding is best understood through understanding one's position within a web of interpersonal interactions (Goldenberg & Goldenberg, 2008). Similarly, the importance of achieving a 'therapeutic space' resonates with other findings from the Dilks *et al.* (2008) study: that is, that the regulation of the emotional pace of therapy, and its opening up of new possibilities for thought, feelings, or actions in the social world, were key to therapeutic change.

Elements comprising the possibility for a new positioning in the world, as described by the current study's participants, seem to reflect previous findings on recovery: development of self (Coleman, 1999); responsibility (Andresen *et al.*, 2003; Pitt *et al.*,

2007; Romme & Escher, 2000); balancing distance in relationships (Bonney & Stickley, 2008; Whitehill, 2003); and hope for the future (Perry, Taylor, & Shaw, 2007; Pitt *et al.*, 2007). Family sessions, with their interactional focus, are likely to have been especially pivotal for developing a sense of locating individual responsibility in mediating change to achieve that sense of 'new positioning'.

Indeed, participants' evolving realization of the role they needed to play in their own recovery was perceived as vital. Previous research indicates that shifting from external to internal locus of control through therapy is crucial to recovery (Andresen *et al.*, 2003; Harrow, Hansford, & Astrachan-Fletcher, 2009; Higginson & Mansell, 2008; Pitt *et al.*, 2007). Again, the family-interactional nature of the sessions may have been critical in this process. Increasing understanding and developing better communication may have yielded a more balanced sense of a position in relation to others, creating a shift from either excessive self-blame or external blame. Moreover, the valued 'shared contained space', through its management of emotional responses, could have given participants the experience of emotional management themselves: increasing, that is, their experience of internal control. Further, they reported an improved balance between independence and support (Bonney & Stickley, 2008) which also suggests more mastery of internal processes. This balance of independence and support may also have created more space to develop a balanced sense of responsibility. Each participant described their own journey to developing more autonomous - or more choice in how to conduct - relationships with their family, while still utilizing its supportive framework.

Those interviewees who reported less of an increase in their sense of personal responsibility were those who also put less emphasis on the role their families played in their recovery. This suggests that opening up to different perspectives/positions and being attentive to others - their effects on you, and your effects on them (or in other words, the systemic notion of 'circularity', Dallos & Draper, 2010) can be key to developing a sense of where personal boundaries, or responsibilities, may lie. That is, paying little attention to others when one characteristically makes attributions of control to them may mean that one is continually missing data that would disconfirm those attributions. In that way, a characteristic external, rather than internal, locus of control would be maintained through reduced attention to interactional processes.

Re-establishing self identity and finding new meanings during recovery seem to be pivotal (Andresen *et al.*, 2003; Repper & Perkins, 2003); meanwhile, Lysaker and Lysaker (2001) suggest that in psychosis people take a singular, all-incorporating self position. To be in a room with different people, all taking different positions, all being encouraged to explore their own position or viewpoints - all within a 'safe' place - can mean that the service-user can 'safely' take a variety of positions about himself or herself. Safety lies in trying these out and then taking steps to integrate the multiple ideas that consequently arise about oneself, and ways one has of behaving towards others, into a sense of who one *is*. Dilks *et al.* (2010) suggest that changes in the development of the self and meaning making are created through the conversational process of therapy. This seems to be what might be occurring for the present participants. This study highlights the family - the single most reinforcing social system - as a place in which this process can be grounded. Readjusting the internal voice of the service user through the reflections of other family members may adjust that service user's perspective of him/herself and his/her relation to the world.

Participants' accounts suggest that both 'containment' and the variety of viewpoints helped them build a new perspective about themselves. Moreover, these enabled them to better regulate emotions. Participants connected both their patterns of relating and

gaining new meanings with having an effect on how they could manage their emotions. This may be something of a rebuttal to the accusation that family therapy, favouring structure and meaning, has neglected the emotional experience of individuals (Carr, 2008). Past research has underscored the importance of emotional change (Christensen *et al.*, 1998; Heatherington, Friedlander, & Greenberg, 2005; Kuipers *et al.*, 2006); the fact that containment, 'the shared containing space', was so important in this study suggests that for people with psychosis such containment was essential to settling and managing emotional states. Though from this study it is not possible to determine which comes first, cognitive or emotional changes. Rather, conditions in the family sessions apparently provided an appropriate emotional climate for changes in patterns of relating, personal meaning, and emotions to take place.

Those participants less advanced in their recovery than others were those who also felt their therapists had not maintained impartiality, or 'neutrality'. It is not possible to tell whether their reports reflected real differences in neutrality across therapists or perhaps other factors, primary among these the participants' states of mind. There were differing levels of diagnosed paranoia within the group. However most participants had reported experiencing paranoia prior to family sessions. For some, then, assessing 'neutrality' would have been difficult. The question, of course, remains as to why some overcame paranoia - and were therefore more able to assess and also experience neutrality - while others did not.

Age is an important variable in adjustment to psychosis (Reed, 2008), and, in particular, may influence intervention outcomes (Haddock *et al.*, 2006). Participants had a wide age range (19-64); differences in their accounts may be at least partly explained by age. In fact, those participants (Tim, Emily, and Bob) whose accounts showed a less developed recovery process were the three oldest. Compared to the others, each had lived apart from their families for long periods; each had experienced a number of episodes of psychosis and held a wider variety of roles in which psychosis has become integrated. Perhaps the delay in receiving effective interventions has meant it is more difficult to separate their sense of who they are from their psychotic experience. The discrepancies between the older and younger participants' descriptions of recovery points to the importance of early intervention (Garety & Jolley, 2000), as the earlier you can change people's sense of themselves as recovered and part of their communities - in this case, their families - the better their outcomes. Despite their less robust outcomes, the three older participants did show benefits from family sessions: they felt supported to move on, gain new understanding, and build confidence. Subjective recovery, these interviews suggest, is not age-dependent. Beneficial interventions can be made available to all ages and stages (Kuipers, 2008). Moreover, given the subtle but evident variations in participants' reports, the road to recovery is idiosyncratic. Outcome measures need to be able to pick up on this diversity.

The degree of change the participants experienced was not directly proportional to the number of sessions they received. For instance, Deborah, who has been involved in family sessions for a relatively extensive period described substantial changes in herself and her relationships and portrayed a well-developed recovery story. In contrast, Bob received more sessions than any of the others, yet he described a less elaborated recovery. Moreover he placed relatively little value on the sharing of experience, in comparison to others who had experienced less sessions. It is possible that Bob was offered more sessions in order to both further develop his recovery story and his sense of a shared experience. His case may reflect that in some instances service-users may have limited

abilities for making such changes. Bob's case indicates that clinical practice could benefit from exploring the question; why is it that certain service users' recovery narratives are less developed, even when they are given increased numbers of sessions?

Limitations of present study

This is a retrospective study, with its built-in limitations: bias in recall and distortion of memory. Further, the pragmatics of time and access made interviewing during treatment or immediately after impossible, creating variability in the interval between end of therapy and interview. The gap for some was longer than for others. However this gave participants time to reflect on the impact of these sessions. What was lost in the memory of specifics was compensated for by the richness of how this experience integrated into their everyday lives and their recovery. While there was also variation in the number of sessions each participant received, it did not appear to create real differences in accounts.

Along with rich detail, the narratives also showed hesitancy, inarticulateness, and inconsistency, all consistent with previous findings on this client group (Perry *et al.*, 2007). But, just as Newton *et al.* (2007) reported, we also found that, given support, our participants could provide insightful, reflective stories. The present study adds to our knowledge precisely because it gives voice to a client group often overlooked for reasons of doubting their ability to speak for themselves. Indeed, the idiographic nature of IPA particularly allowed each individual's meaning to come forth clearly.

Implications for further research

Given the exploratory nature of IPA, these findings are not directly generalizable to the broader population of service-users in family sessions. Nonetheless, it points to further exploration into the proposition that the self is developed through constructing new perspectives. It also raises the research question: how individual therapy versus family therapy, both in their various forms, might be similar or different in their ability to help people who have experienced psychosis develop a more robust sense of self.

Several participants mentioned how isolated they had been, feeling 'different' - and that sessions had helped them re-socialize - the theme we identified, 'developing a new positioning in the world', points to this. The social discourse around 'difference' and 'normality' perhaps is central to the family discussions. The issue of stigma in 'psychosis' and diagnoses such as 'schizophrenia' (British Psychological Society (BPS), 2000; Dinos, Stevens, Serfaty, Weich, & King, 2004; Knight, Wykes, & Hayward, 2003) is hinted at in this study, though largely here unexplored. More research could usefully expand on how therapy deals with this.

Conclusions

The current research findings are limited to those involved in the integrated FI service, as delivered in Somerset, with limited generalizability because of the empirical limitations of the methodology. However, Smith and Osborn (2003) suggest that IPA lends itself to theoretically generalizable conclusions, partly through comparing them to other findings. The results from this study integrate well with previous research that shows the helpfulness towards recovery of interactional family sessions within a containing

therapeutic environment. This enables people with psychosis to explore a variety of different perspectives about the self and others, and about psychosis. The current study extends prior research by focusing on the service user: it highlighted how the sharing of a 'containing environment' with their family in therapy was important to support changing patterns of relating, opening up perspectives, and leading to new meanings. In turn, this enabled a more confident, comfortable positioning in the world for these service-users, and, ultimately, the development of a more integrated sense of self.

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Improving partnerships with families and carers in in-patient mental health services for older people: a staff training programme and family liaison service

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In spite of policies advocating the involvement of families in the care of mental health service users in the UK, there are few examples of initiatives to develop staff confidence and skills in partnership working. This article describes a whole team training initiative and family liaison service to promote family inclusive working on in-patient wards for older people in Somerset, UK. A three-day staff-training programme is described and training outcomes are reported. Staff report a substantial increase in confidence and family meetings held. A pre-and post- training case note audit shows increased consideration of the needs of families. To further increase face to face meetings with families a family liaison service has been established, whereby a staff member with systemic family therapy training joins ward staff to hold family meetings as part of the assessment/admission process. Evaluation of this service has shown it to be effective with positive feedback from families and staff.

Keywords: mental health; families; carers; older people; staff training; in-patient.

