Building Family Skills Together

Key learning from a project that aimed to implement an evidence -based family intervention in the Continuing Care Team of an Adult Mental Health Service

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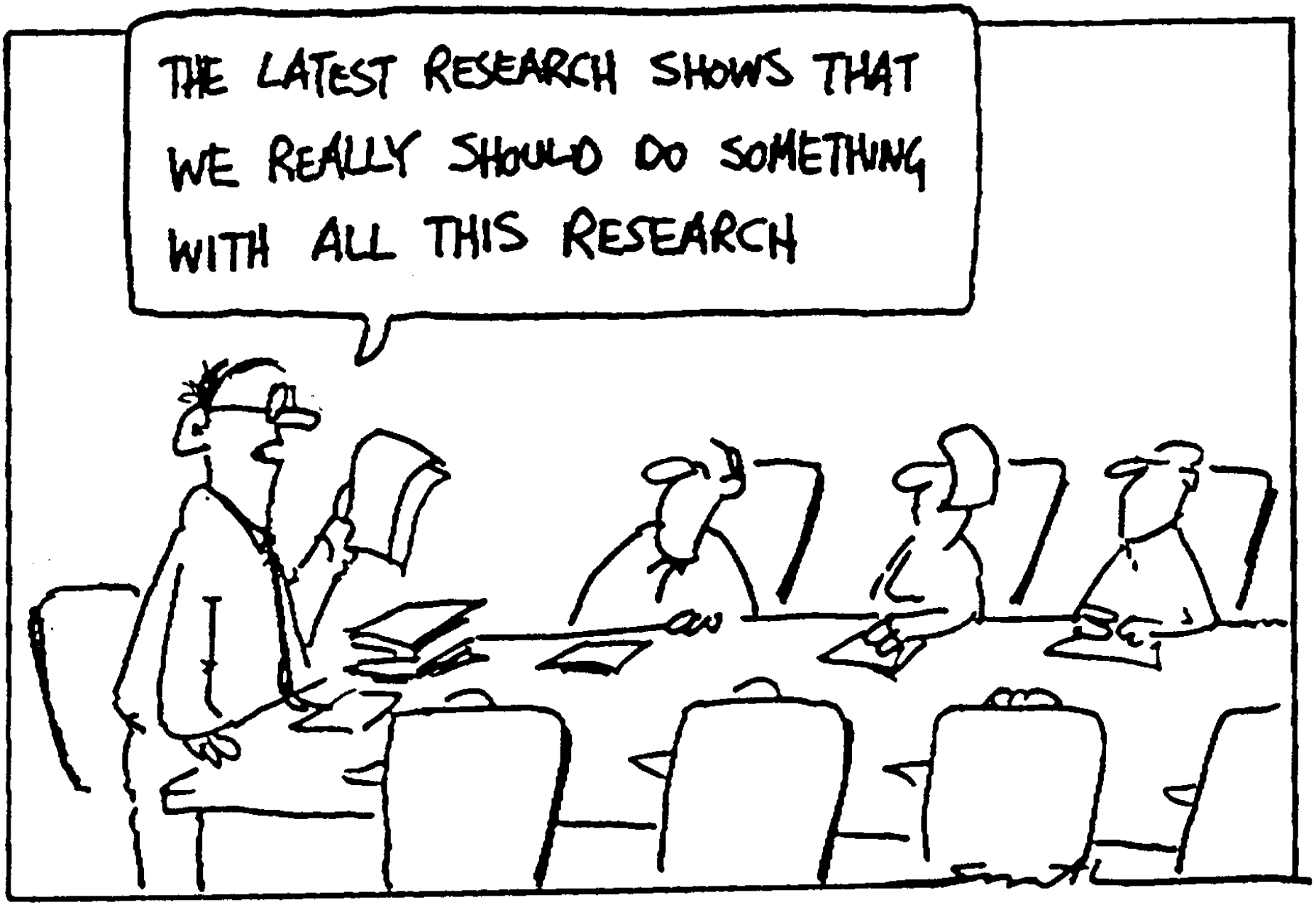
The why, the what, the where and the how of BFST

What is Building Family Skills Together?

