UNIVERSITY OF BIRMINGHAM

Whole family approaches to reablement in mental health

Scoping current practice

Jerry Tew, Gillian Plumridge, Vicky Nicholls, and Harriet Clarke

This report presents independent research funded by the NIHR School for Social Care Research. The views expressed in this publication are those of the authors and not necessarily those of the NIHR School for Social Care Research or the Department of Health, NIHR or NHS.

Acknowledgements:

We would like to express our gratitude to the representatives of services who gave up their time to participate in interviews and send us information to help with the study.

Vicky Nicholls led on the fieldwork and Gillian Plumridge on drafting the report.

The cover photograph is reproduced by courtesy of the Birmingham Eastside Photographic Grid http://www.birmingham-photographic-grid.org.uk/eastside_grid.html. The photographer was Alasdair Tew

Introduction

There is currently a strategic shift in emphasis towards prevention and reablement as a way of both enhancing people's lives and of reducing their need for formal social care and health services (DH, 2008). This study seeks to explore the potential contribution of 'whole family' approaches towards the reablement of adults with mental health difficulties.

This first phase of the study comprises a Scoping Review of current practice. It will be followed by an in-depth exploration of how particular whole family approaches may (or may not) be effective and who is most likely to benefit from them.

The study focuses on services for adults over 18 in England and excludes provision for specialist groups such as those with dementia or eating disorders.

Aims

The aim of the Scoping Review is to find out:

1) What 'whole family' models are in use in England for people with mental health difficulties?
2) Where are they being employed?
3) Who is the service for and how do they define 'family'?
4) How is family work linked to or embedded within wider mental health services?
5) What sort of service package is offered?
6) What is seen as the value base and purpose of the service and what sorts of outcomes are they aiming to achieve
7) How are outcomes currently evaluated?

Context and definitions

Reablement

The concept of reablement serves to focus practice on relatively intensive shorter term interventions that aim to achieve lasting and sustainable *social* outcomes – albeit within certain limitations that may be imposed by ongoing physical or mental ill-health:

> "Reablement focuses on helping an individual gain independence and better functioning rather than resolving their healthcare needs" (SCIE, 2012)

Reablement may be seen as enabling "an individual to improve their physical, mental and emotional well-being" as well as their practical functioning (Geisselmann and Woods, 2010 p.5). Within the field of mental health, reablement connects with the idea of 'recovery', which is understood, from a service user perspective, as taking more control over one's life and re-engaging in social and community life in a way that is satisfying and meaningful, irrespective of any reduction or remission in symptoms (Royal College of Psychiatrists et al, 2007).

Locating it within the context of the government's Putting People First strategy (DH, 2007), it is proposed that reablement in mental health may involve achieving positive outcomes in relation to:

- empowerment, choice and control
- social inclusion
- personal relationships
- mental and emotional wellbeing.

While it is possible that achieving these outcomes may also impact positively on 'clinical' outcomes - such as reduced likelihood of relapse and readmission to hospital – this is beyond the scope of this study.

Whole family approaches

In the implementation of reablement thinking, much of the initial emphasis has been on improving individuals' skills and confidence, particularly for frail or vulnerable older people and for younger people recovering from acute physical illness or managing chronic ill health or impairment. However, for many service users with mental health support needs, the key to re-establishing wellbeing and social participation may be the quality and supportiveness of their immediate network of family and interpersonal relationships (Schon et al, 2009).

In the conceptual review on family focussed practice that fed into the 'Think Family' approach (Cabinet Office, 2008), it was noted that, while there was substantial evidence of approaches which acknowledged the needs of an identified other (e.g. a 'carer'), relatively few practice models sought to engage with people within the context of their whole family - extended as well nuclear - as a relational system (Morris, et al, 2008).

The National Institute for health and Clinical Excellence (NICE) has produced guidelines on schizophrenia that specify family work as an essential component of the care package for people experiencing psychosis. These state that such services should 'include the service user if practical' and should 'take into account the

relationship between the main carer and the service user' (National Institute for Clinical Excellence, 2009: 13). They do not however unpack family as a relational system or insist that a whole family approach is practised.

For the purposes of this study, a whole family approach is 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 p.30).
- Family members are included as people in their own right with multiple roles and relationships inside and outside the family
- There is a flexible definition of who is to be considered 'family' which is based primarily on how this is seen by the person with mental health difficulties. This may include a range of people who are important to them but are not necessarily relatives.

What would not be included as a whole family approach would be:

- Separate work with different family members – e.g. support for carers alongside support for service users
- Working just with specific relationships between family members on the basis of particular roles e.g.
    - parent / child
    - carer / person with 'mental illness'

Literature Review

An initial overview suggested that there is relatively little general or comparative literature on the application of whole family approaches in mental health: much relates just to specific approaches. On the basis of this, a search methodology was devised that started with more generic keywords – some combination of 'family'; 'approach' / 'intervention' / 'therapy'; and a broad range of potential keywords to denote connections with mental health (including diagnostic categories such as 'schizophrenia' or 'depression'). The terms 'family intervention' and 'reablement' were also separately searched. The search was confined to papers written in English. Eight databases were searched; Assia, Cinahl, the Cochrane Library, Embase, Medline, Ovid In-process, Psycihnfo and Web-of-Science. Academic papers were included from 1995 and other literature from 2000. The Internet was also searched (via Google) for any further academic papers and for other information sources such as national and local policy documents.

This search confirmed that significant practice models in mental health were:

- Family Group Conferencing
- Behavioural Family Therapy
- Systemic Family Therapy
- Intensive Family Support

This initial search was then supplemented by more specific searches using the word strings associated with each identified approach and the same range of keywords around mental health.

As a result of searches 1475 abstracts were read and 115 papers selected for further scrutiny. The team then narrowed this down to 39 relevant papers to be included in the literature review. Only descriptions/evaluations of services and programmes that offered whole family involvement (rather than either working with the family to support the service user or identifying and addressing the needs of family members) were included. The following were also excluded:

- Interventions targeted at preventing children of parents with mental health problems developing mental health problems.
- Child as 'patient'
- Interventions or services targeted just at specific groups e.g. for post natal mental health difficulties

Practice models for working with whole families

Family Group Conferencing (FGC)

This is an approach to shared planning and decision making involving extended family which was originally developed in New Zealand within Children and Families services (Connolly, 2006), but is now used increasingly in the UK within a number of Local Authorities (Barnsdale and Walker, 2007). More recently it has been proposed for use in adult and mental health services (Wright, 2008; Tapper, 2010; De Jong and Schout, 2011).

Within this model, an impartial facilitator takes on the role of convening and facilitating a Group Conference process in which all significant people (not just immediate family, but also friends, relatives and others) are brought together to contribute to devising a support plan for a person who is vulnerable. Although this is primarily seen as a one-off event, some or all of these participants may subsequently come back together for one or more review meetings. The format of a Group Conference can be flexible with combinations of individual, small group and large group discussions. The person with the mental health difficulty is involved in this process as much as they are able.