Introduction

Recognition of the needs of family members and carers of people who suffer mental health problems has received increasing emphasis in UK mental health policy and guidance over recent years. This is particularly true in relation to services for older people, where the need to work in partnership with families and carers has been well

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documented (Department of Health [DoH], 2009, 2006). Carers' rights to a needs assessment of their own, together with a written care plan, was established in the Carers' Act of 1995 and reaffirmed in the National Service Framework for Older People (DoH, 2001). Further policy guidance including Developing Services for Families and Carers of People with Mental Illness (DoH, 2002), Everybody's Business (DoH and Care Services Improvement Partnership, 2005) and the National Institute for Health and Clinical Excellence Guidelines for Dementia (DoH, 2006) have outlined how services for families and carers should develop. However, the Health Service Ombudsman (Abraham, 2011) and charitable organizations such as the Princess Royal Trust for Carers (Warner and Wexler, 1998) and the Alzheimer's Society (2009) have emphasized that further progress is required in involving families in their relatives' care. Joint working between NHS and charitable organizations has recently led to development of 'The Triangle of Care', a guide to best practice (Worthington and Rooney, 2010). We would argue that staff require further training to develop the skills and confidence to work in partnership with families and carers (Stanbridge and Burbach, 2004; Burbach and Stanbridge, 2008).

Needs of families and carers

UK national policy has been developed in the context of feedback from families and carers that their 'involvement in care is not adequately recognised and their expert knowledge of the "well person" is not taken into account' (Worthington and Rooney, 2010: 5). The stressful nature of providing care has received increasing acknowledgement, although caring for vulnerable older people can be simultaneously positive (rewarding) as well as negative (Lopez *et al.*, 2005; Robertson *et al.*, 2007). Carers, however, are much more likely to experience mental and physical health problems than the average population and caring can have an adverse effect on work, social activity and leisure, health and finances (Brodaty and Hadzi-Pavlovic, 1990; Coe and Van Houtven, 2009; Cuipers, 2005; Liu and Gallagher-Thompson, 2009; Pinquart and Sorensen, 2003; Schulz and Martire, 2004; Simpson and Benn, 2007; Singleton *et al.*, 2002).

Research studies (for example, Exel *et al.*, 2008; Leavey *et al.*, 1997; Pinfold *et al.*, 2004; Shepherd *et al.*, 1994), and carers' organizations (Age Concern, 2007; Alzheimer's Society, 2009; Rethink/National Institute for Mental Health in England/West Midlands Carers in

Partnership, 2003) have recommended ways in which mental health services can more effectively meet the needs of informal carers and families. What families would like from services includes being listened to and being involved in planning their relative's care and emotional and practical support, including respite care. In addition, they require information about diagnosis, treatment, services, benefits and whom to contact in an emergency. They also ask for advice on ways to respond to their relative and express a wish to develop additional coping skills.

However, most mental health professionals in the UK still complete their pre-registration training without specific skills training in working with families (Stacey and Rayner, 2008). This leaves staff lacking in confidence and ill-equipped to engage with families on the routine basis envisaged by national policy. In order to achieve effective partnership working comprehensive staff training programmes will be required.

Staff training programmes in in-patient services for older people

An extensive literature search revealed there were no training programmes specifically designed to develop the skills of working with families for staff working in older people's in-patient units. However, in the state of Victoria, Australia, the extensive 'Get together FaST' training programme in family-sensitive practice (Farhall, 2000) included an 'aged stream' alongside adult and Child and Adolescent Mental Health Services staff. This stream of 184 staff included some in-patient staff (17%) alongside staff from psycho-geriatric assessment and nursing home teams. This training was widely valued by staff and managers and led to some service improvements, together with increased awareness in staff, who regarded families as less difficult to engage than before training. However, it is interesting to note that the training did not lead to an increase in face-to-face contact between staff and families.

Training programme for staff in in-patient services for older people in Somerset

This staff training programme forms part of a trust-wide initiative that started in 2000. Following extensive consultation with a range of colleagues, service users and their families, we developed a strategy to enhance working partnerships with carers and families, which was

adopted by the Trust Board in December 2002 and updated in 2010 (Stanbridge and Burbach, 2004). This led to the development of a carers and families steering group and a trust-wide training programme (for further details see Stanbridge and Burbach, 2007a).

Staff training programme

Following awareness-raising sessions throughout the trust we have developed a three-day training programme in family inclusive ways of working which we are delivering throughout the mental health trust by means of a whole-team training approach, beginning with the acute in-patient wards (Stanbridge *et al.*, 2009). On completion of the training package in the five acute adult in-patient wards in the Somerset Partnership NHS Foundation Trust, the training was piloted on an in-patient ward for older people.

Pilot in services for older people. The pilot consisted of days one and two of the training package detailed in Table 1. A combination of professionally registered and non-professionally registered staff attended the 2 days. A staff survey completed on day 1 showed that most staff (93%; 27/29) had not received any formal training in working with families and would welcome further training. Few staff (28%; 8/29) recorded that they felt confident about their skills in working with families (a rating of 4 or 5 on a five-point scale) with a mean score of 2.93. An evaluation of the 2-day pilot found that the teaching methods had been appropriate for most staff (86%; 24/28, rating 4 or 5 on a five-point scale), with a mean rating of 4.3. All staff said that the material was appropriate to their needs and most staff (93%; 26/28 scoring either a 4 or 5) said they would recommend the course to colleagues, with a mean rating of 4.4.

A combination of experience from the acute adult in-patient staff training (Stanbridge *et al.*, 2009) together with this 2-day pilot study, led to the development of a 3-day training package for the remaining older people's wards. The structure of the package of training was similar to the acute adult wards, but the content was adapted to reflect the focus on older people.

The 3-day training programme was subsequently delivered on the two remaining older people's wards in the Trust. From an establishment of fifty-three staff from the two wards, 16 who were professionally registered and 22 who were not-professionally registered, representing 72 per cent (38/53) overall, attended days 1 and 2 of the

TABLE 1 *Three-day in-patient training programme*

Day One	<p>Carer's story and discussion.</p> <p>Research findings on family/carer views on mental health services and review of literature on caregiver burden.</p> <p>Introduction to national policy and Trust strategy for partnership working with families and carers, including exercises discussing current practice and personal/organizational obstacles.</p> <p>Focus on information sharing and confidentiality using best practice guidelines and case examples.</p>
Day Two	<p>Introduction to systemic thinking and interaction cycles (including case scenarios).</p> <p>Presentation by the carers assessment worker: assessments and resources for carers and electronic patient records demonstration.</p> <p>The initial family meeting (introduce format and role-play).</p> <p>Development of a ward action plan.</p>
Day Three	<p>Discussion of team progress and implementation of action plan.</p> <p>Constructing a genogram (family tree).</p> <p>The needs of children, including young carers video.</p> <p>Clinical discussion with examples from the group.</p> <p>Evaluation of the training</p>

training and 14 professionally registered and 19 who were not-professionally registered, representing 62 per cent (33/53) overall attended day 3. In all 58 per cent (31/53) of staff attended all 3 days; of those, 14 were professionally registered and 17 were not-professionally registered.

Team training on in-patient wards for older people. In order for staff to attend without closing the wards, the training was run twice on each unit with, where possible, half of the staff attending each time. Days 1 and 2 were provided consecutively to each group with day 3 taking place after a planned gap of a minimum of 1 month. The training took place on the first ward between April and June 2008 and on the second ward between July 2008 and March 2009. In order to involve as many staff as possible, day 3 was offered to staff on the second ward three times. A combination of staff attended the training, including both nursing staff who were professionally registered and those who were not professionally registered, together with ward and deputy ward managers and an activity organizer. The involvement of managers was significant, both in supporting the process and in operationalizing the action plans developed during the training.

Training approach

The training was provided by four of the authors who are all qualified systemic psychotherapists with a range of experience, including one author who had specialized in work with older people and another with many years of caring for a relative with dementia. The 3-day training package has been specifically designed to address staff attitudes, which has also been raised in other studies, for example, Kim and Salyers, (2008). Whereas some staff welcome the shift to more family-oriented services, it is still the case that others feel vulnerable in the face of emotionally distressed relatives and defensive in the face of possible criticism (Walker and Dewar, 2001). Some staff may not appreciate the disempowerment felt by families when their relative is admitted to a psychiatric hospital or the stresses involved in caring. There is thus a need to discuss with staff members the benefits of involving families and carers and to explore their attitudes and beliefs in relation to this. In this we have noticed some 'cultural' differences between adult and older people's wards. Whereas our experience in adult services is that staff do not have a history of routinely making contact with families, staff in older

people's wards tend to describe contact, although not in formal meetings, with families as a regular and expected part of their work. We have found that involving carers in the provision of training is an effective way of addressing the required shift in attitudes (Stanbridge and Burbach, 2007b).

Each of our training courses starts with a family member telling their story. We encourage people to talk about both good and bad experiences of services but specifically ask them to comment on events leading up to contact with services, such as their first experiences and impressions of the services and in-patient unit; their subsequent impressions and experiences; whether they felt included by staff; the quality of their communication with staff and any recommendations they might have. This is followed by a discussion of the research findings into families and carers views on mental health services and the literature relating to caregiver 'burden'. The training also focuses on helping staff extend their commonly held client-centred values and therapeutic skills to working with families. The qualities of empathy, warmth, genuineness and a non-judgemental approach also make up the therapeutic stance required to develop collaborative working partnerships with families and carers. In addition, the training explores the challenging practical and theoretical implications involved in making services truly family and carer friendly. We have found that a useful exercise is to ask staff to consider (individually and in groups) what personal and organizational obstacles stand in the way of family-inclusive practice (Kaas *et al.*, 2003). This allows the trainers to empathize with their difficulties and then facilitate the group to find solutions. In addition, the course specifically addresses the subtleties concerning confidentiality and information-sharing, as this is often raised as an impediment to working in partnership with families (Clarke, 2004).

The three-day training includes a combination of brief didactic presentations and group exercises (see Table 1 for content of in-patient training programme). Although a focus on attitudes is necessary, it is not in itself sufficient for behavioural change, and we therefore emphasise the development of team action plans (which are followed up on day three) together with some skills training. The afternoon on day two is largely devoted to an extended role-play of an initial meeting with a family. We encourage all staff to take turns in interviewing the role-play family, using an agreed format and with intensive support from the trainers (see Table 2 for meeting format). In addition, we introduce other techniques such as genograms (family

TABLE 2 *Initial family liaison meeting*

Aims	<p>To create a rapport with the family.</p> <p>To identify and value the role of the family, and to encourage the maintenance of family relationships.</p> <p>To create a platform for future collaboration (3-way partnership); including discussions around confidentiality and issues of risk.</p> <p>To develop a shared understanding/aims.</p> <p>To understand the context of the individual's problems.</p> <p>To provide information on services, support networks (including carers' assessment) and services.</p>
Content	<p>Contact details; small talk (for example, did you have to take time off work; occupations); rationale for meeting (working together; value family's expertise/knowledge); who is in the household/ family/friends? Plan for session.</p> <p>Who is in the family/social network and nature of their relationships/ involvement? Is there any history of mental health problems in the family?</p> <p>Family's account of development of client's problems:</p> <p>Initial onset of problems (what, when, triggers)</p> <p>How did family members respond (what helped/didn't help)</p> <p>Experience of (accessing) services</p> <p>Who else has been involved</p> <p>How have things developed</p> <p>How have they made sense of what has happened</p> <p>Information on client's interests and activities</p> <p>Impact of the problem on the family/family members.</p> <p>Expectations regarding treatment, including family's goals.</p> <p>Family members' attitudes to working collaboratively:</p> <p>Discussion around confidentiality and information sharing</p> <p>Families views on any risk issues</p> <p>Involvement in care planning process</p> <p>Provide information about support and practical help for carers including the offer of carer registration and a carer's assessment.</p>

tree) and caregiving genograms (Zarit, J., 2009). Learning outcomes for the training are reported in Stanbridge *et al.* 2009.