- Building Family Skills Together (BFST) -an implementation & research program

- Aimed to introduce an evidence-based family intervention (Behavioural Family Therapy, BFT) into routine practice in an Adult Mental Health Service

- Partnership between a clinical mental health service (NorthWest AMHS), a research centre (Psychosocial Research Centre) and a specialist family service (The Bouverie Centre)


THE LATEST RESEARCH SHOWS THAT WE REALLY SHOULD DO SOMETHING WITH ALL THIS RESEARCH

Family Interventions in Mental Health

- Extensive evidence for reduction in relapse & readmission and other benefits for client & family
- Included in treatment guidelines for schizophrenia
- Not routinely offered in mental health services
- Even where training is provided uptake is limited
  - Average no. of families seen post-training ranges from 0.9-3.5 (Kavanagh et al, 1993; Fadden, 1997; Bailey et al, 2003; Brooker et al 2003; Magliano et al, 2005, 2006)

What is Behavioural Family Therapy (BFT)?

- Family intervention that includes consumer
- Assessment, information-sharing, relapse prevention, training in communication & problem-solving skills
- One hour sessions
- Home or clinic-based
- Weekly or fortnightly
- 6-9 months duration

Service Context

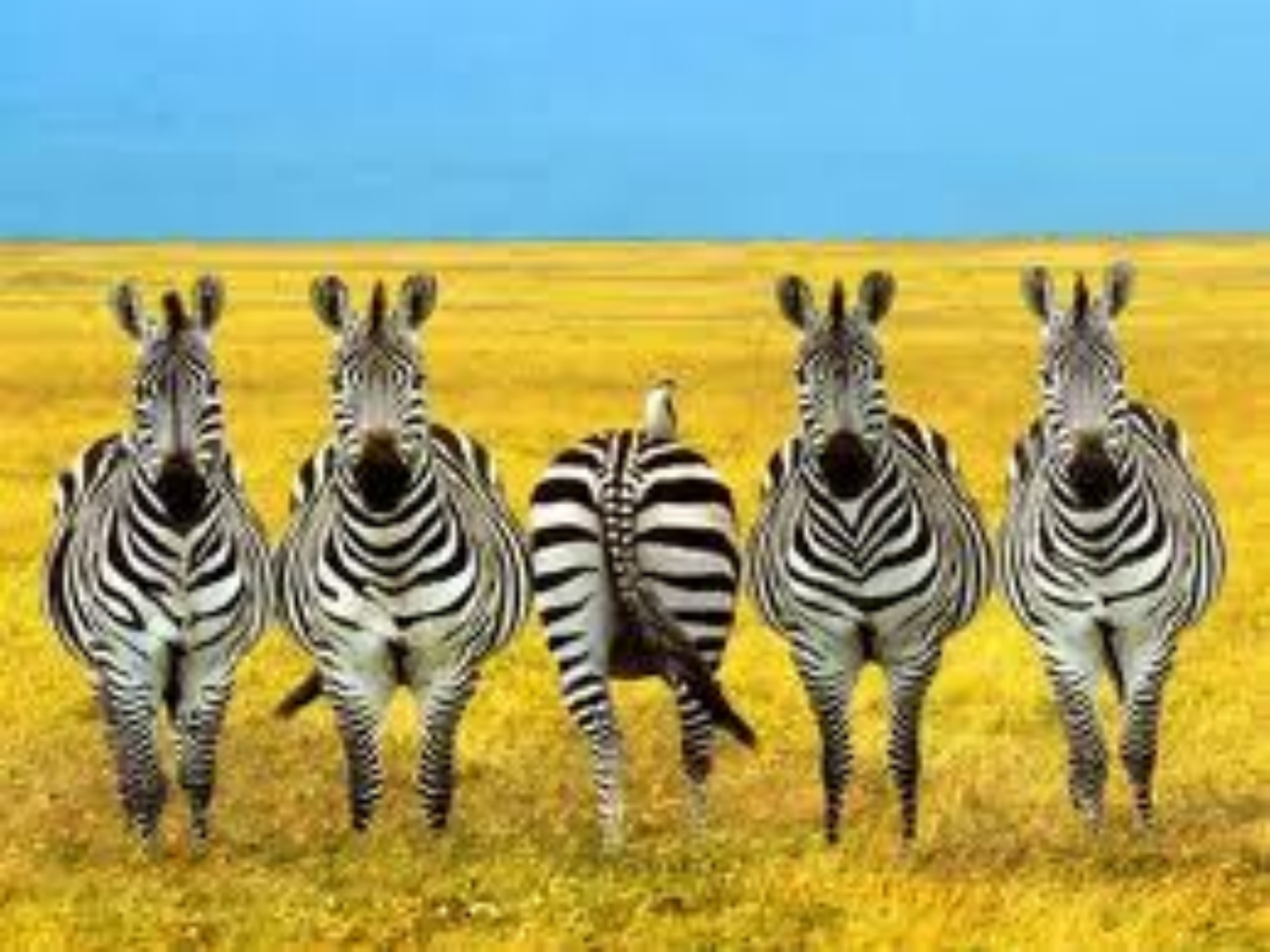
- Continuing Care Team of Area Mental Health Service
- Clients with serious mental illness- culturally diverse and economically disadvantaged area
- Multi-disciplinary case managers, psychiatrists & carer consultants~ 22 EFT
- Mix of recent graduates and experienced staff
- Total team caseload of 350 clients
- Case Manager Caseload 25-30 clients

