WHOLE FAMILY APPROACHES TO REABLEMENT IN MENTAL HEALTH

Models, processes and outcomes

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WHAT WAS THE STUDY ABOUT?

- Value or otherwise of ‘whole family approaches’ in achieving social reablement outcomes – i.e. not clinical outcomes – for people with mental health difficulties

- Links to wider policy agendas
  - Putting People First
    - Choice and control
    - Social capital / accessing the social mainstream
  - No Health without Mental Health
  - Think Family
  - Care Act: focus on wellbeing and preventing long term disability
The Care Act and Whole-Family Approaches - Guidance
WHAT IS REABLEMENT?

- Maximising ‘users’ independence, choice and quality of life’ (OPM, 2012)

- Linking to Sen’s idea of capability, reablement in mental health defined as restoring the possibilities for:
  - making choices and taking charge of one’s life (personal agency or empowerment)
  - taking up opportunities within mainstream community life (social participation).
WHAT IS A ‘WHOLE FAMILY’ APPROACH?

- One that focuses 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 Think Family, 2007 p.30).

- Interest in ‘family’ as a relational network and not just in terms of ‘axial’ role relationships – e.g. parent-child or carer-service user

- User-centred definition of who is to be considered ‘family’
METHODOLOGY

- **Realistic evaluation**: focus on
  - Contexts
  - Mechanisms of change
  - Outcomes

- **Case studies** – 4 identified models; min 5 per model
  - Triangulation of perspectives of service users, family members and practitioners
  - Mixed samples to include successes and failures
# Characteristics of Service User Sample

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Types of data

- Narratives – process and outcome
- Showcards – ‘soft’ measure of change in relation to short scales of grouped items
  - Empowerment
  - Social participation
  - Interpersonal relationships

Particular focus on evaluation of outcomes by service users and family members
THE MODELS

- Systemic family therapy
- Behavioural Family Therapy
- Integrated systemic / behavioural
- Family Group Conferencing

N.B. Open Dialogue not being practised in UK at time of study
WHO WAS INVOLVED?

- No significant differences between models in terms of who was seen as ‘family’ and invited to join the family sessions
  - Much of the work involved immediate (but not necessarily co-resident) family, sometimes with certain other family members coming to specific sessions.
  - Young children were not directly involved
- All professionals were routinely invited to the first part of each Family Group Conference
- Common for care coordinators to be involved as co-facilitators in BFT and ISB approaches.
1** Systemic Family Therapy**

- Primary focus on enmeshed or problematic relationships within family – including situations of violence or abuse
- Opportunity for service user and/or family members to voice difficult issues in safe setting
- Questions, observations and ‘homework’ tasks that lead family members so see and interact with each other in different ways
  - E.g. Narrative reframing

- **Duration:**
  - 6 months – 5 years.
  - Median - 2 years

- **Intensity:**
  - Weekly / fortnightly to start
  - Tapering to monthly / 3 monthly
TYPICAL MECHANISM OF CHANGE

- Having a voice and being heard
- Reflecting on and renegotiating relationships
- Reablement
- Outward focus and practical support
Processes and mechanisms of change: surfacing and resolving relationship issues

Opening up about underlying issues:

- Some things were talked about... quite traumatic things... I found out things about [ ]'s past that obviously was directly affecting everything, that she might not have felt free to say otherwise (SFT2 - FM).

Resolution of an enmeshed family relationship:

- My mum sometimes involved me in her life a bit more than she should do and that I needed to be a bit more independent.... If my mum’s got drama going on, then maybe, you know, that’s just the way she is, and I should just let her do that. I should have my own life, where I can do my own thing (SFT3 - SU).
What helped to translate relationship changes into reablement outcomes?

- **Outward focus: being supported to (re)build a life ‘out there’**
  - You’re ill, so you can’t work. You can’t work, so you can’t move out. You can’t move out, so you’re ill... So, having family therapy, sort of, broke me out of that a little bit more. I started to do courses at a local college, so I’ve been doing that for quite a while. So I’ve got a routine now....I was doing volunteering as well (SFT3 - SU)

- **More flexible / practical approach**
  - ‘She understood about the family and the practical... one time she came to do the shopping with me I didn’t want to go on my own because you know it is difficult’ (SFT5 – SU).
2 Behavioural Family Therapy

- Standard week-by-week programme of topics, activities and exercises – but material often used flexibly by practitioners

- Main areas covered:
  - Psychoeducation
  - Communication skills
  - Problem solving skills

- Package of 8 – 16 family sessions over 3 – 6 months
  - Sessions could be weekly, fortnightly or monthly
  - Took place in family home
**Typical Mechanism of Change**

- **Sharing understanding of mental health issues**
- **Learning more effective ways of communicating**
- **Renegotiating family relationships**
- **Outward focus and practical support**
- **Reablement**
COMMUNICATION SKILLS, RELATIONSHIP CHANGES AND (SOMETIMES) REABLEMENT

‘He gave us stuff to say...ways we could improve on – like more positive – be more positive towards one another and make each other feel good so it was more of a positive environment to live in’. (BFT2 – SU)

‘Well, it's just the fact that they made us realise that we'd got to let go of the girls a bit to get their independence... Because when you've got people who are ill like that, it's very hard to let them ... go’. (BFT1 - FM)

Building an outward focus (e.g. working up to going to College) often resulted from additional work by practitioners outside the core model