Introducing a systemic approach

The aim of our training strategy is not to train large numbers of staff to be family therapists, but rather to increase awareness of the needs of carers and families and to create more family-sensitive mainstream services. However, organizations also need to support the training of a smaller number of qualified systemic family psychotherapists in order to meet more complex and specialist needs. We have found that this group is also well placed to provide the training described in this programme.

Systemic thinking and practice, however, does inform the training package. For example, on the second day the group is introduced to systemic thinking and invited to consider relationships in families in a circular rather than a linear way. There is a range of systemic ideas which are relevant to working with families and older people (Curtis and Dixon, 2005; Fredman, 2010; Richardson, 1997) and there are benefits to teaching these to teams working with older people with mental health problems (Anderson and Ekdawi, 2010; Dixon and Curtis, 2005). In our training programme we have found the mapping of interactional cycles, which consider both beliefs and behaviour, to be particularly helpful. This provides a non-blaming way of looking at the patterns that occur in families and which may maintain problems (see also Charlesworth, 2006). These mutual feedback cycles can be used to illustrate how problems can become more entrenched or increase in severity. For example, in Figure 1, the clients' sister construes her assertions as 'nonsense' and, 'believing that she needs to be put back in touch with reality', confronts and corrects her. The client perceives this behaviour as an affront, feels defensive and restates her position more firmly. In the face of challenges and corrections from significant others, people with memory difficulties who confabulate from time to time may begin to cling on to these beliefs more and more strongly and may eventually express grandiose fabrications.

In the training we explore both helpful and unhelpful patterns of interaction between carers and the cared for. For example, reciprocal warmth may lead to positive reactions and a decrease in carer burden (Reid *et al.*, 2005). However, relationships may also become increasingly fraught and abusive (Cooper *et al.*, 2010). Research has

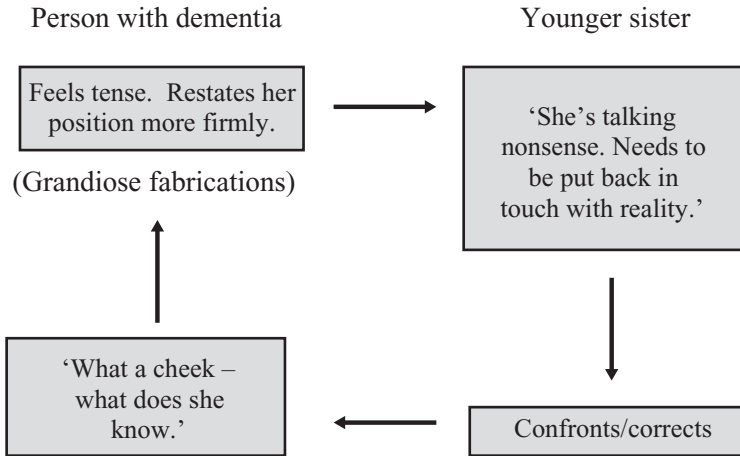


Figure 1. Interactional cycle: confabulation.

highlighted the significance of the quality of the prior relationship (Chesla *et al.*, 1994; Lopez *et al.*, 2005) and the subjective appraisal of care giving (Lawton *et al.*, 1991). This research can be elaborated and illustrated by means of our cognitive interactional format. For example, carers who feel that they cannot cope and are resentful of the burden of care may become increasingly anxious, depressed and angry. This may relate to factors such as the current behaviour of the cared-for relative and the current restriction in the carers' activity (Williamson *et al.*, 1998), as well as the nature of their prior relationship or attachment style (Browne and Shlosberg, 2006). This may become associated with escalating levels of abusive behaviour and neglect. Cared-for relatives may recognise they have become a burden, feel increasingly fearful and abandoned, and consequently become depressed and withdrawn. The problems associated with dementia may therefore become exacerbated, leading to the carer feeling more overwhelmed, hopeless and angry (see Figure 2).

We have also found this perspective useful in the supervision process as a way of considering the patterns that can develop between staff and families/their clients (see Figure 3). If concerned carers feel that their relative's clinical presentation is deteriorating and perceives the busy staff member as not caring they will, understandably, complain about or challenge aspects of the care provided. Such behaviour may be construed by the staff member/s concerned as unreasonable

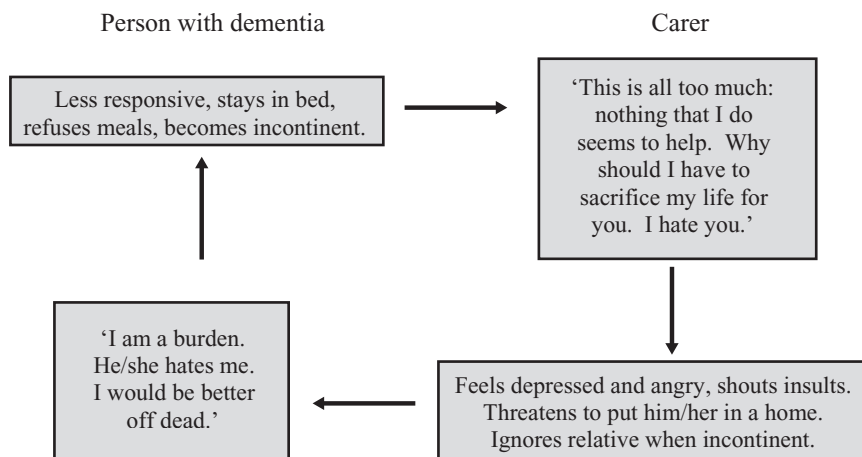


Figure 2. Interactional cycle: elder abuse.

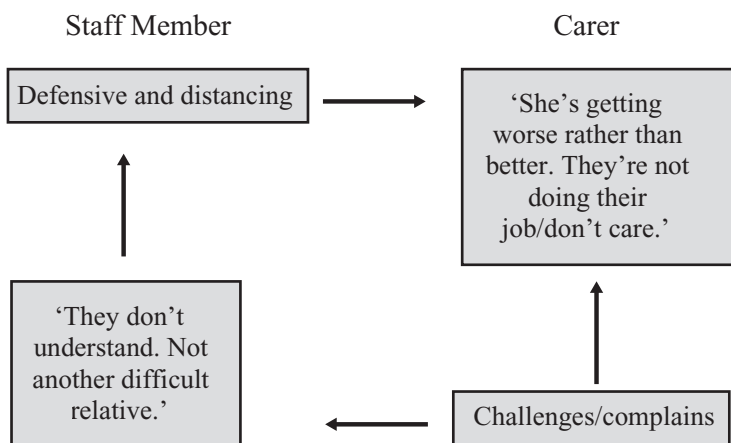


Figure 3. Interactional cycle: older people's ward.

('another difficult relative who doesn't understand'). Such beliefs lead to more defensive and distancing behaviour (Walker and Dewar, 2001) which in turn will reinforce the family members' perception that the staff are cold and uncaring. With their focus on each person's beliefs and behaviour, cognitive-interactional cycles provide a way of understanding each person's position, reducing blame and increasing

tolerance. Considering interactions in this way offers the opportunity for reflection on whether the patterns are helpful or unhelpful and what might be done differently.

Evaluation of training

The effectiveness of the training programme was evaluated in a number of direct and indirect ways, as discussed below.

1. Pre-training and post-training case note audit. We conducted an audit to examine the current practice of in-patient unit staff in recording information on seven specific areas relating to their work with carers and families. The first audit was undertaken immediately before the first 2-day element of the training and was repeated prior to the third day of follow-up training. It was then repeated 1-year post-training. In each case 10 current electronic case records were randomly selected by the Trust's audit department, representing 40 per cent (20/50) of overall case notes. The objective was to identify any changes in practice relating to working with families and carers since the initial two-day training (see Table 3).

This table reflects an improvement in the majority of the items audited: significant improvements were noted in the number of carers

TABLE 3 *Overview of two older people in-patient ward audits pre-training and post-training (per cent)*

	Pre-training	Post-training	1 year
Carer registered on electronic patient record?	25	45	45
Family or friends recorded in 'Contacts' on electronic patient record?	80	100	95
Reference in care programme approach to carer needs, roles or contribution to care (including: family history, support network, carer's views)?	65	95	85
Carer involvement in relapse prevention plan?	12.5	37.5	60
Any carer responsibility for issues identified as problems in the care plan?	35	25	25
Referral for carer's assessment?	10	30	25
Carer need identified in progress notes in electronic patient record?	85	85	95

registered and the number of carers' assessments. In addition, it is evident there was considerably more carer involvement in the relapse prevention planning. The one-year follow-up audit demonstrated that the improvements since the initial pre-training audit were largely maintained.

2. Staff survey. A survey was undertaken at the outset of the training on day one to gain baseline knowledge of staff training, experience and confidence in working with families. Most of the staff (89%; 34/38) reported that they had not received any training in working with families. A few of the staff (11%; 4/38) had some experience of working with families, ranging from a Thorn course to experience gained in a family therapy clinic during their professional training. Few staff (16%; 6/38) rated themselves 'confident' (rating of 4 or 5 on the five-point rating scale) in their skills in working with families and most of the staff (97%; 37/38) said they would like further training in this area. The survey also asked staff the number of times they had sat in a room with a family to discuss issues in the previous month. The survey was repeated for all staff attending the third day of follow-up training. Confidence in working with families had increased – those rating themselves as confident increased from 16 per cent (6/38) to 55 per cent (18/33) and the mean rating increased from 2.7 (range 1–5) to 3.5 (range 2–4) post-training. There was a substantial rise in the number of professionally registered staff rating themselves as confident (from 25%; 4/16 to 79%; 11/14) and this was reflected in the reporting of the more than doubling of meetings with families (mean number of meetings held prior to training 3.2, post-training 7.4). However, this did not occur amongst the staff who were not professionally registered. While the number of staff who were not professionally registered rating themselves as confident increased from 9 per cent (2/22) to 37 per cent (7/19), their participation in meetings held with families was largely unchanged (pre-training mean 2.5, post-training mean 2.3).