The Implementation Strategy

- Family Practice Consultant/Implementation co-ordinator located in service
- Five Day Training Program & Practice Manual
- Co-working
- Monthly Supervision Groups
- Implementation & Governance Groups

Embedded Facilitator (Doherty et al 2010)

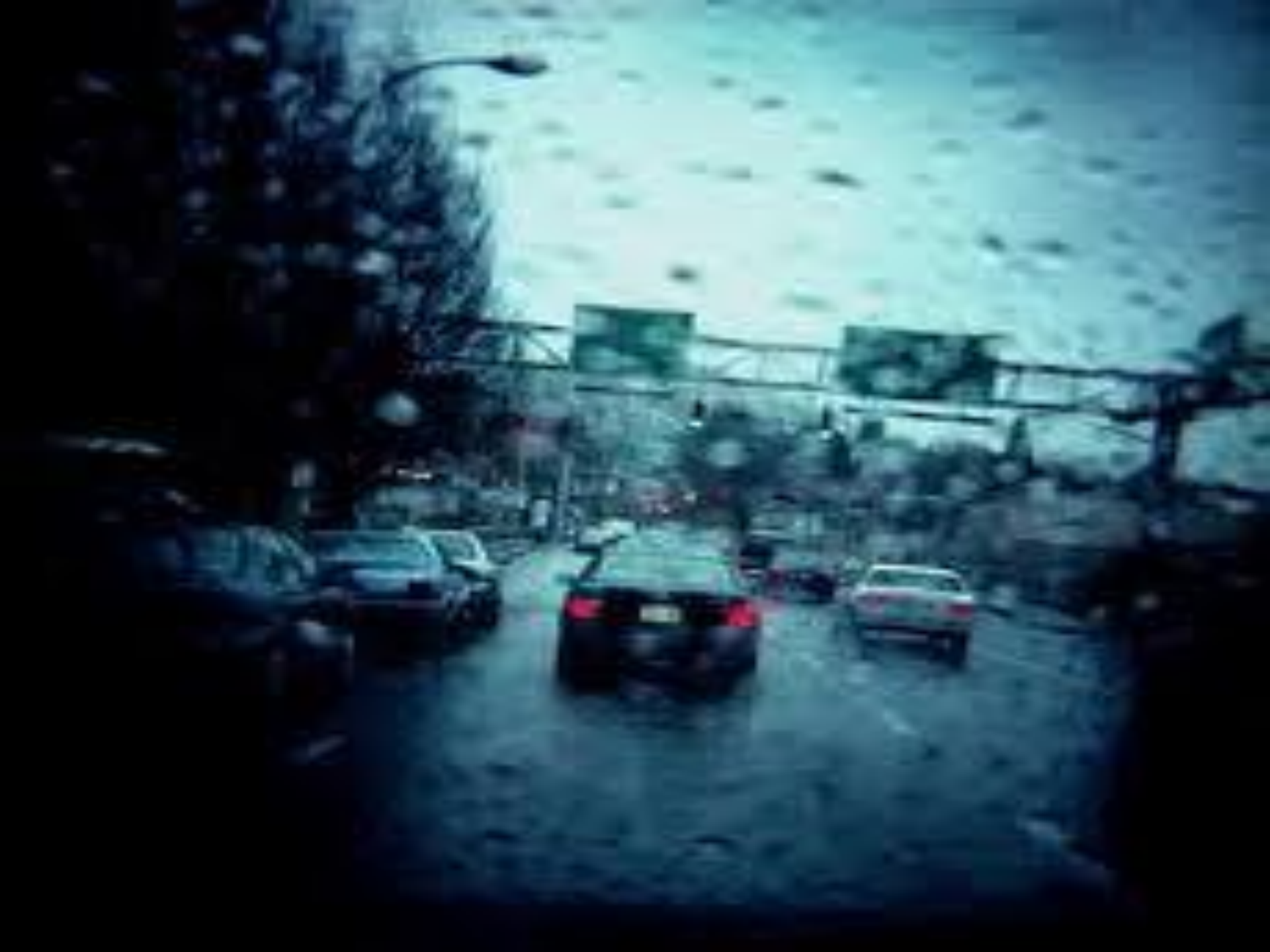
- Based in service 0.5 EFT for over two years
- Physically located in open plan area with practitioners
- Actively involved in all aspects of implementation strategy including co-working with families