• ‘A number of sessions in their home and communication and then it’s the afterwards work, you know, with the family as well. It was a kind of, you know – that the family sessions finished ... but then I continued working with the family as a family ...you’re not sitting down doing sessions, you’re just including them in’ (BFT1 – P)
What didn’t work so well

- The structure of BFT did not always provide sufficient support to discuss or resolve underlying personal or relationship issues:

  ‘I felt it wasn’t about that sort of thing. It was more about sort of surface things and getting on with people rather than about the way I feel inside’. (BFT3-SU)
3 **INTEGRATED SYSTEMIC / BEHAVIOURAL**

- Integration of systemic and behavioural approaches

- Flexibility of focus on
  - Psychoeducation
  - Systemic interactional patterns
  - Communication
  - Individual and family coping strategies / skills
  - Planning and goal setting

- Usually focussed on present and future

- **Duration:**
  - 2 years – 8 years - but often comprising discrete periods of involvement.

- **Intensity:**
  - Usually monthly to start, tapering to 2 monthly / 3 monthly
Typical mechanism of change:

- Shared understanding of mental health issues and coping strategies
- Renegotiating relationships; building confidence and support
- Family provides safe base or supports outward exploration

Reablement
Some reflections on process:

- *I knew what psychosis was because I was experiencing it, but they were in the dark about it and I think it was an educational tool as much as anything (ISB1 – SU)*

- ‘*His perception was different to the reality, so that was the first sort of building block in realising that actually perhaps everyone else’s perception was not quite how he was imagining it to be’* (ISB1 – FM)

- *Family Therapy helped boost my sense of self and therefore my perception ... in my relationships with significant others as well (ISB2 – SU)*
**Family can become ‘safe base’ for reablement**

- ‘I .... felt more comfortable being at home, which means that I feel like I've got a safe haven when things might get a bit shaky ...
  It gave me a good foundation, with helping me to - to socialise. I felt more comfortable going places after I'd been to family therapy. And that's continued’ (ISB1 – SU)

- Family support has changed radically from being very kind and concerned and well meaning ... but actually inadvertently maintaining or exacerbating a problem, to be ... an appropriate level of support for a young adult and is enabling [SU] to start to build an independent life (ISB3 – P)
4 FAMILY GROUP CONFERENCING

- Preparatory meetings with service user and (some) family members

- Facilitated decision-making Conference
  - Family draw up recovery plan

- Some individual support from facilitator for service user and/or family members in carrying out agreed actions in the recovery plan

- Up to 4 review meetings over subsequent 12 months

Who involved:
- Typically service user and family members including wider network (e.g. in-laws) and sometimes involving 3 generations
- Professionals invited for first part of Conference (on family’s terms)
- Typically just ‘core’ family members involved in review meetings
**Typical mechanism of change:**

- Dialogue with professionals / sharing issues
- Making plans / being ‘in the driving seat’
- Outward focus and practical support
- Reflecting on and renegotiating relationships
- Reablement
Processes and mechanisms of change:

- ‘Whatever you had to say, however it would have sounded...[the professionals]...respected that...and they dealt with those questions that you asked’. (FGC6 – FM)

- ‘I came away from there feeling really elated...because I really felt that...the whole experience had brought all five...of us together, much closer.... And that was so nice. (FGC7 – SU)

- However sometimes insufficient support structure to enable all participants to be honest
  - ‘I found out that people weren’t telling the whole truth because... they didn’t want to hurt other people’s feelings.’ (FGC3 – SU)
EMPOWERMENT THROUGH BEING ‘IN THE DRIVING SEAT’ IN THE FGC

‘To have that bit of confidence and that bit of empowerment and control over what’s happening to me ... really helped... I think if I didn’t have family group conferencing, I don’t think I would have made a successful transition home’ (FGC1-SU).

‘When I come away from them it was... quite amazing, because I ... felt, like, ‘Do you know what, I wanna be in control ... of my own life.’ And they gave me strategies ... and I used them ... and I felt good about it.’ (FGC4-SU)
CONCLUSIONS: MODELS AND TYPES OF OUTCOME

 All models have the potential to achieve positive reablement outcomes
  • However, significantly different mechanisms by which this is achieved

 Pre-existing entrenched family relationship difficulties, rather than severity of mental health issue can be main predictor of poor outcome
MODELS AND TYPES OF OUTCOME

- A focus on relationships may or may not be a prerequisite for successful outcomes
  - The structure and focus of systemic models may be most effective in resolving more entrenched relationship issues
  - BFT and FGC models provide practical focus which can work in resolving some relationship issues
- FGC model provides most explicit focus on empowerment and social engagement through Recovery Plan process
 MODELS AND TYPES OF OUTCOME

The process of change may take a number of years (particularly where mental health difficulty may be severe) – and sustained support can achieve life-changing results.

- ‘Briefer’ models (FGC and BFT) may need additional flexibility to support such slow and sustained change processes

- Conversely some strong outcomes achieved through more intense shorter term burst of activity - and ‘briefer’ models may provide best focus for this
CONCLUSIONS ACROSS ALL MODELS

- Being willing to tailor the model to the family, and integrating family work with individual support and care co-ordination linked to best reablement outcomes.
  - Opposite conclusion to conventional Evidence Based Practice model
- There needs to be an explicit focus on engaging with the wider social world if reablement outcomes are to be achieved
  - This may involve flexibility and additional work outside family sessions
- Best outcomes when family work (or preparatory work leading into it) is started when person is still quite unwell – e.g. before discharge from hospital
REFERENCES