A comparison of the staff surveys from each ward highlighted some interesting similarities and differences. Although the mean rating given by staff relating to their experience of working with families was similar on each ward (3.4 and 3.6 for professionally registered staff; 2.4 and 2.7 for non-professionally registered staff), four members of staff reported having had previous formal training in working with families on the second ward. This may be reflected in the differences noted for the number of meetings held with family members reported

by professionally registered staff prior to the training package (mean score of 2.9 compared with a mean score of 3.4 on the ward where some staff had received prior training). There was a noticeable rise in the number of meetings held by professionally registered staff following the training on both wards, although this was more substantial on the second ward (the mean number of meetings held on ward one rose from 2.9 to 5.9 and on the second it rose from 3.4 to 9.3). In addition, there was an increase in the involvement of staff who were not professionally registered in family meetings on the second ward (pre 3.2; post 3.4), but a decline in their involvement in meetings held on ward one (pre 1.4; post 0.9). Lastly, the mean score relating to the self-reported level of skill and confidence in working with families of members of staff was very alike in both wards both before and following training (professionally registered staff mean scores increased from 3 to 3.8 and 3.1 to 3.8; similarly, the means of those who were not professionally registered increased from 2.6 to 3.3 and 2.5 to 3.2).

3. Action plans. At the end of day 2 the staff were asked to develop an action plan to take back to their wards from ideas that had been generated through the training. The following items were identified:

1. To include more information for carers in the ward welcome and admission pack.
2. To allow more protected time to meet with families and develop a 'meet and greet' policy for families and carers visiting units.
3. To make contact with the family, where possible, within 48 hours of the patient's admission.
4. To arrange family meetings within 7 days of admission and to include this on the admission checklist.
5. To liaise and make links with the carers' assessment workers.
6. To improve communication between the different ward, community and care home teams.
7. To develop and identify a unit 'family/carers champion' and family liaison role.
8. To increase the registration of families/carers on the electronic record system and, where appropriate, refer for a formal carers' assessment.

The action plans were reviewed on day 3 and it was evident that progress had been made on both wards. The staff reported that more families and carers were being asked about registering their details on the electronic patient record (EPR) and more carers' assessments were

being offered. On both wards they reported that there had been an increase in contact with families and carers. On one ward this has been achieved through telephoning families and carers following admission. On the other ward it was discovered that most families and carers visited the ward on a Sunday, the day on which the drug-ordering schedule was completed, resulting in fewer staff being available. By the third day of the training, the day for ordering had been changed, thus enabling more staff to meet families and carers. Similarly, information following meetings with families was being recorded on the EPR and both wards had identified a member of staff to act as the unit champion. However, progress was more limited with regard to conducting family meetings within 7 days of admission. Relatively few meetings had been held, reportedly due to staffing levels and shift patterns. Within a busy ward schedule the staff felt that protected time was needed in order to allow family meetings to take place. Although this could not be addressed immediately, the other action plan items were receiving active support from the ward and service managers.

4. Evaluation of the training package. The staff completed an evaluation form at the end of the second and third training days. The teams rated highly the usefulness of the course (mean of 4.3 on a five-point scale) together with the appropriateness of its content and teaching methods. Common themes from the free-text comments were a reported raised awareness of carers' needs, the importance of involving them in the clients' care and an increase in confidence when working with families and carers.

Reflections on the training programme

We have had extremely positive feedback both from within the organization from staff and management, and from representatives of carer organizations. Although the evaluation of the project might be criticized on a number of grounds – for example parts of the survey might have been affected by a reliance on memory and the audit sampled only 40 per cent (20/50) of in-patient case notes, we are encouraged to note that the measures all reflect the same trend to more family-inclusive ways of working. The older people's staff training programme achieved the learning outcomes of increased awareness and the development of basic skills, and produced a shift in attitudes in both staff who were professionally registered and those who were not. The case record audit indicated a significant change in staff practice,

highlighting substantial improvements in most areas following the training. The increase in the number of carers registered, family information recorded under the care programme approach and the referral of families for carers' assessments indicated that the staff were routinely holding families and carers in mind.

Similarly, the training had a positive impact on the confidence of both staff who were professionally registered and those who were not, as evidenced in the staff survey and comments made in the open-ended evaluation. While an increase in confidence was noted in all staff, a more visible development was apparent in professionally registered staff, which was further reflected in the number of face-to-face meetings held with families following the training. Interestingly, on one ward where four of the staff had received previous training in working with families, all staff were involved in more meetings with families, both prior to and following the training, compared to the other ward where no previous training had been received. This could imply that where staff had received training in family ways of working, these practices were already being disseminated to other ward staff, encouraging a more family-inclusive culture on the ward and reinforcing the link between training and increased contact with families (Kaas *et al.*, 2003; Kim and Salyers, 2008).

The team action plans demonstrated a commitment from ward staff to implement and maintain the skills and knowledge gained during the training. This was confirmed on the third-day of follow-up where progress in a number of areas had been made, including changes in ward procedures that had enabled an increase in the face-to-face and telephone contact with families and carers. A combination of the training and the subsequent action plans meant that the personal and organizational obstacles to family-inclusive practice identified by staff in the exercise on the first day of training (see Table 4) were successfully addressed or brought to the attention of the ward managers.

Training into practice

Although there have been positive changes in practice following the training we are aware that further progress will require ongoing training, consultation and organizational initiatives. To bring about more regular family meetings is a particular challenge. We are approaching this in a number of ways. Following consultation within the Trust we have established best practice guidelines (available from

TABLE 4 *Personal and organizational obstacles*

Personal
Lack of experience, training, knowledge and confidence
Concerns about family expectations and dynamics
Concerns surrounding information-sharing and confidentiality
Untrained staff raised questions surrounding the boundaries of their role
Organizational
Lack of time, appropriate meeting place and resources
Staff shift patterns and the pressure of the workload

the first author) that specify that families should be involved in the assessment process and a family meeting held within 7 days of admission. We have also developed the role of ward champions to promote family-inclusive working and have appointed a family liaison specialist (Carter, 2011) to support staff in carrying out family assessments in all our wards for older people.

Family liaison service

Although the training programme has resulted in positive changes in staff confidence, clinical practice and more families being seen, it did not lead to all families being routinely involved in the assessment process. In order to address this we have developed a family liaison service and established a family liaison specialist post to work alongside ward staff to hold meetings with families and carers as part of the admission process. This post provides 1 day a week to each of the three older people's wards. By providing extra time from a member of staff who has a systemic family therapy training and experience of working with families to work alongside in-patient staff it was hoped that more family meetings could be held within 7 days of a patient's admission. It was also hoped that this would increase the confidence and skills of staff in working more closely with families.

The family liaison service was initially piloted on one of the acute adult in-patient wards and resulted in a significant increase in face-to-face meetings between staff and families (Carter, 2011; Stanbridge *et al.*, 2009). It has now been successfully implemented on four acute and three older people's wards with the provision of 1 day a week of specialist time on each ward. Feedback from families attending meetings has been very positive (Gore and Stanbridge, 2011) and semi-structured interviews with staff also report their positive experience of

meetings (Rapsey and Stanbridge, 2009). For a full description of the family liaison service and an evaluation of its implementation on all adult and older people's psychiatric wards in Somerset see Stanbridge (2011).

The service has now been operating on two older people's wards for 12 months, with encouraging results. On one ward, out of sixty-two admissions over 12 months, 79 per cent (49/62) of families were offered a meeting. This figure rises to 89 per cent (49/55) when admissions where there was no family available are excluded. Thirty-five meetings were held representing 63 per cent (35/55) of admissions where a family was available.

On the second ward, out of 141 admissions over the 12 months, 65 per cent (92/141) of families were offered a meeting, rising to 71 per cent (92/129) when admissions where there was no family available are excluded. Seventy-one meetings were held representing 55 per cent (71/129) of admissions where a family was available. For case examples and discussion of family liaison meetings in both adult and older people's services see Leftwich *et al.* (2011).

Meetings were not always possible within the goal of 7 days; however, seventy-nine per cent of meetings were held within 14 days of a patient's admission. In most (61%) of these meetings the family liaison worker was joined by another member of staff, including nursing, occupational therapy and medical staff. The goal of holding a meeting within 7 days of a patient's admission is now an established part of the care pathway. It has been included in the admission checklist and is auditable by means of a specifically created screen in the EPR.

Conclusions

Our training programme and family liaison service have led to staff having more direct involvement with families and carers and developing a greater appreciation of their needs. By working more collaboratively with families staff make it possible for families to receive both practical and emotional support together with the information they require in order to cope effectively.

For most families routine involvement in the initial assessment and admission process can form the basis for a successful ongoing three-way partnership between service users, families and professionals. However, some families may also benefit from more focused family-based approaches involving problem-solving or systemic

interventions, in particular in order to access appropriate support systems and where family dynamics have become problematic (Richardson, 1997; Zarit, S.H., 2009).

We have found that the combination of staff training together with a new family liaison service initiative has successfully enabled increased partnership working. There have been a number of key elements in this process. Providing training to the whole team has been important in facilitating the development of a family-inclusive team culture. The involvement of family members and carers in providing the training has positively affected staff attitudes and has ensured that the experience of the family remains central to the training. Our experience has been that follow-up initiatives in the form of action plans, audits, top-up training, supervision and consultation, and the availability of specialist family therapy and carers assessment services have also been essential. In addition, the introduction of systemic ideas, including interactional cycles, has been helpful in providing teams with frameworks for understanding and supervision.

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Chapter 9

Towards the systemic understanding of family emotional atmosphere and outcome after psychosis.

Frank Burbach

There is compelling evidence for the importance of family emotional atmosphere in determining the course of psychosis, but considerable debate about the theoretical underpinnings of research in this area, and their clinical implications.

The most influential body of literature derives from the research using the “Expressed Emotion” rating scales. This measure of emotional atmosphere has been used in a large number of research studies, including randomised controlled trials of family interventions, and has contributed to the widespread recognition of the need to involve relatives in mental health services and to offer formal family interventions. Unfortunately, the focus of the research effort on relapse has led to a widespread, over-simplified perception of expressed emotion (EE) as a unidirectional, binary concept.

Despite a number of useful reviews, casual browsing of the current EE literature can quickly lead to confusion, due to the range of research studies exploring different facets of EE and their relationship to other concepts. EE is increasingly recognised as reflecting interactions between the person with psychosis and their relative/care-giver, but relatively little use has been made of systemic theory to guide research in this area. However, two recent research foci - coping styles and appraisal processes - have brought EE research and systemic theory within touching distance. This chapter will focus on the more recent research, which could help to develop a systemic, and specifically cognitive-interactional, formulation of family emotional atmosphere and outcome after psychosis.

“Expressed emotion” – The original studies

The “Expressed Emotion” (EE) rating scales were developed in the course of three research projects in the 1950’s and 60’s by George Brown and colleagues investigating family relationships associated with relapse.