The plan builds on the contributions that the various participants (including the person with a mental health difficulty) each commit to make, together with

professional or service assistance where this is felt to be needed. If this plan is supported by the relevant authorities, it is implemented for an agreed period and then some or all of the original participants are invited back to review its success. In its emphasis on encouraging family members to take ownership of their situation and exploring what they may be able to do for themselves (Lupton, 1998), this approach fits well with ideas of reablement.

Evaluations of FGC have suggested high levels of satisfaction, but provide limited data as to outcomes and processes of change (Barnsdale and Walker, 2007), and there has been little systematic evaluation of its use with adults.

Systemic Family Therapy (SFT)

This is a longstanding and evolving approach which focuses on relationships both within the family and between family members and their wider social context. As a body of practice it is perhaps less homogeneous than other practice approaches. Although once characterised by a more clinical approach, for example with therapy sessions being observed by reflecting teams behind one-way mirrors, much of current practice is more informal and collaborative.

Systemic approaches explore how the beliefs, expectations and behaviours of different family members may interact to form self-reinforcing patterns – and the solutions to current difficulties are found through enabling family members to find their own ways of changing those patterns that may be unhelpful to them. (Burnham, 1988; Dallos and Draper, 2000). In common with other whole family approaches, it is seen as important not to 'pathologise' either individual or family, and to utilise family strengths in order to find solutions. As with FGC, it can be seen as relevant to involve a broader range of significant others and not just immediate family.

Recent developments of the approach have increasingly focussed on exploring narrative constructions – how the 'stories' that family members have been using to explain what is going on (and their role within this) may frame issues in ways that make them hard to resolve (White and Epston, 1990; Anderson and Levin, 1998). For example, a particular family member may become identified as 'the problem'. Therapeutic interventions may involve gentle challenges and experiments, and the use of questions to open up new ways of perceiving situations. In such ways, family members may be enabled to start to reframe a situation in a different way that allows them to feel that they may have more influence over it – and hence to collaborate more effectively in finding solutions.

Because of the relatively idiosyncratic and context-led nature of this approach, it has not lent itself to replicable outcome evaluation studies – although some smaller scale studies suggest positive outcomes in terms of avoiding relapse (Bertrando et al, 2006).

Behavioural Family Therapy (BFT)

This is a practice model that has been developed specifically within mental health services and focuses primarily on family members learning enhanced communication and problem-solving skills – particularly around expressing emotions in ways that are clear and non-intrusive (Falloon and Coverdale, 1994; Fadden, 2006a). This is seen as particularly important in enabling someone with psychosis (or other forms of mental distress) to feel comfortable and supported within their family situation.

The approach provides a format for assessing current communication and problem solving behaviours – and identifying where enhanced skills would be useful, particularly in relation to achieving the specific goals and aspirations expressed by each family member. It then offers a repertoire of cognitive behavioural strategies for learning and practicing specific skills.

This approach has an explicit psychoeducational focus (MacFarlane et al, 2003). This involves helping family members to understand the nature of a person's mental distress, and hence what may be potentially hard or stressful for them (such as dealing with unfocussed critical comments), and what forms of support or interaction may be particularly beneficial for them (such as the overt expression of warmth).

Unlike systemic approaches, BFT tends to follow a more standardized approach which lends itself more easily to evaluation studies. These provide strong evidence as to positive clinical outcomes, such as reductions in relapse rates and hospitalisation (Pilling et al, 2002) – leading to its inclusion within NICE guidelines for schizophrenia. However, there is less evaluation of social outcomes – although one study reported significant improvements in social relationships, motivation towards employment, maintaining social interests and management of social conflicts (Magliano et al, 2006).

Intensive Family Support (IFS)

There has been increased recognition, particularly through programmes such as targeted family support (Tunstill et al, 2009) and Family Intervention Projects (Nixon et al, 2008), that certain families may face a range of challenges at the same time which cumulatively overwhelm their coping abilities. Challenges may include disability, substance misuse, child protection issues, social exclusion and mental health concerns. Such families may sometimes also be viewed externally as 'problem' or 'troublesome' families.

Models of family support can initially be quite directive, with combinations of sanctions and rewards designed to steer families back to ways of operating that enable them to function more successfully. Part of the package may be the deployment of family support workers who work alongside family members, offering a combination of practical and emotional support to help them accomplish tasks of daily living, such as cleaning the house or maintaining discipline.

Although research has identified that over half the families involved in Family Intervention Projects included adults with identified mental health difficulties, much of practice has tended to focus on parenting and childcare, with the mental health of parents often being unaddressed (White et al, 2008).

Recently, under the aegis of the 'Think Family' policy initiative (Cabinet Office 2008), a number of projects have sought to focus specifically on families where there are parents with mental health difficulties who also have childcare issues. However, much of the initiative involves 'joining up' existing services, rather than offering a genuinely whole family approach to family support.

Where there is direct engagement with families, there can be an ambiguity as to whether the service is seeking to enable the adult with mental health difficulties as a person in their own right, or just to help them be a more effective parent. For example, the website of the voluntary sector organisation, Family Action, states that their "services work with the whole family unit and seek to meet the individual needs of each family member", but then qualifies this by stating that they are "supporting the need of the adult(s) in their role as a parent(s) and responding to the related but separate needs of the children" (http://www.family-action.org.uk/section.aspx?id=780 accessed on 28/5/12). A multi-modal evaluation of Family Action's Building Bridges programme includes case studies of adults with mental health problems who had been given intensive practical and emotional support around housing, future employability and confidence. While the emphasis is on helping these individuals to become better parents, other outcomes can result from the intensive support that is offered (Family Action, 2011).

Ethical review

An opinion was sought from the Chair of a local NHS Research Ethics Committee who judged that this Scoping Review did not require Research Ethics Committee approval.

Methodology for Scoping Review

The first stage aims to identify all services in England, whether located in statutory health or social care, or voluntary sector services, which appear to be offering whole family approaches where adults are experiencing mental health difficulties. As many of these services may not have high visibility outside their immediate service contexts, a four-pronged search strategy was employed:

1) Following up recognised sites with a commitment to whole family practice – e.g. the pilot sites linked to the national 'Think child, think parent, think family' initiative (which was developed by and is being evaluated by SCIE).
2) Systematic enquiry at a senior organisational level via key national 'umbrella' organizations such as ADASS and the Care Quality Commission.
3) Key word based web searches using Google
4) A snowballing approach using enquiry at a practitioner / service user / carer level via relevant interest group networks, such as the Association for Family Therapy, the Social Perspectives Network, the Meriden Training Programme and the Parental Mental Health and Child Welfare Network.

The experience of searching confirmed that there was little information on family focussed services collated at a national level – so the most effective search strategy involved snowballing via informal networking, backed up by more systematic web searches.