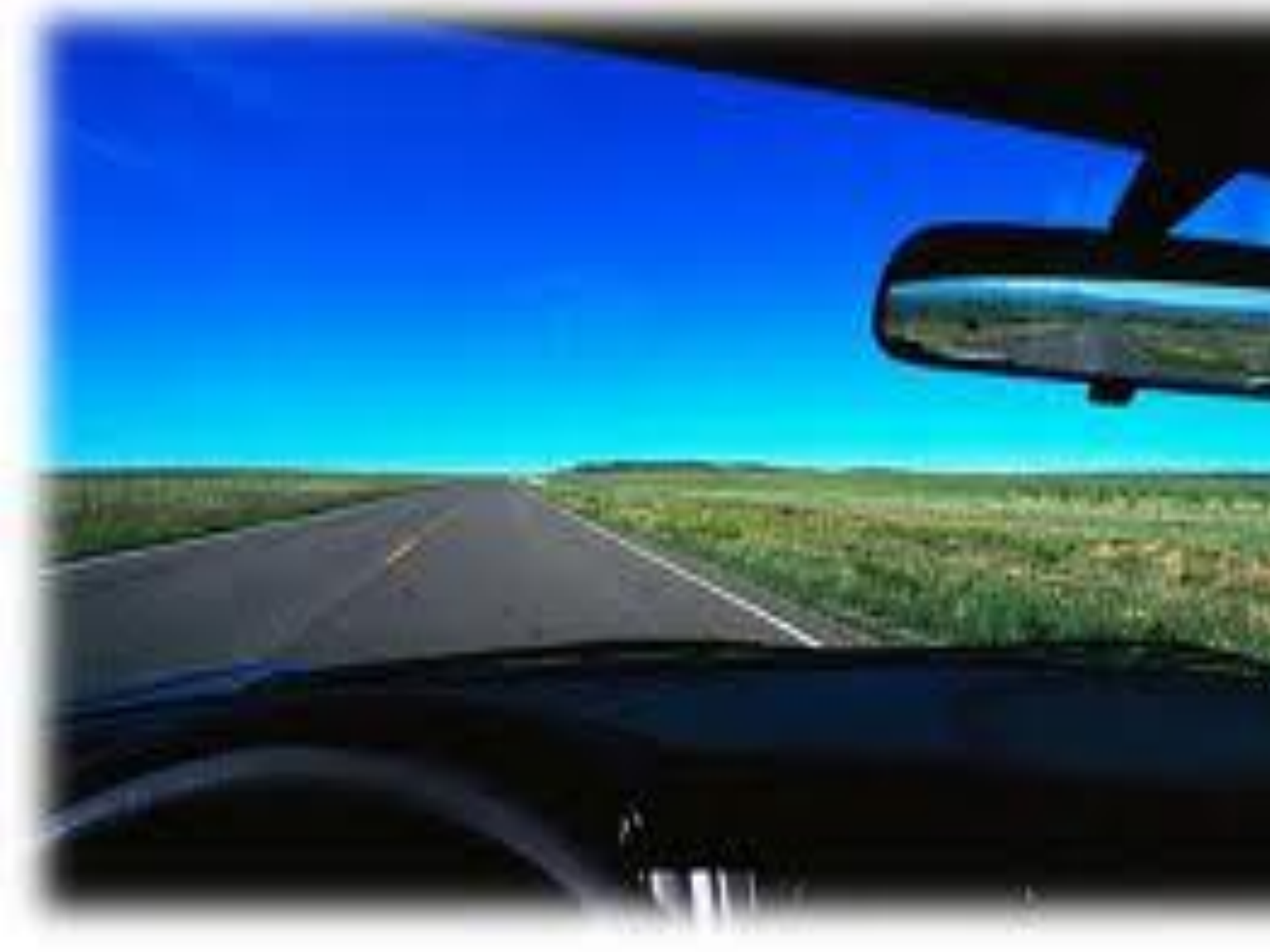


Ethnographic Action Research Design

- How to best implement a family intervention within routine clinical practice in a Continuing Care Team
  - The impact of an embedded facilitator as a intensive implementation support strategy
  - The particular value of a ‘whole of team’ training & implementation strategy
  - Captures an ‘up close and personal’ experience and driver’s seat view of the implementation process

Some Views from the Drivers Seat





The Families

Families' Engagement in BFT

- Identified ~90 clients diagnosed with schizophrenia living with family members
- 22 directly declined participating in BFT
- 31 families participated in BFT (at least three sessions)

‘I’d rather poke my eye out with a blunt stick……’

- Not all clients or families were receptive to participating in BFT
  - Practical constraints
  - Nature of family relationships
  - Fear of ‘rocking the boat’

‘Maybe it’s worth the risk…..’

Families participated in BFT to

- Learn more about the condition & reduce the likelihood of relapse
- Deal with conflict & communication difficulties
- Involve less involved family members more
- Show commitment to their ill relative

The Practitioners

Training, uptake and co-work (May 2006- December 2008)

- 27 practitioners trained (comprising 22 case managers 2 carer consultants and 3 psychiatrists)
- 20 practitioners conducted BFT
- Seven practitioners did see not a family (three left within 3 months of training)

Training, co-work and uptake (May 2006- December 2008)

- Average number of families seen per practitioner trained(1.2)
- Three practitioners saw 3 families; seven saw 2; ten saw 1family
- Family Practice Consultant co-worked with 23 clinicians of the 27 trained

‘But I hardly know you….’

Low levels of incidental contact between family-practitioner may account for difficulty in identifying & engaging families in BFT

‘I’ll only do it if you come too’

Practitioners are highly anxious about seeing families and doing BFT but co-working helps

‘Difficult but different’

BFT offers practitioners a positive contrast to ‘usual’ practice