The first study appeared to show that patients with schizophrenia were more likely to relapse if they returned to live with parents or wives, whereas those with other disorders appeared to do better on their return to live with the family. The second study found that ratings based on the relatives’ comments effectively predicted deterioration in the patient’s clinical state in the follow-up period, while ratings based on the patient did not. They also found that low face-to-face contact could be protective for those returning to “highly emotionally-involved” homes. In the third study, a structured interview schedule, the Camberwell Family Interview (CFI) was used with parents while patients were still hospitalised, and was repeated 9 months after discharge; when 35 out of 101 people had relapsed. The audiotape of this interview was rated on five subscales (criticism, hostility, emotional over-involvement (EOI), warmth and positive comments), taking into account both the content and tone of the comments.

In order to simplify the analysis, the three scales most clearly related to relapse (criticism, hostility, EOI) were combined into a single index of EE and relatives assigned to either a High-EE or Low-EE group. This combined index of EE gave a better prediction of relapse than any individual component: 58% of patients returning to High-EE relatives relapsed, compared with 16% discharged to Low-EE homes.

Warmth was also related to relapse, but had complex interrelationships with the other scales. Those rated low in warmth also tended to be highly critical, whereas those high in warmth tended to be associated with over-involvement. However, if relatives showed considerable warmth without criticism or over-involvement, patients did very well (9% relapse rate).

The findings of an independent, small-scale replication study (Vaughn & Leff, 1976) were remarkably consistent with the original study (Brown et al, 1972), which allowed the results to be combined to explore the interaction between medication, the family environment, contact with relatives and relapse rates. While these findings suggested that either low face-to-face contact or regular maintenance on medication gives a measure of protection in a High-EE environment, the role of medication in Low-EE environments was unclear. However, the aggregate analysis of data from 25

studies by Bebbington and Kuipers (1994) indicated that medication reduces the relapse rate for those living with High- or Low-EE relatives (see Fig.1). An additional analysis confirmed that high contact with a High-EE relative increases the risk of relapse but indicated that high contact with Low-EE families may be protective.

SEE FIG.1 BELOW

The current status of EE

The predictive validity of the expressed emotion index in a range of settings has been confirmed by numerous studies, with few negative results. Following their meta-analysis of 26 studies, Butzlaff & Hooley (1998) concluded that EE was now established as a robust predictor of schizophrenic relapse (High-EE relapse rate = 65%; Low-EE = 35%) and suggested that further replication studies were no longer required. Research has also confirmed that EE is significantly associated with relapse in depression (with particular sensitivity to criticism by partners) and in a range of other mental health problems, including bipolar disorder, anorexia, post-traumatic stress disorder and childhood psychological disorders. Research is required in all of these areas in to corroborate these findings (see Wearden et al, 2000, for a review of EE research with both psychiatric and medical conditions).

Throughout the past four decades, EE has thus proved a popular research tool due to its predictive validity. However, researchers have also struggled to define its meaning and construct validity.

Construct validity

A key question has been the construct validity of the EE ratings. There was an assumption that the attitudes expressed by relatives reflected their behaviour towards the person with schizophrenia, but this was not confirmed until a Californian research team (Valone et al, 1983), found that parents who expressed attitudes rated as 'High-EE' were significantly more critical in face-to-face interactions with their disturbed, but non-psychotic adolescent children.

This research team has also conducted the first study supporting the construct validity of EE with people diagnosed with schizophrenia (Miklowitz et al, 1984). EE was rated at the time of hospitalisation and followed with two family discussions

approximately 2 weeks after discharge. These were rated on dimensions of Affective Style: critical statements (benign or harsh) and neutral-intrusive statements (implying that the parent has a special insight into their child's attitudes, ideas or emotions). This study confirmed that High-EE parents (N=34) made more negative affective statements than Low-EE parents (N=28) in the interaction task. When parents rated as highly critical were compared with those rated as highly emotionally overinvolved (EOI), the former tended to make more critical comments during interactions, whereas the latter used more intrusive, invasive statements.

Using a more detailed family-interaction coding system Hahlweg et al, (1989), found that High-EE critical relatives were characterised by a negative interactional style – more negative non-verbal affect, criticism and negative solution proposals - than either Low-EE or High-EOI relatives when discussing an emotionally-sensitive family problem with the patient. The latter groups also made more overtly positive and supportive comments than did the High-EE critical relatives.

So what is EE measuring?

Although the construct validity studies reviewed above confirm that the attitudes expressed by relatives do reflect their behaviour towards the person with schizophrenia, it still remains a challenge to describe what EE is measuring.

In a further analysis of their data, Vaughn & Leff (1981) have identified four characteristic attitudes and behaviours that tend to distinguish relatives who are highly critical or over-involved from those who are not (see Fig.2). Their content analysis indicated that high-EE relatives were significantly more likely to take an unsympathetic view of the illness, exert “considerable pressure on the patient to behave as a normal individual might be expected to act” (p44); and drew attention to the centrality of illness appraisals.

SEE FIG.2 BELOW

A Critique of EE

An originator of the field, Julian Leff (1989), has acknowledged that it was “unfortunate that the general term Expressed Emotion was applied to (the) index” (p135) as it has led to assumptions that any emotional expression by a relative is harmful to the person with psychosis. Leff reviewed the psycho-physiological

evidence that Low-EE relatives may be “providing active emotional support which enables the patients to habituate to an arousing situation” (p135). If the ‘warmth’ scale had not been excluded from the EE index, or other positive scales such as ‘compassion’ or ‘tolerance’ had been included, then the research effort may have had an equal emphasis on resilience or recovery. Unfortunately the index focussed research on the negative impact of relatives’ attitudes to the person with psychosis.

This linear causal perspective on EE has predominated; despite Brown et al (1972) recognising that EE reflects “a quality of relationship with a particular person (the patient), not a general tendency to react to everyone in the same way” (p246). Unfortunately, relatively few studies have involved a two-way examination of this process within the particular relationships. Furthermore, it has been a relatively recent development to view EE as a normal coping strategy and developmental process, rather than a pathological one. It is also unfortunate, that the patient’s construal of his/her parents remains under-researched, despite literature reviews recognising that the way “High-EE is perceived by the patient, and how the stress is translated into florid symptoms” is a gap in our understanding (Kuipers and Bebbington, 1988:905).

Studies involving direct observation of family interactions

The Californian researchers have studied the reciprocal influencing processes between parents and children with recent onset schizophrenia.

Miklowitz and Strachan et al (1989) found that families rated as High-EE (critical) used many more harshly critical statements in direct interactions than those rated as critical initially, and later as Low-EE or emotionally over-involved. They also found that the patient’s coping style was not related to their clinical attributes, but rather to the relatives’ interactional affective style and their pattern of EE attitudes. Interactions involving consistently Low-EE relatives featured tolerant, low-key exchanges, with a low rate of criticism; neutral behaviour by relatives; and autonomous statements by patients. In contrast, consistently High-EE attitudes were associated with reciprocal levels of criticism by both parties.

Subsequent studies found that, when discussing emotionally-loaded family problems, it made no difference whether the patient or parents instigated a negative sequence. High-EE families were characterised by patterns of ‘attack – counterattack’ (criticism followed by returned criticism) and ‘attack – justify’ (e.g. parent criticises,

patient makes excuses). In other studies, the Californian group has shown that such patterns are apparent in verbal content and non-verbal behaviour and therefore conclude that these are transactional patterns that are “reciprocal and systemic in nature, rather than linear and unidirectional, as was the original EE concept” (Strachan et al, 1989: 180). In Rosenfarb et al’s (1995) study High-EE relatives were more likely to respond critically to the first unusual thought verbalised by the patient; and this, in turn, evoked further unusual thoughts.

This work has resulted in the widespread acknowledgment that EE is best understood as an index of a transactional process. Tarrier (1991) concluded that these results “... argue against a trait model of EE, and support a conceptualisation of EE as representing coping and response styles that develop over time and interact with patients’ behaviour” (p321). Hooley (1985) similarly concluded “EE is a complex measure reflecting the interaction between a patient and a relative at a particular point in time” (p137).

Studies of relatives’ coping behaviours and attributional styles

Two particularly fruitful research avenues shed further light on aspects of the family atmosphere measured by the EE index – coping and attributions.

Greenly (1986) reanalysed Brown’s original data set and found that families who expressed fear and anxiety about the patient were more likely to express high levels of criticism and over-involvement, and that this behaviour changed depending on whether the family attributed the patient’s behaviour to a ‘real’ illness or not. EE may thus be described as a coping behaviour and a form of social control. Hooley (1985) reached a similar conclusion from an attributions perspective: “High-EE relatives may ... be individuals who attempt to cope by trying to exert control over what may actually be uncontrollable behaviour in the patient” (p134).

Birchwood and Cochrane’s (1990) study of the coping behaviours of family members found that ‘coercion’ was more commonly adopted when dealing with a relative with low social functioning. Another small study (Raune et al, 2004), investigating carer appraisal in first episode psychosis, found that even at this early stage, 43% of relatives had high levels of EE linked to increased levels of subjective burden, avoidant coping (disengagement and substance use) and perceived poor interpersonal functioning in patients. As a result, High-EE criticism or EOI have come to be conceptualised as forms of maladaptive coping. Furthermore it is now

clear that, despite any objective differences in symptom severity, High- and Low-EE relatives appear to differ in their beliefs about the individual with psychosis and the problem behaviours associated with their illness.

In their comprehensive review of the field, Barrowclough and Hooley (2003) reported that all studies to date confirmed that criticism and hostility in relatives reflected their underlying beliefs that the person could do more to control their symptoms and problems, and that their failure to do so was due to some specific quality (e.g. a habit or trait) that was unique to him/her.

It is interesting to note that, from an attributional perspective, high EOI relatives are very similar to relatives rated as Low-EE. There is a tendency for high EOI relatives to make even fewer blaming attributions than Low-EE relatives, and to make significantly more attributions implicating illness as the sole cause for the patient's problems.

Importantly, a few studies have also found that the more family members viewed ill relatives as having control over their symptoms and behaviour, the less likely they are to express warmth. Further research into the reflexive capacity of relatives and attributive processes related to sympathy and compassion may be theoretically and clinically important. Two other findings in this literature are interesting: Hostile relatives identify fewer causal attributions (Brewin et al,1991), i.e. they simply blame the patient, which appears to indicate the importance of helping families to develop multifaceted causal explanations. In High-EE dyads there was a greater discrepancy between the illness models of schizophrenia held by patients and relatives, with the relatives having a more negative model of illness than the patients (Lobban et al, 2006). The authors note that this implies the need for a systemic approach, focusing on both the patients' and relatives' beliefs, and the discrepancies between them.