Inclusion / exclusion criteria

The following criteria were used in determining which services to include within the study:

1) The service is offered to families where one (or more) person aged 18 or over has a diagnosed mental health difficulty and where this difficulty (rather than, say, substance misuse or learning disability) is the major contributor to their current level of disablement.
2) This adult and their mental health needs may not necessarily be the prime reason for service involvement in the family – but addressing their needs would have to be seen as part of the overall remit of the service.
3) Specialist services such as forensic, eating disorder, perinatal mental health services or dementia services are not included. More generically focussed services such as Early Intervention in Psychosis are included.
4) 'Family' may be interpreted flexibly to include partners, parents, children, 'extended' family and / or other friends or neighbours who offer an ongoing commitment. However, services working just with couples, or working on relational issues in the context of individual therapy, are excluded.
5) The service model must directly include the person with a mental health difficulty (i.e. services offering separate work with carers or children are excluded).

Sample for follow-up

From the searches, 62 services were identified which were seen as potentially fitting within the inclusion criteria. 3 services declined to be involved in the study.

Out of this, a national sample of 16 services was selected for follow-up. The criteria for selection were:

- Representation for each of the main practice models that had emerged from the search of the literature, so as to include examples of:
    - Family Group Conferencing
    - Behavioural family therapy
    - Systemic family therapy
    - Intensive Family Support
- Evidence of significant scale of operation
- Geographical spread across England

Telephone interviews

Selected agencies were asked to indentify key informants who would be willing to take part in a telephone interview. One selected agency was unable to provide an informant who was available to be interviewed. Semi-structured interviews were conducted with one or more informants from the remaining 15 agencies which are listed in Appendix 1. The interviews were conducted between July 2011 and January 2012.

The interviews were not tape recorded, but full notes were taken. The findings were collated and cross-tabulated. The data collected was used both to inform this Report and to decide on which sites to research for Stage 2 of the study. Many of these services also provided written documentation. Both this and information readily available on the services' websites was used to supplement and clarify interviews in providing information for this report.

Findings

Throughout this section examples of services that demonstrate particular points are given. However, this does not necessarily mean that other services do not also offer something similar. Short names for services are used throughout (see Appendix 1)

1 What 'whole family' models are in use in England for people with mental health difficulties?

A number of services were found that fitted the criteria for a whole family approach. These included services offering:

- Family Group Conferencing (FGC)
- Behavioural family therapy (BFT)
- Systemic family therapy (SFT)

What also emerged from the survey was that some services were using a combination of systemic and behavioural family therapy models - either in an ad hoc

or pragmatic fashion, or, in Somerset, as part of a more formalised integrated 'hybrid' model (Burbach and Stanbridge, 1998; 2006). This has tentatively been termed a 'cognitive interactional' model.

When other services described elements of hybridity this was often due to staff delivering one model but being trained in another. Some service informants (Barnet, Bristol) suggested that SFT draws on a range of models including behavioural ideas so is likely to include elements of BFT within it. In some services, BFT was located within a wider commitment to systemic practice – defined in Northumberland's strategy as "work with families (and other human groups including professional systems) which may be less intensive than more structured psychotherapeutic intervention, but which draws upon family therapy ideas and practices."

Interviews with services using an IFS model did not yield convincing evidence that these had moved beyond a parenting focus to a genuine whole family way of working, in which the reablement of the adult as a person in their own right would be clearly on the agenda for family focussed interventions. Two slightly different approaches were found – which both aimed at supporting the engagement of parents with mental health difficulties with local Children's Centres. In one site, (Southwark) designated mental health practitioners each liaised with a group of Children's Centres to provide direct work with parents and advice and consultancy to Children's Centre staff. In the other, (Liverpool) family support workers were attached to community mental health teams – primarily to work with service users who were also parents so as to enable them to access parenting and child focussed support services.

Some of the systemic services (Parkside and to some degree Bristol) appeared to have similarities to the IFS model in that they focussed on parents and (minor) children, worked closely with a lot of other agencies and sometimes offered a more practical level of support.

2 In what settings are whole family models being employed?

Overall, services are mostly offered within the NHS with perhaps surprisingly little local authority or voluntary sector involvement. However this differs between models (see Table 1).

BFT and SFT services are located almost exclusively within NHS provider organisations – although a minority involve partnership arrangements with Local Authority social care services and one involves partnership arrangements with a voluntary sector organisation involving support for children and young people (Parkside - NSPCC).

Table 1: Prevalence and location of whole family practice models

Location in	NHS Mental Health Trusts	NHS Primary Care Organisations Trusts	Partnerships involving NHS Trusts and Local Authority social care	Local Authority (adult services) only	Partnerships involving NHS Trusts and Local Authority or voluntary children's services
Family Group Conferencing			1	1	
Behavioural Family Therapy	22	10	2		
Systemic Family Therapy	15	2			1
Hybrid / cognitive interactional			1		
Intensive Family Support					2
N.B. This table is based on the best information that was available at the time of the survey, but may be subject to change – e.g. due to organisational restructuring. Primary Care organisations include services that have been reconfigured as not-for-profit social enterprises					

The formalised hybrid or 'cognitive interactional model' was offered in a Partnership Trust (Somerset) which, since 1998, has had integrated social care and health responsibilities. Four other Trusts which offer SFT at a significant level also have therapists trained in BFT.

Of the two FGC services, one is operated through a partnership between a Local Authority and an NHS Trust (North Essex) and the other entirely within a Local Authority (Hampshire). IFS services are typically delivered in partnerships involving NHS Mental Health Trusts and Local Authority or voluntary sector Children's Centres.

Overall, some sort of a family service for adults with mental health difficulties is available in many areas in England, although there are 12 Mental Health Trusts that do not appear to offer any such service (and some which offer both BFT and SFT). As a model, BFT is most widespread (24 Mental Health Trusts and 10 PCTs) with SFT also being offered in a substantial number of areas (one or more full time equivalent post in 16 Mental Health Trusts and 2 PCTs) (see Table 1). FGC and IFS services are much less commonly available. Typically, areas offering BFT had a higher number of staff trained in the model than those using SFT, but it is important

to recognise that having a cohort of trained staff does not necessarily translate into the level of service delivery that might be expected (Fadden, 2006b).

3 Who are services for and how do they define 'family'?

Although the majority of adults with mental health difficulties are connected to 'family' of some sort (although relationships may have become strained or distant), relatively few receive a whole family service. It remains a little unclear what are the various mechanisms whereby some families are offered such a service and others are not. In many instances, this would seem to be dictated by organisational factors (referral routes and where a service is located) rather than any explicit criteria relating to the characteristics of individuals or their families. This will be discussed further in the next Section.

Mental health status

There were significant differences between services and between models as to how services were targeted in relation to mental health status. Where family work was located within Early Intervention Services (e.g. Leicestershire), it would tend only to be available for people with psychosis. Other services were explicitly open to people with other diagnoses such as personality disorder and depression. Some services (e.g. Barnet), as a result of organisational restructuring, were now having to limit their availability just to families where a person's diagnosis falls within specific HoNOS PbR care clusters[1]. Most services were offered where there was an adult in the family who met the criteria for secondary level mental health services and many were subject to the Care Programme Approach (e.g. Oxleas. Essex). Some informants however, specifically said they did not exclude people because mental health problems were not 'severe enough' (Kensington, Bristol, Parkside and Southwark).

