UNIVERSITY OF BIRMINGHAM

Research findings

Can whole family approaches contribute to the reablement of people with mental health difficulties?

KEY POINTS FROM THE RESEARCH

- Although rarely embedded as a core service option available to all mental health service users, some family inclusive practice activity was taking place in many areas in England. Four distinct practice models were identified as being offered in one of more geographical areas (see Table 1):
  - Systemic family therapy (SFT)
  - Behavioural family therapy (BFT)
  - Family group conferencing (FGC)
  - Integrated systemic / behavioural approach (ISB)
- The accounts elicited from service users and (independently) from family members and practitioners demonstrated that whole family approaches can contribute to the reablement of people with mental health difficulties – although no one approach worked for everybody in all situations. In turn, reablement outcomes were closely associated with reported improvements in wellbeing.
- The case studies suggested different mechanisms of change both between models and for different families receiving the same service model. Where they were successful, whole family approaches enabled the family to provide a more effective 'safe base' from which service users could venture outwards and (re)engage with mainstream community life.

This project looked beyond the individual to explore how more inclusive service approaches that engage with families may enable people with mental health difficulties to lead fuller lives. The fieldwork comprised:

A national survey: to establish what 'whole family' practice models were being used in England and their prevalence.

Case studies: finding out from service users, family members and practitioners their perceptions of whether and how a family inclusive approach may have helped to bring about positive social outcomes in terms of improved family relationships, mental wellbeing and reablement.

Reablement
Within the context of mental health services, reablement was defined as regaining control over one's life (empowerment) and being able to engage in mainstream social activity (social inclusion). This also connects with more socially oriented conceptions of 'recovery' developed by mental health service users (Slade, 2009).

A whole family approach was defined as one in which:

– The focus is on "relationships between different family members and uses family strengths to limit negative impacts of family problems and encourages progress towards positive outcomes" (Cabinet Office, 2007).

– Family members are included in the process as people in their own right – with their own lives inside and outside the family – and not just in their roles as parents or carers.

– There is a flexible definition of who is to be considered 'family' which may include a range of 'significant others' who are not necessarily relatives.

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NHS National Institute for Health Research

Table 1: The four practice models

Systemic Family Therapy (SFT)	Invites family members to focus on relationships and interactions, and their ways of understanding these. Difficulties are resolved through finding new ways of perceiving situations and acting towards one another, using such techniques as circular questioning and narrative reframing (Dallos and Draper, 2000).
Behavioural Family Therapy (BFT)	A psycho-educational approach, taking the format of a course over a set number of sessions (Fadden, 2006). It starts with sharing what it is like to live with a mental health difficulty and how to manage challenges or stresses more successfully – with a focus on family members learning enhanced communication and problem-solving skills. It is recommended in NICE guideline CG178 for the treatment of psychosis and schizophrenia.
Family Group Conferencing (FGC)	An inclusive meeting in which key decisions about care and support are made by the person and their family– with professionals on hand to provide information and advice, but not to make the decisions (Wright, 2008). Although the main focus is on the meeting, the independent facilitator may undertake preliminary work with family members, organise subsequent review meetings and help to support and follow up decisions afterwards.
Integrated systemic / behavioural approach (ISB)	Also termed a 'cognitive interactional' model – incorporates some ideas and practices from BFT (and also cognitive behavioural therapy) within a wider systemic/family focus. It can incorporate a psycho-educational component as well as an emphasis on understanding and improving family relationships (Burbach and Stanbridge, 1998).

While BFT and FGC approaches focus on briefer and more intensive (weekly or fortnightly) interventions, usually over a period of 3 – 6 months, SFT and ISB interventions could typically be for between six months and five years – but often with the frequency of meetings tapering off to monthly or three monthly.

FINDINGS

Prevalence and availability of family inclusive services

In a national survey, the research team found that some form of a family service for adults with mental health difficulties was available in approximately 75% of all the Mental Health Trusts in England. However, this was rarely part of the mainstream service 'offer', with access typically only by specialist referral where specific family difficulties had been indentified – apart from some Early Intervention services where family approaches were more embedded. In some areas, more than one service model was available – although these would typically be located within separate parts of the service, rather than providing an opportunity for choice for service users and their families.

Family inclusive services were mostly offered within the NHS mental health trusts (65%) and primary care organisations (21%), with only one service being located within a Local Authority. The remainder (12%) involved partnership arrangements between NHS, Local Authorities and voluntary sector organisations.