Patients' perceptions of their parents

Although largely ignored in the EE literature, there is some evidence of the effect of the perception of parents on the course of illness. Warner and Atkinson (1988), using the Parental Bonding Instrument (PBI), demonstrated that the manner in which patients remember their parents' care and protection in the first 16 years of life was associated with varying severity of illness. Those who perceived their parents positively, and were in frequent contact with them, experienced a better outcome. The

opposite was true for those who perceived their parents negatively. Scott et al (1993) used the Family Interpersonal Perception Test (FIPT) to simultaneously assess how family members see themselves and each other, and how they think family members see them. Parents' and patient's views of each other were more negative in those with worse outcome, but of particular significance was how patients expected their parents to see them. They concluded that this revealed "patterns of interaction in which the patients' role in outcome is at least as important as that of the parents" (p62).

An interactional view of family emotional atmosphere

Any understanding of the family emotional climate and outcome after psychosis has to take into account the interactional processes partially measured by the unidirectional EE index. In addition, appraisals, affect and behaviour need to be considered. Unfortunately, many clinicians are still reliant on the original research manuals and are not aware of recent developments in the field. However, some therapists have overcome problems inherent in the earlier linear psycho-educational approaches by integrating systemic family therapy and psycho-educational family management (Burbach and Stanbridge, 1998, 2006; Meddings et al, 2009), and have made particular use of Circular Questioning – therapeutic questions which reveal relationships between members of a family. Many contemporary systemic therapists also adopt constructivist or social constructionist approaches, exploring how people use language in a way that shapes and defines appraisals. There is a particular interest in the way in which family members both construe one another, and behave in a way which is coherent with that construction; and how the actions of each validate or invalidate the other's construction of their relationship. These elegant approaches are therapeutically useful and compatible with the emerging literature on appraisals, interactions and family emotional atmosphere.

Although their classic cognitive-behavioural family interventions text (Barrowclough and TARRIER, 1997) has not been updated, Barrowclough and Lobban (2009) presented a format for the formulation of problem behaviours in the context of family interactions, reflecting the more recent research on appraisals and interactions. They describe their approach as a 'basic family CBT model' of 'linked vicious circles' with behaviours of one person triggering thoughts/beliefs, feelings and behaviours of another. Their joint formulation diagram mirrors the earlier work of Harry Procter (1985, 1987) who integrated George Kelly's personal construct therapy

and systemic therapy. His bow-tie diagram and interview format link “the individual processes of meaning making to the delicate social ecology of intimate personal relationships that sustain them” and is “particularly useful as a means of clarifying complex interactive sequences in conflicted couples and families, and in suggesting a road map for intervention” (Neimeyer, 2009: 41). A simplification of this diagram is used in the ‘cognitive - interactive approach’ (Burbach, 2000) developed in the Family Interventions Service in Somerset.

This ‘cognitive-interactional’ diagram can be used to illustrate the patterns of interaction commonly described in the EE literature (see Fig. 3).

A complementary pattern of interaction is likely to become increasingly entrenched over time. The more frustrated, critical or intrusive the parent becomes, the more the young person feels overwhelmed and hopeless, and consequently does less and withdraws. Sustained or increasing inactivity and withdrawal strengthens the parents’ belief that their child is lazy and results in increased attempts to control their behaviour through criticism or intrusiveness.

In behavioural terms, these processes can be described as intermittent reinforcement of the parents’ behaviour (e.g. the young person sometimes complies with demands) and negative reinforcement of the young adult’s behaviour (e.g. withdrawal reduces exposure to parental criticism). In systemic terms, the family members could be described as being caught up in a pursuit – withdrawal cycle.

SEE FIG.3 BELOW

Further detailed research will be required to clarify the common interactional patterns underlying family emotional atmosphere and their relationship to outcome after psychosis, but the Californian group has clearly described how High-EE (critical) relatives tend to become locked into chains of negative interactions with their offspring with schizophrenia. Critical relatives display more negative verbal and non-verbal behaviour, and less positive verbal and non-verbal behaviour. The patients in these interactions are themselves more critical of their parents, use more justifications for their behaviour, express more disagreements and display more negative non-verbal behaviour. In contrast, Low-EE relatives were able to break negative chains of interaction sooner and to adopt a more neutral, non-critical, facilitative stance. This was associated with more frequent use of autonomous

statements by the young person with schizophrenia and enabled more effective problem-solving by the family.

Miklowitz et al (1989) found that High-EE-critical families became locked either into symmetrical critical interactions or complementary interactions. Figure 3 illustrates the complementary pattern, in which the young person with schizophrenia is self-denigrating and appears to have internalised the criticism. A symmetrical pattern of mutual criticism is illustrated in Figure 4. The previous examples are of simple dyadic relationships. Young people with psychosis commonly receive different messages because various family members perceive them differently. A common example is illustrated in Figure 5.

SEE FIGS.4&5 BELOW

Causality and blame

One of the main difficulties with the EE research literature has been the definitive categorisation of families as either High-EE or Low-EE. As a result, minor changes in ratings may result in the re-categorisation of the family. In addition, the correlation of High-EE with relapse is commonly misunderstood by professionals as implying causation. The fact that EE ratings are based on the relatives' views of the patient, and that many professionals hold unsophisticated linear understanding of causation, has resulted in many families being labelled as "problem families" and being blamed for ongoing mental health problems in the patient (Hatfield et al, 1987). Such unidirectional models of understanding have predominated, despite Brown et al (1972) stating that they "cannot specify the direction of cause and effect, but the fact that a decrease in expressed emotion at follow-up accompanied an improvement in the patients' behaviour strongly suggests that there is a two-way relationship" (p255).

Although the initial research effort was devoted to proving the empirical link between High-EE and relapse (1 in Figure 6), subsequent studies have demonstrated that relatives' EE levels may, in part, develop as a result of prolonged contact with a poorly-functioning family member (2 in Figure 6). For example, in a cross-sectional study, Hooley and Richters (1995) found that relatives' critical comments were clearly related to the duration of the patient's illness, appearing to peak and stabilise just over three years into the illness.

Developmental view

More recently, EE has come to be seen as reflecting a normal developmental process of adjustment to the onset and development of a devastating illness. Consequently, EE measures the constantly changing, interactive, mutually reciprocal family relationships (3 in Figure 6). Studies examining the family emotional climate during the development of the first episode psychosis are beginning to shed some light on this developmental process. A study involving relatives of 30 people admitted for a first episode psychosis (Stirling et al, 1993) found that, while 13 out of 16 High-EE households (81%) contained at least one key relative with high emotional over-involvement at admission, only 4 out of 11 (36%) High-EE households were rated High-EOI at 18-month follow-up (mostly due to critical comments).

Another small-scale first-episode psychosis study (Patterson et al, 2005; see also Chapter 10, this volume) also found considerable variation in EE status over time, with 28% of relatives obtaining a different EE rating at 9-month follow-up. Loss appeared to be a major feature in EOI relationships for both relatives and patients, and was linked to subjective ‘burden’ of carers. At 9-month follow-up, loss had decreased in those changing from High-EOI to High-CC or Low-EE and the authors noted that “the results are consistent with Bowlby’s attachment theory, where EOI and coercive criticism may be understood as adaptive reactions to perceived loss” (p59). These developmental patterns can be represented as 4i and 4ii in Figure 6. (The coping and attributions literature is also summarised in Fig.6)

SEE FIG.6 BELOW

A recent study by McFarlane and Cook (2007) compared the components of EE in parents of young people experiencing attenuated psychotic symptoms and judged to be at high risk of psychosis (N=16) with two groups in which patients had a well-established disorder. The parents of the prodromal or high-risk group were found to be “warmer, less rejecting, less protective, and less fused with their child compared with parents of people with established cases of schizophrenia” (p194). The study also found significant positive correlations between duration of the prodromal phase and rejection and protectiveness, as well as a decrease in warmth. This suggests that expressed emotion, specifically EOI, develops out of parents’ initial concerns about the young person’s deterioration in functioning. They

hypothesised that “rejection and criticism emerge, on average, after chronicity develops and perhaps as family members begin to both lose hope and find themselves increasingly frustrated and unable to help the afflicted member of the family”, and suggested that “a better term might well be *expressed exasperation*” (p195).

Although contemporary theories about EE are no longer simple unidirectional ones, they still place an emphasis on the symptoms/problem behaviours of the child (e.g. Kavanagh, 1992). A truly systemic understanding would accept that such interactional cycles might begin so subtly that it is impossible to determine the person initiating the interaction. In some cases, this process would begin following the development of symptoms/problem behaviours in the young person, and in others the parental High-EE may result in such patterns developing from the earliest interactions with the newborn infant.

There may be many different developmental processes involved in “High-EE” and the onset or relapse of psychosis in those who have a predisposition to such symptoms. This does not imply that parental attitudes and behaviours, as reflected in the EE measure, are uniquely and ubiquitously associated with the onset of psychosis. It simply reflects the need to develop more comprehensive models regarding stress and vulnerability in psychosis. The Finnish adoption study (Tienari et al, 2004) has demonstrated that common family dynamics are implicated in triggering the onset of psychosis in genetically-predisposed individuals. They found that genetically at-risk adoptees, reared in families which had higher levels of criticism/conflict; constricted/flat affect; poor intergenerational boundaries; a chaotic family structure or unusual communication, were more likely to develop schizophrenia spectrum disorders, whereas there was no increase in such disorders among genetically-predisposed adoptees raised in healthier families.

Conclusion

In 1992, Birchwood and Shepherd commented that “the *precise* changes to the family interior that are the goal of family interventions are undifferentiated and scatter-shot in nature. This is not a criticism but an inevitable consequence of an empirical construct such as EE” (p311), and called for theoretical innovation. Fortunately, there has been considerable progress in exploring the nature of the family emotional atmosphere and its relationship with outcome in psychosis since this paper.

The original hypothesis of Brown et al (1972) was “that a high degree of expressed emotion is an index of characteristics in relatives which are likely to cause a florid relapse of symptoms, independently of other factors such as length of history, type of symptomatology or severity of previous behavioural disturbance” (p242). The initial research studies summarised in this chapter largely confirmed this hypothesis. However, subsequent studies have shown that EE is not the stable index it was once conceived to be, but is influenced by a range of variables. Interactional studies, in particular, clearly indicate that a more subtle developmental perspective is required to understand the processes creating High-EE and poor outcome as a variety of responses from relatives and the patient can contribute to the development of helpful or harmful interactional cycles.