Family related factors

Some systemic services required the adults in question to acknowledge that there was a problem and/or to want to engage with the service. This was less likely to be stipulated by services following other models. Conversely, several services (again systemic) were happy to work with 'family' without the service user him/herself if they were not willing to engage initially.

For certain services, the 'entry criteria' related to the needs of other family members, principally children – and this could be dictated by funding source (e.g. from Sure

[1] The introduction of Payment by Results (PbR) in the NHS has resulted in services being organized according to 'care clusters' of related diagnoses that are linked to Health of the Nation Outcome Scores (HoNOS).

Start for Liverpool IFS service) or service location (e.g. being linked to Child and Adolescent Mental Health Services - Parkside and Bristol).

Some systemic services (Parkside and Bristol) and the IFS services were only offered to families that included parents (or carers) of a child/children up to a certain age. For IFS services, funding dictated such criteria with an emphasis on under fives – although Liverpool had recently extended the inclusion criteria to any child under 18. Systemic services in Bristol and Parkside would only work with families with an adult with a mental health difficulty where a child or young person under 18 in the family was also seen to meet the criteria for involvement with Child and Adolescent Mental Health Services.

Exclusion criteria

Some informants (e.g. Somerset) said their service had no specific exclusion criteria. Some BFT service providers (including those within Early Intervention Services) mentioned exclusion criteria such as complex safeguarding concerns, presenting as a high risk to others, severe learning difficulties or substance misuse. In all cases they suggested they would refer such individuals to services they felt to be more appropriate.

Definition of 'family'

Systemic and FGC services had an open definition of family, based around notions such as who the service user saw as family or as significant, and who was providing support, rather than on biological or legal ties. There was however, some variance in expectations, from some services making comments such as 'occasionally may involve a neighbour or friend' to others where it seemed usual to expect a variety of people (parents, siblings, friends, neighbours etc). In some instances other significant others would be invited, including employers, representatives of religious organisations or other professionals. Some services (Humber, Northumberland. Essex) actively encouraged the involvement of the care coordinator).

Although the general view was that the service user was proactive in selecting who was included, in some services, service providers also made suggestions as to who might also be involved, but these would have to be agreed by family members. The FGC service had the widest definition, trying to engage the 'whole network' in the family conference. As well as a wide definition of family/friends they would also try to include the care coordinator and other relevant professionals.

BFT services, and particularly those located as part of Early Intervention Services, tended to focus more on more immediate family units such as people living together in the same household or families of origin where a person may be living on their own. However these still mentioned the possibility of including friends, neighbours and others, perhaps where a young person did not have ties to their family of origin, for example because they had been in the care of the Local Authority (Kent) or have no formal family (Leicestershire). Early Intervention Services (e.g. Birmingham, Kent)

suggested that whilst young people were often open to including family, some were clear that they did not want any family involvement.

IFS services also seemed more likely to focus on an immediate family unit of parent(s) and children and perhaps also grandparents, but did say they could include neighbours, friends etc.

Including Children

Some services worked specifically with children (Bristol, Parkside, Liverpool, SLAM). Others had differing views about including children; usually the decision was based on parent's views, allowing for any safeguarding concerns. Informants from several services said it was rare for them to work with younger children. In the FGC model children were included in the conference but not expected to stay for all of it and could write their plan with a worker before the meeting.

Some informants, particularly from BFT services, suggested that staff were from adult mental health backgrounds and therefore not always confident or comfortable to work with children.

4 How is family work linked to or embedded within wider mental health services?

Referral route

Referral routes were varied and did not appear generally to be related to service models; although family services that were part of Early Intervention services were most likely to receive direct referrals from General Practitioners (GPs). Some other service informants said this happened 'occasionally' or 'sometimes', and the Kensington informant suggested that up to 50% of referrals came from GPs.

In some services (such as Barnet) family focussed practitioners were involved as part of a multi-disciplinary approach in the screening of referrals into secondary services and identifying where there might be value in offering a family service. However, for the majority of services, referrals came from within mental health trusts, (from psychiatrists/consultants, care coordinators, CMHTs, CAMHS, wards); with several service providers explaining that they were essentially tertiary services. This meant that they were reliant on clinicians in secondary services to 'think family' in their assessments which could be 'hit and miss' and give services little effective control over inclusion/exclusion criteria. At Parkside a named practitioner linked to CMHTs attended their intake meetings and undertook joint assessments with CMHT colleagues to ensure the appropriateness of referrals.

Only Meriden, Parkside and Essex (i.e. one BFT service, one systemic service and the FGC service) explicitly stated that they accepted self referrals. Others suggested that things might change by saying, for example, 'not yet' about self referrals.

Some informants mentioned other sources of referrals such as social services (Southwark, Kensington, Parkside), the voluntary sector (Parkside) and health visitors/ midwives (Southwark). Others suggested that they were aiming to expand potential sources of referrals. For example, Liverpool were developing a pathway for perinatal nurses to refer into.

Location within organisational structures

Essentially two different models emerged:

- Specialist 'tertiary' service accepting cross-referrals within secondary care mental health services, or
- Strategic integration of family thinking and family work across the whole mental health service.

The former may be seen as the more traditional model – but one which may potentially lead to the marginalisation of family work as a very specialist endeavour only suited to a small minority of situations. This emerges as the dominant model particularly where there is a very small (usually SFT) resource within a Trust, who are perhaps just able to operate on only one day or half a day a week, and are therefore only able to impact on a relatively small number of the people using the overall services of the Trust (e.g. Kensington, Barnet, Bristol).

In those services where family work is being given more priority, serious attempts are being made to mainstream family thinking – although this may require quite a radical shift in organisational culture and practices, and may meet significant institutional and professional resistance along the way. Informants from some SFT services, for example, said they may be involved in initial assessments or may work alongside other Trust staff, so that service users were viewed as part of a relational system.

In most services, those providing family approaches liaised and/or co-worked with other staff within Mental Health Trusts, including care co-ordinators and other staff within CAHMS and/or adult services. This could be both to offer and to receive support. For example it might be to provide an overview of the family when this has been identified as helpful (Barnet) or provided when staff from other teams, are newly trained or not confident, or when cases are especially complex. In some instances, staff from other mental health services supported family work, for example in Liverpool, where a clinical psychologist from CAMHS provided sessions for reflective practice.

The informant from Southwark said they actively promoted the value of family work in other mental health services (e.g. Early Intervention Services) and provided training for those working in adult mental health services so that they felt more confident working with families.

Embedding in organisations

Some Trust policies specifically aimed to embed family services more formally into their work. In Somerset, family inclusive working was particularly well embedded with a trust-wide strategy to enhance working partnerships with carers and families, under which all assessments and interventions were undertaken with a social network perspective. The Family Intervention team also aimed to train staff of different levels and disciplines across the trust, to create local teams with relevant skills within them.

