



Does implementing ‘family’ involvement in initial assessments lead to better treatment outcomes in service users with psychosis: an inter-team study within NHS community mental health

Maeve Malley¹, Lucy Hickey², Fernitta Osei-Mensah³, Naureen Whittinger, ⁴
Greenwich Adult Mental Health Services, Oxleas NHS Foundation Trust, London

1. Dr, Consultant Systemic Psychotherapist
2. Dr, Head of Psychological Therapies in Primary Care
3. Assistant Psychologist
4. Dr, Consultant Psychologist



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This paper documents a project introducing Initial Family Meetings (IFM's) into a Community Mental Health service in South-East London, as a way to promote greater involvement of significant others of people with psychosis, in mental health assessment and treatment. Results indicated that family involvement did not directly correlate with treatment outcomes, but clients and significant others reported overall positive experiences when attending IFMs. We consider what differences were brought about by this initiative in terms of attitudinal shifts within



relational networks and clinical contexts and fostering a greater systemic awareness within the service.

Introduction

Why?

The need for the involvement of families and significant others in the care planning and treatment of clients with psychosis has been clear for a number of years.^{1,2,3} Key benefits identified for service users have included accessing and engaging with services^{4,5}; maintaining medication adherence⁶, social functioning⁷ and engagement with psychological therapy⁸; reducing symptom severity⁹, the risk of relapse¹⁰ and the frequency and duration of inpatient admissions¹¹.

For significant others, the benefits are a greater awareness of what services can offer, a context where the views of the whole relational system can be taken into consideration, a sense of being involved in the definition of the difficulties, what works well or poorly (from more than one perspective) and support in the difficulties connected with the mental health issues.

Clinicians may also feel supported by the involvement of a wider relational group, getting some sense of the history from more than one perspective and of building a relationship early on with a wider network of support for their clients.

Despite this considerable evidence base and the multi-faceted positives of involvement, there are consistent findings of poor family/significant other's involvement across mental health services^{12,13,14,15}. This is especially problematic given that therapeutic family/significant other's interventions (FI) have long been recommended as a core element in the treatment of psychosis within clinical guideline^{s16}. Although, the implementation rates for family/significant other's interventions reflect poor involvement for them in mental health services more widely^{17,18}.

Key barriers to family/significant other's involvement identified within mental health services cluster around service users and their families, clinicians, and the systems of services themselves^{19,20}. This has included service user concerns around confidentiality and sharing information²¹, clinician attitudes and lack of training and experience in working with families^{22,23}, organisational issues universal to mental health services – including caseload size, workload, and the professional training background of most healthcare professionals^{24,25} where the focus is on the individual and the diagnosis, and the de-contextualising culture of mental health services²⁶.

Investigations into these key barriers have led to calls for interventions targeting the structure and culture of mental health services²⁷. The ultimate goal of these interventions should be the instigation of a 'cultural and organisational shift' towards involving families/significant others and 'the development of clear practice guidelines for the reorganisation of clinical teams'²⁸. Particularly, there is a need to evaluate the impact of family/significant other's involvement on service users, significant others²⁹ and clinicians and for 'further research into effective service-wide strategies that explore with families how their engagement can be positively fostered'³⁰.



Where?

Geography and population

The two NHS teams we're discussing are sited within Greenwich, an area in South-East London, whose population includes the very rich, the very poor and a lot in-between – not unlike much of London.

Just over a quarter of a million people live there; it's a slightly younger population than the London average and racially mixed (*Fig 1*).

As you can see from the study sample and, not surprisingly, given the disproportionate representation generally of Black people diagnosed with severe and enduring mental health problems, they are over-represented in the group of people we discuss, as compared with general population figures.

	Whites	Multiracial	Asian	Black	Other
Royal Greenwich	62.5%	4.8%	11.7%	19.1%	1.9%
London	59.8%	5.0%	18.5%	13.3%	3.4%
England	85.4%	2.3%	7.8%	3.5%	1.0%
Study	55.8%	7.1%	6.6%	27.8%	2.7%

The service

Like all NHS services in England, these services are run by an NHS 'Trust' – in this case, called Oxleas NHS Trust. Oxleas employs 3,500+ staff in a mixture of professions in mental health and physical health services.

It has a very small systemic psychotherapy staff group, who mainly sit within psychological therapies. Aside from this group, very few professionals within the Trust are tasked, or confident, about working with family and significant others and in considering the wider context of service users' lives, despite being keen to learn skills in this area.