Kuipers and Bebbington (1988) hypothesised three basic family EE patterns: 1) High-EE families that have difficulty with any stress, and remain High-EE at re-assessment; 2) families with effective coping strategies, who deal with all problems with little expression of negative emotion, and remain Low-EE; and 3) those who are usually Low-EE, except at times of extreme stress, such as an exacerbation of symptoms or re-hospitalisation, when they become High-EE. Most families probably fall into the third category, with the trauma related to the onset of psychosis and its treatment severely affecting the ability of the family to function effectively in multiple ways. These families can be described in systemic terms as “trauma – organised systems”. Families differ in their ability to meet the new demands imposed by the illness; with the result that in some cases their reactions protect against further episodes, and in others they contribute to the risk of relapse. Family members are often extremely concerned and stressed by the psychosis, and act with the best of intentions (eg. trying to maintain established patterns of interaction), but inadvertently reinforce dysfunctional behaviour. One can hypothesise about the various interactional patterns that evolve over time in the other groups of families identified by Kuipers and Bebbington (1988).

The initially Low-EE group may perhaps better be described in terms of four possible developmental trajectories: Some relatives adjust well to the new situation and continue to do so, remaining Low-EE; but many of those who are initially Low-EE become frustrated and critical (High-EE) over time. Other Low-EE families may be unhelpfully detached and cool, with such severely lowered expectations that they inadvertently reinforce a ‘sick (overly dependent) role’. These families may become

more detached with time (remaining Low-EE), but others may become critical over time (High-EE).

It is argued that the High-EE – High-EE group also can be better understood in terms of circular causality rather than unidirectional (linear) causality. Although many writers in the field have understandably focused on the family emotional climate associated with relapse, rather than on similar factors associated with the onset of psychosis, it is possible to place this small research literature in the same theoretical framework. There are clearly a minority of families where the parents, perhaps due to their own attachment difficulties or mental health problems, are unable to cope with stressful life-cycle transitions such as having a child. As the Finnish adoption study has demonstrated, children raised in families that function in a range of suboptimal ways might be at higher risk of psychosis. Systemically oriented family interventions may involve the exploration of the onset and subsequent development of psychosis in terms of reciprocal interactions. This would include validating parental perceptions that ‘something was not right’, and their attempts to positively influence their child’s behaviour. In addition it would include the recognition that children, who have increased vulnerability to psychosis due to a range of psychosocial stressors and their genetic inheritance, may well be adversely affected by inappropriate parental over-involvement, poor communication, criticism etc.

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Figure 1: Four characteristic response styles (Vaughn & Leff, 1981)

Low-EE relatives	High-EE relatives
1. respect the patients' desire for social distance	1. are highly intrusive, "making repeated attempts to establish contact or to offer unsolicited (and frequently critical) advice" (p43)
2. are not overly anxious and able to exert a calming influence when family members are distressed	2. respond with anger and / or acute distress (which relatives recognised tended to upset the patient further)
3. take the view that the patient is suffering from a legitimate illness	3. doubt that the patient is genuinely ill and blame them/ hold them responsible for their for their difficulties
4. are tolerant of disturbed behaviour and long term social impairment	4. are intolerant of symptom behaviours and low performance

Figure 2: Percentage Relapse according to EE, Contact and Medication status from Bebbington and Kuipers' (1994) aggregate analysis

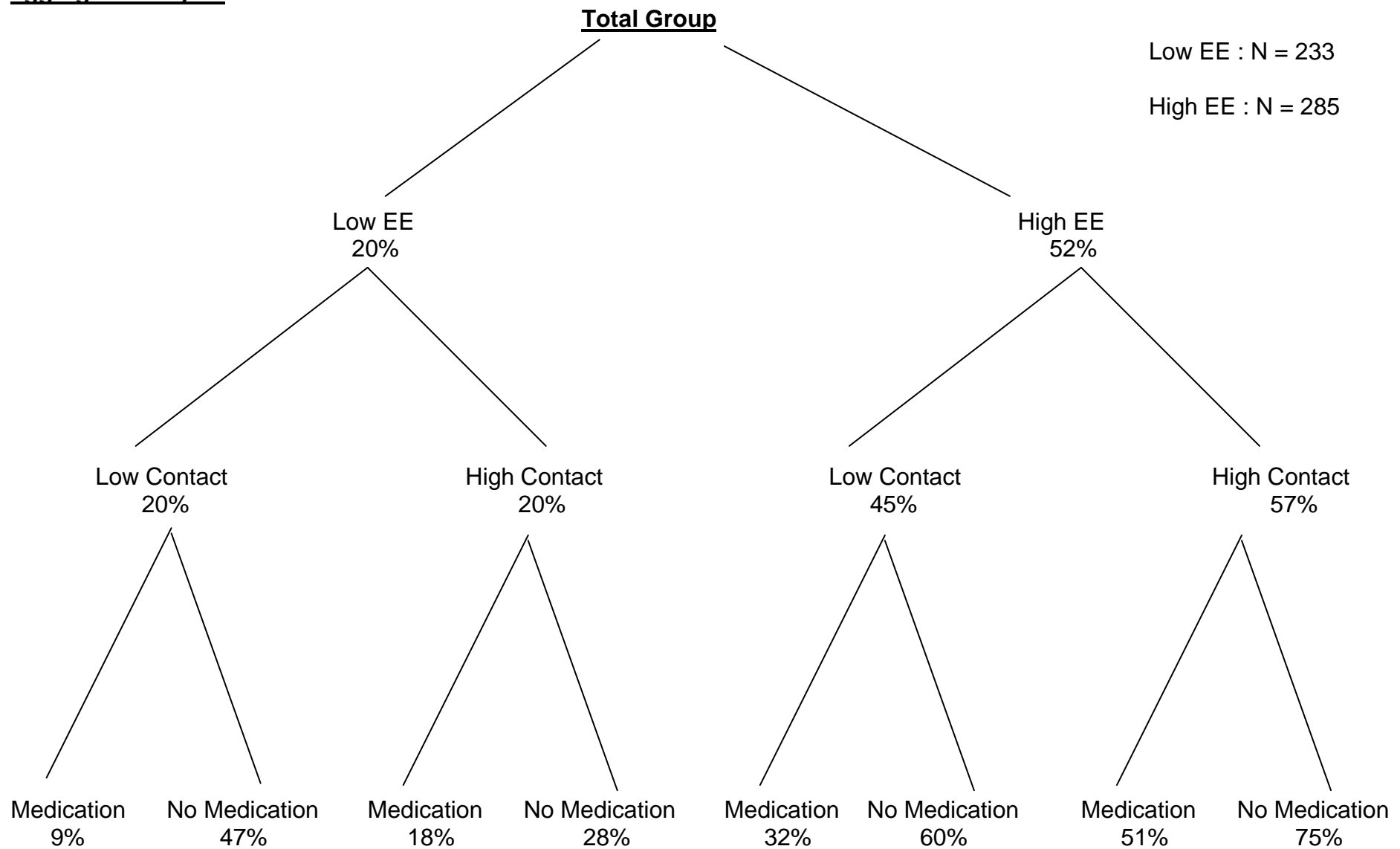


Figure 3: A cognitive – interactional diagram of a complementary transactional pattern