Some services (Humber, Northumberland) had policies to ensure family services were offered at different levels throughout the trust's work. These were generally based around a 'cascade' idea where trained practitioners worked with those with complex needs and supported other workers to deliver family interventions at a 'lower' level. In Humber, specialist practitioners also trained 'Champions' who supported other staff within community teams to offer family interventions and support the involvement of families at care co-ordination level. Similarly Northumberland had a family therapy strategy (being implemented at the time of the study) that was designed to cover a continuum of work from specialist family psychotherapy to staff using family therapy ideas to inform their case work. The strategy proposed that each clinical team within the Trust should be enabled to offer basic family work as an integral element of the interventions which are routinely offered. The informant from Northumberland also said they did not want a separate referral system because they wanted a family perspective to be integrated

Although located within Birmingham and Solihull Mental Health Foundation Trust, the Meriden Family Programme has operated as a training and consultancy service with a wider geographical remit, aiming to bring about attitudinal and organisational change and ensure that family work became firmly embedded within services. They had a cascade system of training to ensure the widespread dissemination and sustainability of the programme. Therapists were trained as trainers and supervisors. These trainers provided in-service courses in their own localities to multi-disciplinary professional groups, service users and family members. Meriden also offered on-going contact with managers and key individuals within services to identify barriers to the implementation of family work and solutions for overcoming these obstacles. Concrete structures could then be put in place to ensure sustainability including recording and auditing systems, and ensuring that the provision of family work was written into clinicians' job descriptions.

Although family work is an explicit part of the Early Intervention service model, the degree to which this was integral to service delivery was variable. It appeared that Early Intervention work often included families at some basic level, but BFT or whole family approaches were less widespread than might have been expected. In many instances, individual work could be standard whilst family work was only offered if requested or specifically indicated by initial assessments (e.g. because identified problems were family-related).

There was some acknowledgment, even from services that described themselves as embedded in trusts, that there could be difficulties in getting family work consistent across the teams within the trust and in keeping family work in the forefront of service provision. Family services had not always been developed in a strategic way; provision was sometimes described as patchy and delivery could depend on geographical area or a specific diagnosis rather than clinical priorities. Although research has shown them to be cost effective (Tarrier et al, 1991), family services are seen as expensive and it was acknowledged that financial difficulties within trusts could lead to a reduction in the number of families who were offered them (Kent).

Working with other services

Arrangements for working with social workers were variable. Some services had social workers in their teams (Barnet, Leicestershire) and this was seen as helpful. Other services said there was less integration than there used to be (for example because social workers no longer worked as part of CMHTs (Northumberland). Interviewees said that services worked with a variety of other statutory and voluntary services (often related to child care) in a number of capacities and at different levels. For services working with children, it was acknowledged that whilst involvement with social workers could be useful, being seen as separate from social services could also be helpful (Bristol).

Some systemic service providers said they liaised or worked with primary as well as secondary NHS services (Kensington), and with social care and the voluntary sector. Informants from IFS services suggested they worked in a practical way alongside other services, linking and co-ordinating mental health services to other statutory and voluntary sector services that families were involved with (e.g. social services, health visitors, children's services, schools). These were generally related to child care.

Tensions between services

There was some feeling within some of the services where family work was offered at different levels, that whilst the time of trained therapists was protected, family work was not always seen as a priority for other trained workers who had additional clinical roles and faced conflicting demands. The ability for these workers to work with families was dependent on factors such as individual and team workloads and tensions within teams associated with specialism versus genericism (Northumberland). Access to family therapy supervision could also be problematic. Supportive management was seen as helpful with this and in terms of working flexibly across teams (Meriden).

There were also some comments that were critical of the way mainstream mental health services saw or described service users. Interviewees felt for example that service users were often labelled, or sometimes constructed as a 'mad person'. Mainstream services did not always invite service users to meetings, their problems were often individualized and there did not always seem to be a belief that those suffering mental health difficulties could move on.

5 What sort of service packages are offered?

Duration of service

The most salient observation was that informants from all services talked about flexibility in terms of the numbers of sessions offered and the overall duration of the service.

Informants from SFT services who commented, said the average number of sessions varied from 4 -12 but was commonly around 10. Specific families however could be seen anything from twice to 25 plus times over several years. The Parkside literature suggests 'as many sessions as is needed.' SFT service providers also talked about the frequency of sessions, which was generally spaced between two and four weeks apart. The Parkside informant talked about seeing families more often when they were in crisis, sometimes several times a week. In all SFT services sessions lasted one to one-an-a-half hours. The majority of systemic services said they offered an option of a follow-up session which could be written into the plan at discharge, which as well as offering a safety net, offered some families a focus or goal.

BFT services tended to offer a more standardised 10 - 12 session package of weekly sessions, although in practice there could again be considerable flexibility (Meriden), and the opportunity for follow-up was offered (Kent, Meriden). The Somerset informant said they offered an average of 15-20 sessions with the possibility of subsequent follow-up and review if family members requested this, so that service users had the safety net of not having to 'jump back through all the hoops' if they felt they needed further support. IFS services tended to be more open-ended, with the Liverpool informant talking about flexibility, and balancing 'as long as is needed' with a high demand for the service.

FGC was different as this model is based on an initial family conference, with up to three follow up review meetings.

Who is seen together?

The FGC model was based on a clear structure where the meetings bring together family members and significant others - and may include key professionals joining for part of the time. However, over and above this, there are likely to be a number of individual meetings with the service user and family members, both leading up to the conference and between the conference and follow up reviews.

Some BFT service providers said that they would meet with individuals prior to setting up family meetings – and would then expect all family members to attend all sessions where practicable. In Somerset people were also seen both as families and individuals and again individual meetings often led to a whole family meeting.

SFT services tended to operate more flexibly. Most informants said they might see the whole family together sometimes and different combinations of individuals at others. This could depend on who would engage or on relationships between individuals. For example, a young person with mental health difficulties could be seen with the partner they lived with and then separately with their parents, if this was most helpful to their recovery. Informants from several services said there were some families who would never be seen all together.

Practicalities

Family Group Conferences were nearly always held at the service user's home or a friend or relatives home, because it was felt that people would be more relaxed than in a professional location. In contrast SFT services were normally offered in the clinic but could be offered in other locations including schools (Bristol, Parkside). Southwark, Somerset and BFT service providers talked about seeing families both in clinic and home settings, although some said home was preferred.

SFT service informants generally said they used reflective teams who could view the session through a one-way screen or by video. However, this was seen as expensive and some said they used this approach less these days and felt they could not use it as often as they wanted to.

6 What are seen as the value base and purpose of the services and what sorts of outcomes are they aiming to achieve?

Services had generally been set up to meet national guidelines and policy recommendations (Barnet, Somerset, Meriden, Humber, Essex, Bristol) and on the basis of existing research evidence (Somerset, Liverpool, Humber). Providers of some services also said they were set up specifically to address an identified need (Liverpool, Parkside), or to bridge services for adults and children (Bristol).