The service we're talking about works with people with 'severe and enduring' mental health problems – in other words, they're likely to have diagnoses of Bipolar Affective Disorder and/or psychosis or schizophrenia.

The history

In 2007, Oxleas commissioned training to help services involve families routinely. All the teams in the Trust attended an initial two-day training and a short follow-up training, several months later. This was both expensive and time-consuming, though effective in raising the profile of family-inclusive practice.



However, without ongoing supervision, buy-in from Service and Team Managers and the structural changes in practice and our electronic record system which would require clinicians to routinely see families/significant others at an early stage, and to be able to monitor the effectiveness of this as a service intervention, this approach tended to fall away over time.

Since then, there was an acknowledgement within the Trust of the need to work with people's 'wider networks' - generally assumed to be 'family' - but in practice clients still tended to be seen as an individual with a diagnosis: this was still the dominant paradigm. Consequently, an emphasis on medication and 'stabilisation'/risk management was seen as the treatment of choice.

In 2015, our Adult Mental Health services were redesigned and teams working with people with psychosis were a pilot site for involving families in initial meetings and evaluation of this work – hence initial family meetings were developed. The project has been led by senior psychological therapists and backed by our medical and managerial colleagues. Other clinicians who have been involved in a meeting have provided consistently positive feedback. Their feedback indicated that meetings provided clarity, a wider understanding of clients and their wider system, and helped uncover different points of view.

The 'initial family meeting'

The initial family meeting is the first appointment a client is offered after being referred to our community team. It involves meeting with the client and anyone that they wish to bring to gather information that builds a greater understanding of the reason for referral to the team and the client's goals. We ask both client and significant others their views, using the DIALOG+ assessment³¹ to help structure the appointment.

Method:

We have taken two approaches to exploring the relative benefits of including significant others in the initial appointment based around two research questions:

1. What are the differences in treatment outcomes and service engagement between service users who attend an initial appointment with significant others and those who don't?
2. What are the experiences of service users and their families who have attended an initial family meeting?

The study formed part of routine service evaluation and was registered with the trust Research and Development department at Oxleas.

Treatment Outcomes and Service Engagement

To answer our first research question, we carried out a quantitative analysis of routine client data obtained from our clinical record system, including inpatient, crisis, and community contacts.



Sample:

Participants were obtained from the teams' record of clients who attended an initial family meeting from July 2019 to July 2021. In total there were 171 participants who attended an IFM during this period: 97 females and 74 males.

Clients were working age adults between 18-65 years, and were from varying ethnicities and religions. We did not include clients who were under the team but did not attend an IFM.

Materials:

Microsoft Excel was used to create and access the spreadsheet to record client IFM attendance. The NHS version of IBM SPSS Statistics called PSPP, was used as the statistical test to analyse the dataset with the p level set to <.05.

Design and analyses:

This study used a quasi-experimental design as clients were not randomly assigned to groups. A mixed methods design was also used, incorporating both quantitative outcomes and qualitative feedback from participants to consider both 'hard' outcomes and participant experiences of IFMs.

The independent variable was whether clients attended their initial assessment with family members or whether they attended alone. The dependent variables were visible relapse indicators in the community which included planned and unplanned contact with mental health services or hospital admissions.

Procedure:

Initial family meeting appointments were carried out during normal working hours at one of the psychosis team bases or virtually on Microsoft Teams. Prior to the appointment, service users were provided information about the purpose and process of the meeting via a letter to their home address and were encouraged to choose who they wanted to bring to the appointment.

IFMs were recorded on a spreadsheet detailing with whom the service user attended e.g., Mother and Father, or if they had attended alone. Data was stored securely within the Oxleas network on a secure shared network drive within the service and was only used for the purpose of this study. No identifiable information relating to participants was retained, therefore gaining informed consent was not required.

Data of IFMs were collected over a 2-year period, from July 2019 to July 2021, with a 6-month period used to determine the treatment outcomes. Additional information from the clinical records system 'RiO' was also pulled onto the spreadsheet which was used to measure treatment outcomes. The relapse indicators which were used as quantitative measures were:



- Number of hospital admissions after IFM
- Number of psychology appointments attended after IFM
- Number of crisis calls after IFM
- Number of merlin reports (police contact) after IFM
- Duty contact (unplanned team contact) after IFM
- Number of home treatment team calls after IFM
- Total number of team contact after IFM
- Total number of accident and emergency (A&E) after IFM

These variables were reduced to three categories: Number of hospital admissions, unplanned service contact and planned service contact. Unplanned service contact included calls to the Trust Crisis Telephone line, Police reports, Accident and Emergency department attendance and duty contact. Planned contact included Home Treatment Team contact, other mental health service team contact and psychology appointment attendance.