As a model, BFT was most widespread (24 Mental Health Trusts and 10 Primary Care Trusts) – probably due to its specific mention in NICE guidelines. SFT was offered in 16 Mental Health Trusts and 2 Primary Care Trusts. FGC and ISB approaches were only operational in one or two areas – and were usually located in health and social care partnership Trusts. In addition, two areas offered a model of intensive family support for families where a parent had mental health

difficulties and this was seen as affecting their ability to look after dependent children. However, as the focus of these services was primarily on parenting, these were not seen as providing a sufficient focus on adult reablement to justify inclusion within the remainder of this study.

Outcomes

Although the research design did not allow for any direct comparison of effectiveness between models (see Table 1), it found that, for each model, there were instances where substantial reablement outcomes had been achieved and where these changes were explicitly attributed to the family work. In some instances but not all, these were associated with positive reported changes in family relationships. In almost all instances, positive reablement outcomes were associated with reported improvements in wellbeing.

Good outcomes could be achieved when family work (or preparatory work leading into it) was started when the person was still quite unwell (and in hospital) – and no-one expressed the view that it had been started too early.

It was reported that it could be reassuring to have a sense of having family around even if one still could not communicate one's thoughts and wishes very easily.

For some, life-changing reablement outcomes (such as achieving independent living and entering employment or full-time study) were achieved through a slow and incremental process that took place over a number of years – particularly where mental health difficulties had been severe. While enabling this fitted more easily with the more long-term approach of SFT and ISB models, similar results were also achieved where a more intensive, shorter-term involvement had been followed up with ongoing support (e.g. where one of the practitioners involved in the family work was also the care co-ordinator). For others, substantial reablement outcomes were achieved through more intense, shorter-term 'bursts' of activity – and the briefer BFT and FGC models were best placed to provide a focus and structure for enabling this.

Where no (or very little) positive change was reported, no association emerged between lack of progress and the severity of a person's distress or their diagnosis. Instead, factors that militated against a family inclusive approach being helpful included:

- the service being offered later on after the service user had been 'in the system' for some years
- family relationship difficulties pre-dating the onset of a person's mental distress (particularly an issue for briefer FGC and BFT models)
- the service user or a key family member failing to engage with the family meetings early on in the process. (Within the sample, continuing with ongoing work with the rest of the family did not lead to significant change or better subsequent engagement.)

Mechanisms of change

Although the narratives from each of the case studies were very different, certain common themes emerged across models where reablement outcomes were achieved:

- Bringing families together could be an effective way of mobilising and sustaining energy and motivation – for the service user and family members. With its focus on the 'event' of the Conference meeting, the FGC approach seemed to be particularly successful in this regard.
- Although using different techniques and strategies, all models could enable families to provide a more supportive 'safe base' (physically and/or emotionally) from which the service user could start to engage with their wider world. This applied both when service users were living with wider family and when they lived separately but benefited from the availability of support and encouragement from family members.
- Across all models, a focus on inter-personal relationships (particularly with SFT) or communication (particularly with BFT) could be seen by family members as a key step towards creating a 'safe base' for wider social engagement and empowerment. However, family relationships were not necessarily seen as an issue - and, particularly with the FGC approach, a more practical focus could also be effective.

Conversely, in families where improved relationships were reported (particularly with SFT), service users were not always enabled to use this as a safe base from which to re-engage in the wider world.

- Sometimes the best outcomes were achieved by practitioners willing to step outside their particular model – particularly in supporting family members to connect into wider social activities and networks, and to help people sustain change (or deal with setbacks) beyond the prescribed periods of intervention.

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ABOUT THE STUDY

For each service model studied, providers were asked to provide a cross-sectional sample of five or more families (22 in total), including some they saw as 'successes' and others where they did not think that the model had been effective. Using a Realistic Evaluation approach (Pawson and Tilley, 1997), the study employed a Comparative Case Study design to examine the association between outcomes and mechanisms of change. After completion of the intervention, separate semi-structured interviews were undertaken with the service user, family member(s) and a practitioner – and participants were also asked to rate their perceptions of how things were before and after the intervention using 5 point Likert scaled questions relating to the following domains:

- personal and family relationships
- empowerment
- social inclusion
- wellbeing.

For the first three of these domains, participants used bespoke Scorecards devised for the study. For wellbeing, service users completed the 14 item WEMBWS scale (Tennant et al, 2007). While the quantitative data was only descriptive of the samples studied, it was nevertheless helpful in identifying more precisely and consistently across the Case Studies where participants considered that change had or had not taken place. Interestingly, the scores for each domain, given independently by each informant, rarely differed by more than one Likert scale point.

A full report on prevalence and availability of family inclusive services across England is available in "Whole family approaches to reablement in mental health – Scoping current practice" available on the Family Potential research centre website (www.familypotential.org). A fuller discussion of mechanisms and outcomes is being submitted for Journal publication. Once available, a link will be posted on the website.

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