Value base

Informants from all services described a very person or family centred approach to their work – one that was characterised by a collaborative or facilitative approach ('doing with' rather than 'doing to') and which sought to identify and build upon the strengths and capacities of the family and family members.

The service user and/or family were described in various ways that suggested that they and their views and needs were considered central to service decisions and provision (Bristol, Essex, Oxleas, Somerset). It was seen as important that family members were not 'pigeon holed' or labelled but should define their own relationships and needs (Liverpool, Northumberland). There were comments about respecting (Southwark) and valuing families as precious commodities (Barnet) and

valuing the differences and uniqueness of family members (Parkside, Liverpool). It was seen as crucial to remember that families and family members were doing their best (Kent) and to avoid blame (Bristol).

Overall, BFT, FGC and IFS services came over as being more goal orientated – although trying to give family members the responsibility for setting these - whilst SFT services focused more on relationships.

Purpose and intended outcomes

There were interesting differences between models and services in terms of their primary emphasis – and all of these may be seen as potentially contributing to the reablement of adults with mental health difficulties:

a) Prevention and psycho-education

No service saw its role in terms of primary prevention – i.e. seeking to resolve issues before a person's mental health difficulties became serious.

However, informants from the FGC service, Southwark, Somerset and BFT services all talked about prevention in the sense of helping family members recognise early relapse signs and sometimes making a family plan primarily to help to prevent relapse or re-admission to hospital.

BFT is described in the information provided by Meriden as a psycho-educational approach, where the early sessions are educational and include discussion about the relevant mental health problems and the help available. Informants from Early Intervention Services said that they shared information about mental health, symptoms, recovery and the impact on the family. This allows family members to ask questions and to have realistic expectations. Some SFT services (e.g. Kensington), also talked about helping family members achieve realistic expectations.

The Somerset informant felt that providing information to family members and answering their questions was important, but said they did not start with information provision in the way BFT services did. They were keen to deliver information in a sensitive, rather than 'teacher-pupil' way.

The only systemic services where informants specifically talked about educating family members were those focusing on parenting (Bristol and Parkside). As with IFS services, this was mainly in terms of helping children to understand parents' mental health problems and parents to understand the potential impact of these on their children.

The FGC informant discussed 'education' in terms of family members understanding the person identified as having a mental health difficulty. As part of this they explained that those close to the person with mental health difficulties may become so involved that they are limiting that person's ability to move on.

b) Decision making and support planning

Reaching decisions and working collaboratively to develop a support plan provides the primary focus of the FGC approach. The FGC informant explained how having everyone together could allow the resolution, not just of major issues, but also of apparently minor practical issues (such as the best time of day to make a phone call) that could nevertheless cause significant frustrations.

With BFT, the primary focus is on communication and problem solving skills to help decision making within the family, rather than making decisions per se. Problem solving and goal setting and reviewing were described as a specific part of BFT, with families being encouraged to lead their own support plans. A specific focus on learning clearer ways of communicating could help service users become more confident in being actively involved in family decision making. The Meriden informant suggested that families could have meetings when they all get together without any professionals and 'nip any problems in the bud, before they stew'.

Some of the systemic service informants said that decision making was not a primary focus of their work, but aspects of the family therapy, such as sharing and exploring each other's views and stories, may enable families to make decisions. The respondent in Kensington talked about drawing out 'the more shy stories', and looking to discover and hear these. Others felt that aiding decision making was a more explicit part of their work. Parkside for example aimed to develop problem solving and planning skills for adult and child members of families, and to improve capacity for making choices in the future.

Somerset's work was described as very non directive; the aim was to help people to develop an understanding of their situation and thus an ability to see possible solutions. Service providers offer ideas, for example based on other people's experiences, rather than telling service users and family members what their goals should be.

Similarly the IFS service providers described helping families to identify their own issues, needs and wishes and encouraging and enabling them to find their own solutions and ways of working towards goals.

Only informants from the FGC service, Bristol and Southwark talked specifically about Advanced Care planning. In the latter, they would talk to the family about practical considerations such as who would care for children if a parent were in hospital

c) Effective communication

Developing and encouraging effective family communication was described as a core and very important focus of the work of all types of service. Effective family communication was often seen as prerequisite for the success of other aspects of family work. Improving family communication could be about helping people to find different ways of talking and listening to each other, and managing conflict (Humber).

Informants from Meriden described the BFT model as addressing this in a more formal way, structuring sessions around four different areas of communication skills:

- expressing negative feelings
- making requests
- active listening skills and
- being more able to express difficult feelings.

As with some of the other services they stressed how important it was for everybody in a family to have a voice. Service users, children, grandparents and other family members were all identified as potentially lacking a voice. Service users might be 'talked about' rather than 'talked with' (Oxleas). Grandparents often lacked information, and could find the opening of channels of communication to be a great relief (Bristol). In Somerset they aimed to help families reach a shared understanding of their family story. Families did not always consider the impact of mental ill-health on children and hence they could become effectively invisible (Parkside and Bristol). Children need to feel that it is 'OK' for them to talk about family difficulties (FGC) and several service providers said they used play techniques to help them express their views (e.g. Southwark, Parkside). The Parkside informant also said they aimed to help children to develop the emotional literacy and vocabulary to enable them to better recognise and communicate their feelings.

d) Enabling wider social engagement for family members

Again all types of services considered supporting family members' interaction and engagement with the wider community to be important.

There was acknowledgement, particularly within SFT and IFS services, that mental health difficulties often occurred in a context of social isolation. Informants felt it was important for families to have other formal and informal support systems. They felt that people could effectively become 'stuck' within mental health services, lacking the confidence (or finding it too stressful) to move outside of a social network that comprised just their immediate family and mental health services. IFS informants particularly focussed on building confidence and self esteem. Liverpool and Southwark IFS services shared an aim of getting families to use children's centres. The Humber informant suggested that it was important for services not to be too protective, and to look with families at ways of supporting the associated stress rather than not taking the risks.

Engagement with the wider community was described both in terms of social activities and in terms of linking families to other services and resources. In some services the latter could be in terms of helping people to change their perspective about other services and see that they could be useful to them. Alternatively it could be very practical, for example accompanying family members to services or acting as a link between the family and for example school, when this relationship was difficult.

Informants from the Essex FGC service and Meriden explained how family work could practically facilitate social activity by, for example, giving opportunity to find someone to go to an activity with, or to provide transport, or to look after children so that an adult could attend an activity.

Informants from the services that focussed more on parenting talked specifically about integrating children back into the community. This could be in terms of integrating them back into school or in terms of building children's resilience by encouraging friendships, hobbies and contact with reliable adults (Bristol, Parkside). Linking children into young carer groups was common to many services.

Encouraging young people with mental health difficulties to engage in social activities was a very important part of Early Intervention Services. However, the main focus for promoting this tended to be outside the context of family work.

e) Enhancing the quality of relationships and resolving relationship difficulties

Although an emphasis on resolving relationship difficulties is more explicit within the SFT model, informants from all services talked about working with families to enhance relationships and resolve difficulties.