Client and Significant Other Experiences

To answer our second question, we conducted video or telephone calls with people who had attended IFMs with significant others between June 2020 – February 2021. In total, 11 service users and 9 family members (parents, spouses, and siblings) participated in this part of our study. The semi-structured interviews were based on a proforma of standard questions that had been agreed by the research team. Interviews generally lasted around 20 minutes and were recorded. We established themes within the transcribed data using thematic analysis³².

Results

Treatment Outcomes and Service Engagement

Eighty-nine (89) clients attended an IFM with family, whilst eighty-two (82) clients attended alone. Parametric assumptions were met and so an independent t-test was conducted.

There was no significant effect between hospital admissions and those who attended an IFM with family or alone $t_{(167)} = 1.46$, $p = <.05$.

There was no significant effect between unplanned service contact and those who attended an IFM with family or alone $t_{(169)} = .99$, $p = <.05$. There was no significant effect between planned service contact and those who attended an IFM with family or alone $t_{(169)} = .98$, $p = <.05$.

**Table 1. Descriptive statistics for treatment outcome measures depending on initial family meeting attendance**

	<u>Attended with family</u>			<u>Attended alone</u>		
	<i>M</i>	<i>SD</i>	<i>SE</i>	<i>M</i>	<i>SD</i>	<i>SE</i>
Hospital admission	.16	.48	.05	.07	.26	.03
Unplanned contact	1.71	4.21	.45	1.16	2.88	.32
Planned contact	10.12	10.21	1.08	8.72	8.38	.93

Client and Significant Other Experiences

We found clients and significant others centred their verbal feedback to us around five main themes: their journey to help, perceived roles of family members, their experiences of the IFM, family communication patterns, and new insights and change arising from the IFM. Significant others frequently reported feeling alone before accessing help from mental health services. Both clients and family members saw significant others as offering support and facilitation at the appointments, with family members sometimes describing themselves as having a “duty” to care and support.

Within the IFMs, different perspectives were often raised. Clients and significant others often reflected in the interviews about their typical family communication patterns, describing themselves as families that usually talked with each other or families that don't typically talk. Regardless of the typical pattern, they reported gaining new learning from what they heard at an IFM. This prompted thoughts about change, including taking risks to talk more with each other after the meeting. Overall, both clients and significant others felt the meeting was different to previous appointments and expressed it was good that family members were included.

Discussion

A causal relationship between treatment outcomes and IFM attendance with or without family members could not be inferred through our quantitative analysis. However, we found through our qualitative analysis that IFMs do provide an important opportunity for different perspectives on problems and possible solutions. Moreover, based on the feedback of our clients and family members, we have learned that including significant others as part of the conversation at an IFM led to positive ongoing relational experiences.

Continuing our qualitative and quantitative evaluation will enable development of the approach. Drawing conclusions about the impact of systemic interventions on relational and health systems through quantitative methodologies is however dependent on access to information not currently routinely collected within UK health services. We hope in future to be able to collect information



on relational outcomes as part of our ongoing research. We note too, that the IFM initiative is still relatively new and being limited to one site, our study sample is limited in number.

Conclusion

Our study to date demonstrates that clinicians, clients and significant others value the IFM as a way of changing perspectives and understanding. This feedback can be used to develop a pathway for ongoing family work over a longer period of time beyond the family meeting. Continuing to gain this feedback will help to shape the way the service is offered to make this both accessible and productive to clients and significant others. Our awareness that the meetings are perceived as useful can help embed the meetings into routine practice and to generalise to other teams within mental health services.

To date, we do not have evidence of measurable changes to the level of contact with services and this could be explored if clients and significant others attended family meetings over a longer period of time beyond the initial meeting. Treatment outcome measures can also be used to compare level of improvement following the meetings as another indicator of quantitative change.

The use of the DIALOG+ assessment and care planning tool in the Adult Mental Health service is a new development to broaden the range of domains of the client's life explored at the assessment stage. This tool lends itself to incorporation into an IFM as the focus is more on the context of a client's difficulties than the focus on internal processes.

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