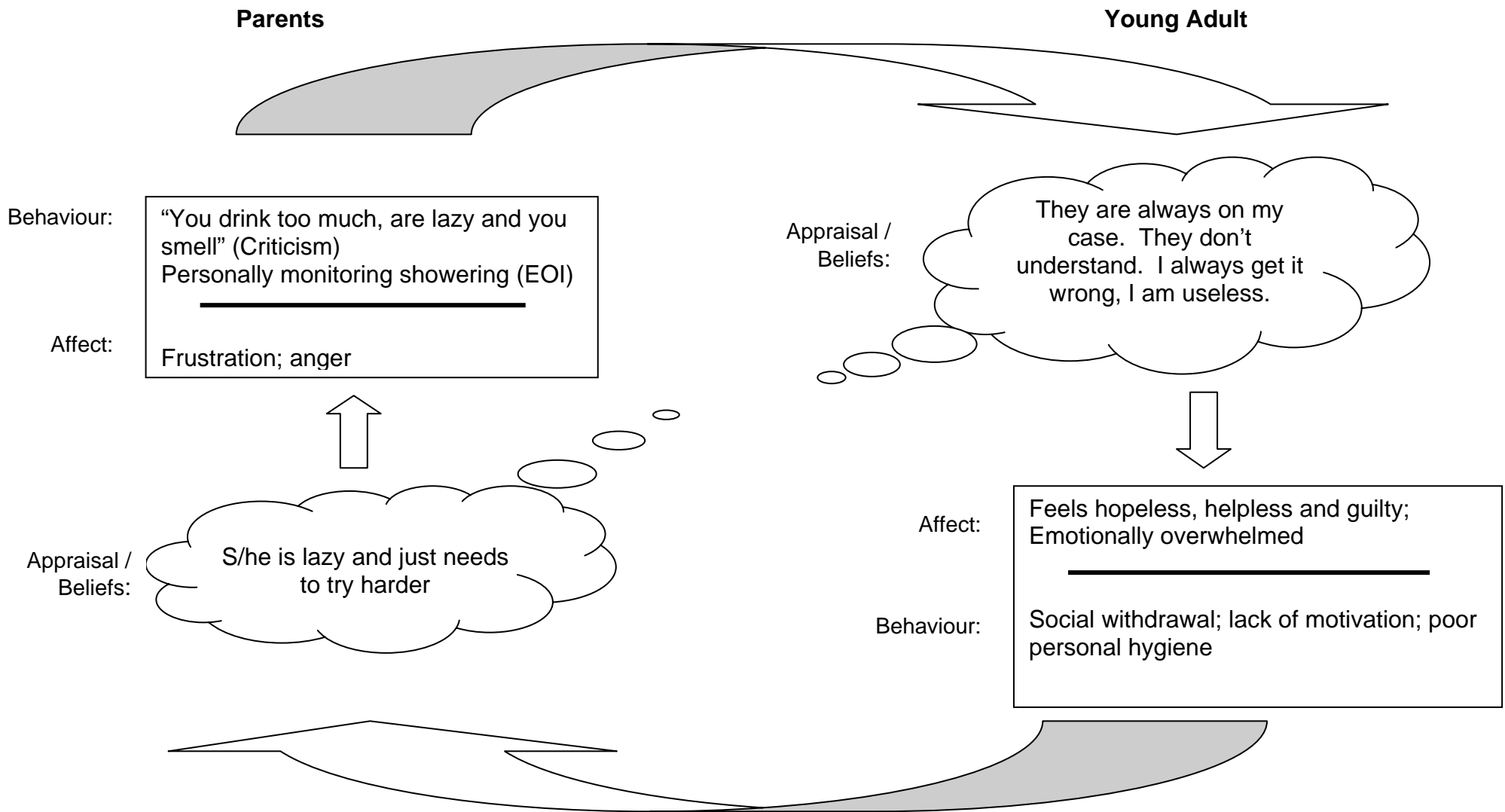


Figure 4: A cognitive – interactional diagram of symmetrical counter – criticism

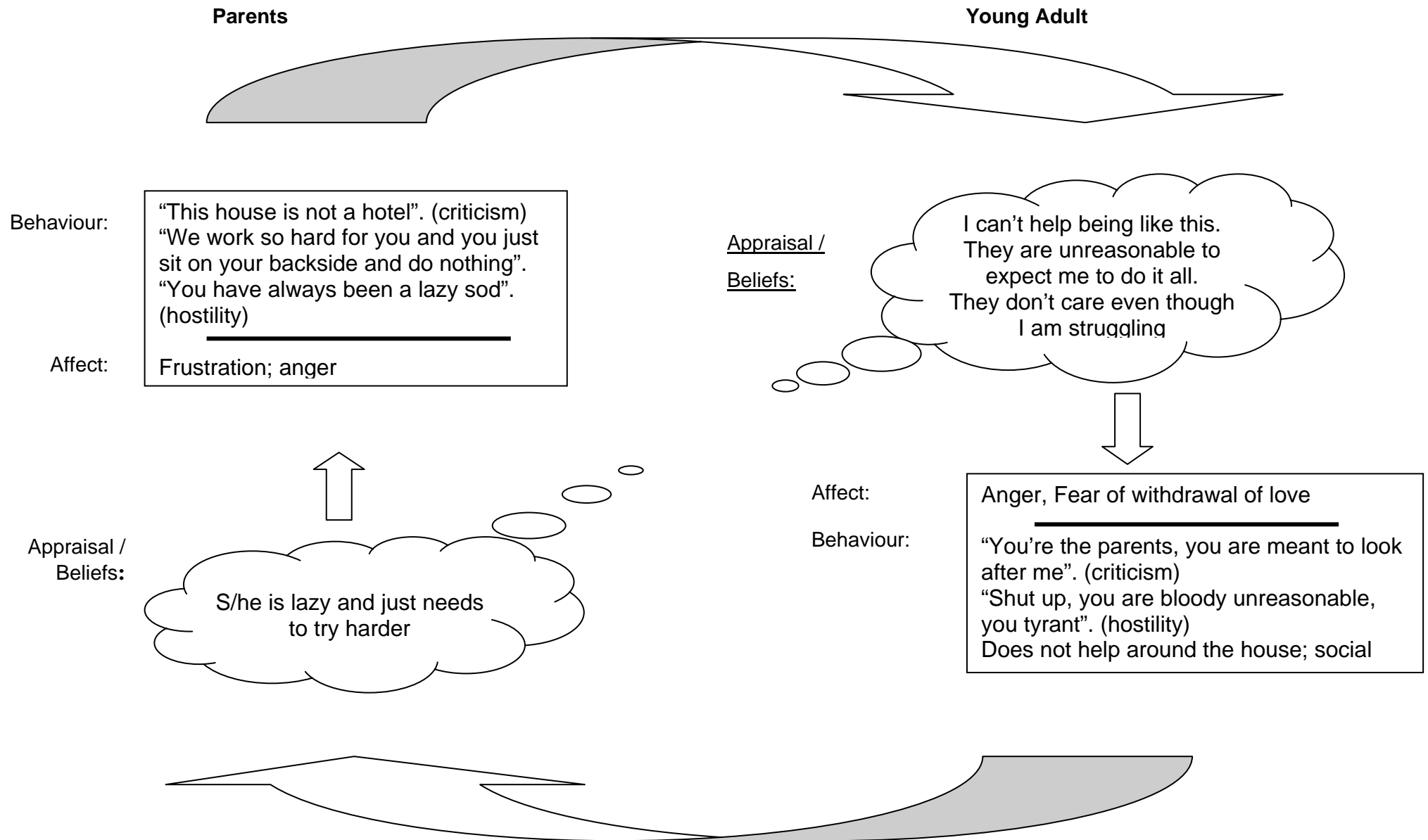


Figure 5 : A Cognitive interactional diagram illustrating mixed messages and resultant confusion

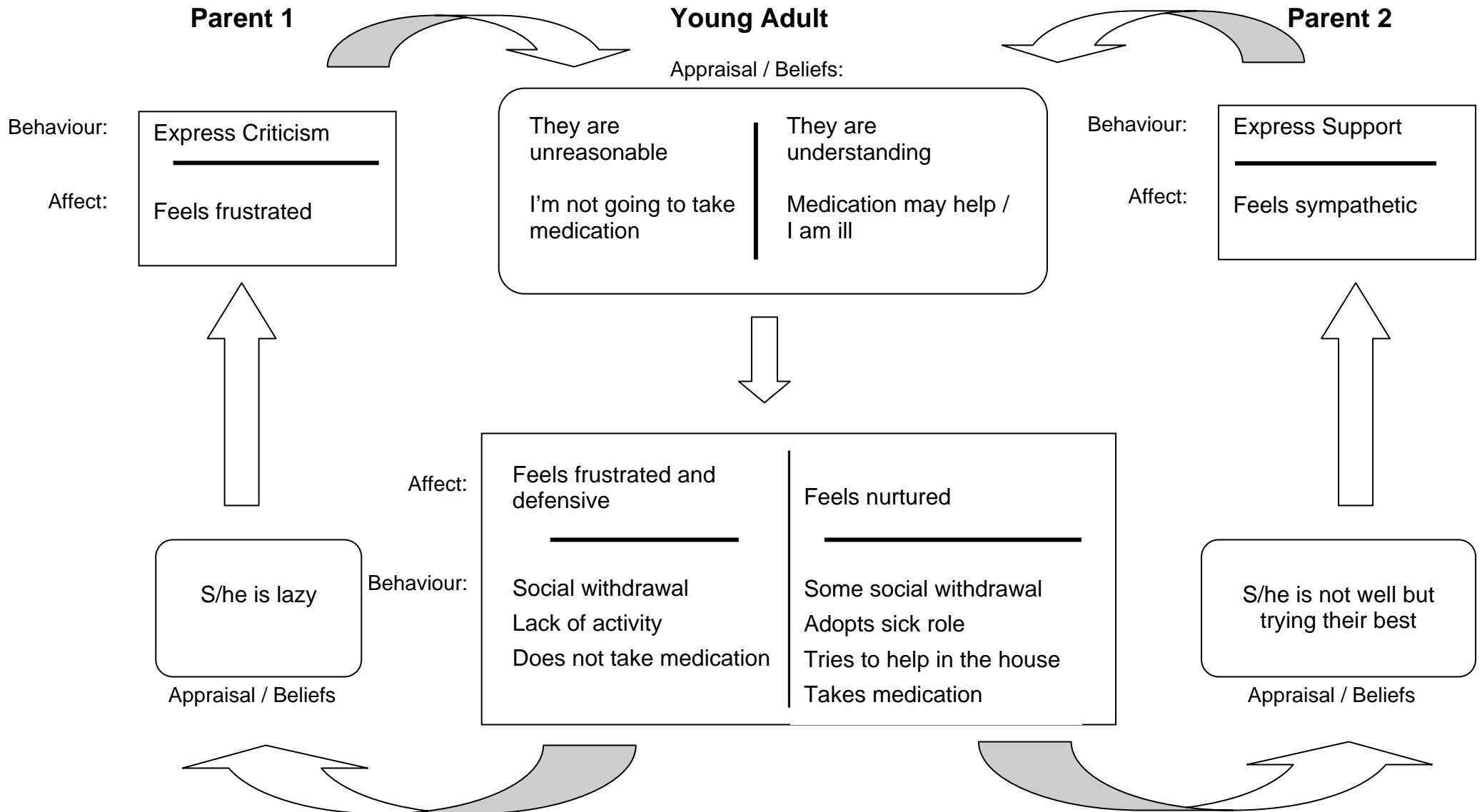
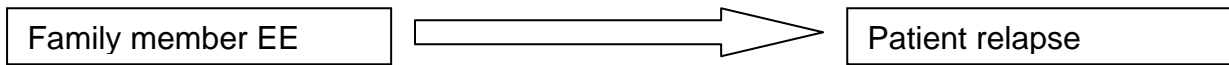
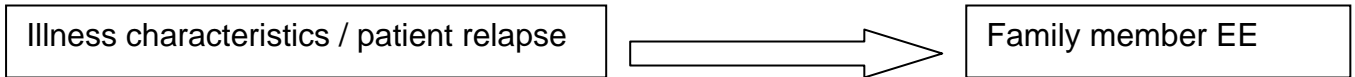


Figure 6: Models of EE

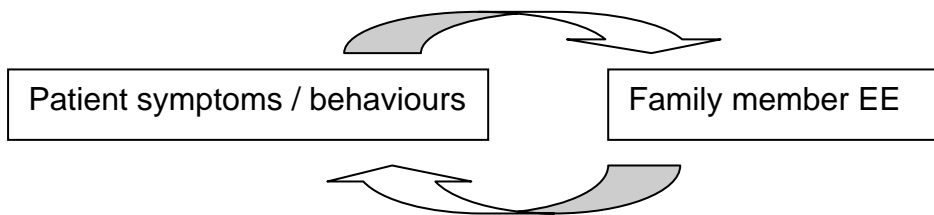
1. EE is causative



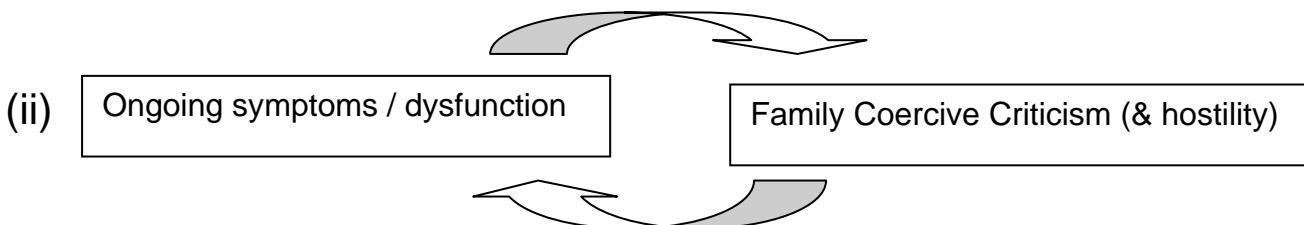
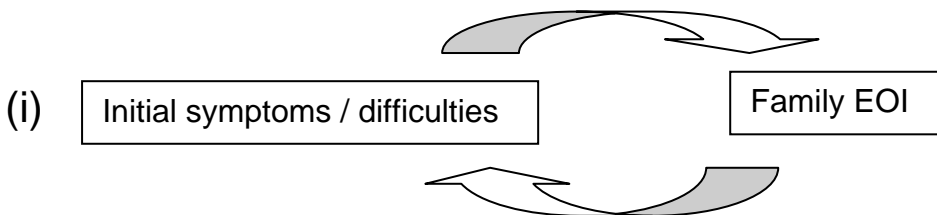
2. EE is reactive



3. EE reflects on interactional process



4. EE reflects a developmental process



5. EE reflects carer appraisal and coping styles