From a systemic perspective, the informant in Oxleas said that they work on improving the relationship skills of everyone in the system. Where individuals in families may take up particular roles, the family may need to be encouraged to think about the utility of these. Informants from some services talked about considering relationships with the whole family together. Parkside used circularity to aid an understanding of how a family is an interconnected unit rather than a group of individuals living separate lives.

Sometimes individuals with mental health difficulties were helped to change their perspectives and/or behaviours in terms of family relationships. For example they may be helped to understand that it is their interpretation of the behaviour of other family members towards them that is negative rather than the intention behind the behaviour. Likewise, they could be helped to tell others how they felt in response to their behaviour rather than becoming angry with them. They and other family members could be helped to understand that people may behave in ways that don't intend to cause problems but may inadvertently contribute to difficulties. Sometimes specific individuals were helped to understand each other better. This could, for example, involve couples and helping the well partner to gain a better understanding of the unwell partner's behaviour and also of their feelings about having mental health difficulties and not, for example, wanting to be treated like a patient (Kensington). Early Intervention Services (e.g. Birmingham) might address conflicts between parents about how a young person was progressing. The Northumberland informant said they found that such work was most successful if the service became involved earlier, when it was less likely that conflict had arisen.

Informants from both Meriden and Somerset talked about encouraging family members to see each other more positively or to focus on the positives within relationships. It was recognised how important it was to look at family relationships and how easily tension, blame and guilt build up in families if issues are not addressed.

Many services considered the relationships between parents and children, focussing on parent's understanding of how mental illness can impact on children. This could be quite complex, for example when three or four adults all parent the same children. Service providers stressed that this was done in a non judgmental way, feeling that many parents did not appreciate how aware children could be of family circumstances that did not seem to directly affect them. Such work was described as potentially very supportive and healing so that parents and child(ren) could move forward 'as allies' (Bristol).

Informants from the FGC, IFS and some systemic services also talked about working with families on, sometimes difficult, relationships in the neighbourhood or with service providers.

f) Identifying aspirations, strengths and resources

Informants from a range of services talked about helping families to recognise and draw on their strengths both as individuals and as a family. Several felt this was particularly important in light of the comments made about mainstream mental health services' potential negativity and construction of service users as 'mad people'. The Essex informant explained how family members get used to talking in negative ways about mental health, and this contributes to them not noticing strengths. The Humber informant explained how constructing a service user firstly as 'a person' was very empowering. The Oxleas informant talked about family members identifying what they enjoyed as well as what their strengths were.

Whereas the focus of FGC and SFT models can be more on resolving specific difficulties, the explicit focus of BFT services is on enhancing the skills and capacities of family members so that they can resolve issues for themselves.

Informants from the IFS and BFT services also talked about helping families and individual members to identify and achieve goals. The Southwark informant explained how they looked at these very practically, exploring for example who in a family had the strengths and/or resources to help another family member achieve their goals.

7. How are outcomes currently evaluated?

There is currently no agreed framework for evaluating family focussed services.

Three of the SFT services (Barnet, Humber and Oxleas) were taking part in piloting the SCORE evaluation methodology (Stratton et al, 2010) which focuses on family members' assessment of changes in their internal relationships and functioning, but does not consider whether such changes may also impact on the external functioning of family members – so is of little value in assessing the possible contribution of the family work for reablement.

IFS services are mainly focussed on evaluating outcomes for children. Liverpool is starting to use the Family Star tool which assesses progress in relation to more effective parenting, defined in terms of:

1. Promoting good health
2. meeting emotional needs
3. keeping your child safe
4. building community
5. supporting learning
6. setting boundaries
7. encouraging work aspirations
8. providing home and money

(Triangle consulting http://www.outcomesstar.org.uk/family-star/)

The Somerset informant said they had regular internal audits of the service, and Barnet had also undertaken an internal audit of the previous 12 months. Both said these indicated the effectiveness of their services with Barnet reporting significant drops in a number of measures (e.g. days as an in-patient, and contacts with community mental health and home treatment teams). An evaluation in Essex reported similar findings but this was undertaken about 10 years ago. Parkside produced an annual report and had invited the NSPCC to undertake an evaluation (although this would focus mainly on outcomes for children). In Liverpool, staff had received some training in assessing families using the General Assessment of Family Functioning Scale (GARF) which was included in DSM-IV (American Psychiatric Association, 1994). Improvements in GARF scores were being noted consistently, but it was recognised that this is a subjective measure and that the improvements may reflect better understanding by staff as well as any objective changes in the families themselves.

7 Conclusions

Despite their relatively low profile at national level, family approaches in mental health are perhaps more widespread that is generally recognised. However, provision is patchy, with a commitment to mainstreaming family approaches within a few areas, but this way of working being seen as a specialist (and potentially marginalised) activity elsewhere.

It is striking how the great majority of activity takes place in, or is led by NHS provider organisations, with Local Authority adults' services seeming to have little commitment to whole family approaches in mental health – even though this is a social rather than medical form of intervention. The key exception to this was in relation to Family Group Conferencing where Local Authority adults' services were more integrally involved or providing leadership. Otherwise Local Authorities only tended to be involved in relation to the welfare of children.

There were many underlying similarities that emerged across the different models. There was a strong commitment to identifying and working on strengths – and of enhancing the capability of the family as a resource – which fits well with the idea or reablement. Apart from Family Group conferencing which is typically a one-off event (with subsequent review), most approaches involved a package of sessions (typically around 10 but subject to more or less flexibility depending on the model).

To a greater or lesser extent, all services took a flexible and pragmatic approach as to what constitutes 'family' – tending to take the lead from what 'family' see as the network of people that are important to them. Some services took an active role in prompting service users to think more widely as to who might usefully be involved.

A range of different practice models were in evidence. Behavioural and systemic family therapy approaches were most widespread, with some potential hybridisation between the two – which is becoming formalised as a 'cognitive interactional' approach (Burbach and Stanbridge, 2006). Alongside these, two less common models were found: Family Group Conferencing and Intensive Family Support. However, at this stage of development, Intensive Family Support services would still seem to have a primary focus on parenting – and are not yet to be seen as offering a whole family approach as defined in this study. For this reason, although they were included in this Scoping Review, they will not be included in the second phase of the project as they do not specifically aim to affect the reablement or recovery of the adult with mental health difficulties.

Different models tended to place a different emphasis on what they saw as the intended outcomes of the service. While most services focussed on enhancing communication, some models had more of a preventative / educational focus while others were more concerned with decision making and support planning. There were also significant differences in the degree to which they focussed internally on

resolving relationship issues and / or externally on enabling wider social engagement. Directly or indirectly, all of these outcomes may be seen to have the potential to contribute to the reablement of adults with mental health difficulties. However, this is not currently being evaluated in any systematic way.