- –Knowing clients & family members differently
- –Being part of and witnessing change

‘We are early adopters..… for our own particular reasons!’

- A small group of practitioners saw more families because they variously
  - Liked working with families
  - Enjoyed the opportunity to try a new approach
  - Felt an obligation to offer an newly available intervention to their clients

The Service

Organizational change achieved

- Extension of operating hours
- Additional time for Carer Consultants
- Routine reporting of family contact data
- Routine consideration of BFT at clinical reviews
- BFST Coordinator established in service
- ‘Champion’ roles established within teams

‘We can talk about it more when I see you in a month’

The dominant office based & ‘passive’ practice culture did not fit with the assertive practice needed to engage families in BFT

Staff Turnover: A Dark Cloud with a Very Thin Silver Lining

- Turnover directly reduced capacity to see families, amplified workload and affected project morale
- New staff saw family work as a given

Implementation Strategy

‘But what do you really think?’

Team culture discouraged open expression of dissatisfaction and this inhibited feedback about how practitioners experienced trying to integrate BFT into their existing work role

‘High Expectations’

- An assumption that increased implementation support would lead to increased rates of uptake created unrealistically high expectations
- These expectations created an unhelpful climate for BFST

Key Learning

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- Embedded facilitator role maybe viable as a ‘rapid ethnography’ to inform an implementation strategy
- Client/family demographics & preferences, workload and staff turnover, set parameters for uptake
- In turn levels of uptake will determine whether it is viable to have all practitioners providing BFT

Key Findings

- Increasing levels of routine practitioner-family contact may help with engagement of families in intensive family interventions

- Co-working may be particularly valuable for implementing family interventions

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