References

Anderson T and Levin S (1998) Generative conversations: a postmodern approach to conceptualising and working with human systems. In M Hoyt (ed) *The handbook of constructive therapies.* San Fransisco: Jossey-Bass

Barnsdale L and Walker M (2007) *Examining the Use and Impact of Family Group Conferencing*. Edinburgh: Scottish Executive

Bertrando P, Cecchin G, Clerici M, Beltz J, Milesi A, Cazzullo CL (2006). Expressed emotion and Milan systemic intervention: A pilot study on families of people with a diagnosis of schizophrenia. *Journal of Family Therapy* 28(1): 81-102

Burbach F and Stanbridge R (1998) A family intervention in psychosis service integrating the systemic and family management approaches. *Journal of Family Therapy* 20: 311-325

Burbach F and Stanbridge R (2006) Somerset's family interventions in psychosis service: an update. *Journal of Family Therapy* 28: 39-57

Burnham J (1988) *Family Therapy: First Steps towards a Systemic Approach*. London: Routledge

Cabinet Office (2007) *Reaching out: think family. Analysis and themes from the Families At Risk review.* London: Cabinet Office Social Exclusion Task Force

Cabinet Office (2008) *Think family: improving the life chances of families at risk. London*: Cabinet Office Social Exclusion Task Force

Connolly M (2006) Fifteen Years of Family Group Conferencing. *British Journal of Social Work* 36(4): 523-540

Dallos R and Draper R (2000) *An introduction to family therapy: systemic theory and practice*. Buckingham: Open University Press

De Jong G, and Schout G (2011). Family group conferences in public mental health care: An exploration of opportunities. *International Journal of Mental Health Nursing* 20(1): 63-74

DH (2007) *Putting people first: a shared vision and commitment to the transformation of adult social care*. London: Department of Health

DH (2008) *Making a strategic shift towards prevention and early intervention*. London: Department of Health

Fadden G (2006a) Family interventions. In Roberts G, Davenport S, Holloway F, Tattan T (eds) *Enabling recovery*. London: Gaskell pp.158-169

Fadden G (2006b) Training and disseminating family interventions for schizophrenia: developing family intervention skills with multi-disciplinary groups. *Journal of Family Therapy* 28: 23-38

Falloon I and Coverdale J (1994) Cognitive-behavioral family interventions for major mental-disorders. *Behaviour Change* 11(4): 213-222

Family Action (2011) *Building Bridges: an independent evaluation of a family support service*. London, Family Action.

Geisselmann C and Woods A (2010) *Making the Strategic Shift" Efficiency Programme*. North West Joint Improvement Partnership. www.northwestjip.co.uk

Lupton C (1998) User empowerment or family self-reliance? The Family Group Conference model *British Journal of Social Work* 28(1): 107-128

Magliano L, Fiorillo A, Malangone C, De Rosa C, Maj M (2006) Patient functioning and family burden in a controlled, real-world trial of family psychoeducation for schizophrenia. *Psychiatric Services* 57(12): 1784-1791

McFarlane WR, Dixon L, Lukens E, Luckstead A (2003) Family psychoeducation and schizophrenia: a review of the literature. *Journal of Marital and Family Therapy* 29(2):223-45

Morris K, Hughes N, Clarke H, Tew J, Mason P, Galvani S, Lewis A, Loveless L (2008) *Think family: a literature review of whole family approaches*. London: Cabinet Office Social Exclusion Task Force

Nixon J, Parr S, Hunter C, Sanderson D, Whittle S (2008) *The longer term outcomes for families who had worked with Intensive Family Support Projects*. London. Department for Communities and Local Government

Pilling S, Bebbington P, Kuipers E, Garety P, Geddes J, Orbach g, Morgan C (2002) Psychological treatments in schizophrenia : 1. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological medicine 32*: 763-782

Royal College of Psychiatrists, Social Care Institute for Excellence, and Care Services Improvement Partnership (2007) *Position Paper 8: A common purpose: recovery in future mental health services.* London: Social Care Institute for Excellence

Schon U K, Denhov A, Topor, A (2009) Social relationships as a decisive factor in recovering from severe mental illness. *International Journal of Psychiatry* 55(4): 336-347

SCIE (2012) *Making the move to delivering reablement*. London: SCIE

Stratton P, Bland J, Janes E, Lask J (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family*

Therapy. 32: 232-258

Tarrier N, Lowson K, Barrowclough C (1991) Some aspects of family interventions in schizophrenia, II: financial considerations. *British Journal of Psychiatry* 159: 481–484

Tapper L (2010) Using family group conferences in safeguarding adults. *Journal of Adult Protection* 12(1): 27-31

Tunstill J, Blewitt J, Meadows, P (2009) *Evaluating the delivery by Action for Children of targeted family support*. London: Action for Children

White C, Warrener M, Reeves A, La Valle I (2008) *Family Intervention Projects: An Evaluation of Their Design, Setup and Early Outcomes*. National Centre for Social Research, DCSF-RW047. www.dcsf.gov.uk/research/data/uploadfiles/acf44f.pdf

Wright T (2008) Using family group conference in mental health. *Nursing Times* 104(4): 34-35

Appendix 1: Services included in the first phase of the study for telephone interview

Name of Service (The name given in brackets is the name used throughout the report)	**Service Provider(s)**
Family Group Conferencing	
Essex Family Group Conferencing (Essex)	North Essex Partnership NHS foundation Trust and Essex County Council
Behavioural family therapy	
Meriden Family Programme (Meriden)	Birmingham and Solihull NHS Foundation Trust
Birmingham and Solihull Early Intervention Service (Birmingham)	Birmingham and Solihull NHS Foundation Trust
Northumberland, Tyne and Wear Family Therapy Services (Northumberland)	Northumberland, Tyne and Wear NHS Foundation Trust
Psychosis Intervention and Early Recovery (Leicestershire)	Leicestershire Partnership NHS Trust
Early Intervention for Psychosis Service (Kent)	Kent and Medway NHS and Social Care Partnership Trust
Systemic family therapy	
Barnet, Enfield and Haringey Family Work Service (Barnet)	Barnet, Enfield and Haringey Mental Health NHS Trust
Joint Adult Services and Young People's Family Clinic (Bristol)	North Bristol NHS Trust (Community and Child Health Partnership CAMHS service) and Avon and Wiltshire Mental Health Partnership NHS Trust (Psychological Therapies service for adults)
Adult Family Service (Humber)	Humber NHS Foundation Trust
Family Consultation Service (Oxleas)	Oxleas NHS Foundation Trust

Parkside Clinic Parental Mental Health Service (Parkside)	Central and North West London NHS Foundation Trust
Kensington and Chelsea Adult Mental Health Service (Kensington)	Central and North West London NHS foundation Trust
Intensive Family Support	
Liverpool Family Support Worker Service (Liverpool)	Mersey Care NHS Trust and Liverpool NHS Primary Care Trust and Liverpool City Council
Parental Mental Health Service (Southwark)	South London and Maudsley NHS Foundation Trust
Hybrid Service	
Somerset Family Support Service (Somerset)	Somerset Partnership NHS Trust