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DOI:
10.1093/bjsw/bcw106

Family-inclusive approaches to reablement in mental health: models, mechanisms and outcomes

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This paper reports findings from independent research funded by the National Institute for Health Research / School for Social Care Research. The views expressed 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.

This Paper reports on a national study of 'whole family' models of practice – and how these may (or may not) contribute to the reablement of people with mental health difficulties. Using a capabilities-based perspective, it is argued that, within the context of mental health, reablement may best be defined in terms of empowerment and social participation.

Framed within a realist evaluation methodology, the study employs a comparative case study design to explore the relationships between contexts of intervention, mechanisms of change, and the achievement (or otherwise) of reablement outcomes. Four distinct practice approaches in current use were examined: systemic family therapy, behavioural family therapy, family group conferencing and an integrated systemic/behavioural approach. Using a sample of 22 families, separate interviews were undertaken with service users, family members and practitioners, and narrative accounts were triangulated with scaled responses to scorecard questions.

From an analysis of this data, heuristic models of change are derived for each approach. From this, a composite schema is developed that charts how, with different starting points and routes, engaging with whole families may lead to the construction of a secure and empowering base from which service users may reconnect with wider social worlds.

Keywords: Mental health, family therapy, group conferencing; empowerment; social participation

Although not new within adult social care, the concept of reablement is only recently being applied in mental health services in England (Reidy et al, 2013). It may be defined as a relatively intensive period of intervention that focuses on 'restoring independent functioning rather than resolving health care issues' (SCIE, 2013 p.33) and hence may be seen as linking to the social aspects of mental health recovery (Tew et al, 2012). Despite a tendency to see reablement in rather narrow terms as the 're-skilling' of individuals, we would argue that, particularly in the context of mental health, enablement should be seen in a social context: what one is able to do may depend hugely on one's inter-personal relationships and connections.

Engaging with families has long been seen as a core task of social work – but, while there is strong evidence that certain family-inclusive ways of working can improve clinical outcomes for people with serious mental health difficulties (NICE, 2014), there has been little direct examination of whether (and how) such ways of working may support social outcomes such as reablement. In this study, we report on a national study exploring how different 'whole family' practice models may or may not achieve this.

Conceptualising reablement

It has been proposed that reablement aims to maximise 'users' independence, choice and quality of life' (OPM, 2012 p.4). This may be linked theoretically to the concept of 'capability' (Sen,1993; Hopper, 2007). This defines the parameters of a 'life worth living', not in terms of some measure of the conditions in which people live (as in some conventional definitions of 'quality of life'), but as a combination of being

able to exercise personal agency and having the ability to access, as a full and equal citizen, the sorts of social opportunities that they may value.

Applying this to the field of mental health, we may conceptualise reablement as restoring the possibilities for:

- making choices and taking charge of one's life (personal agency or empowerment) and
- taking up opportunities within mainstream community life (social participation).

This connects with what have been identified as two of the core processes of personal recovery: empowerment and connectedness (Leamy et al, 2011) – and with the idea of recovery capitals – the range of social and other resources that people may need in order to reclaim a life of value and to flourish, rather than just to survive in the world around them (Tew, 2013).

Family-inclusive approaches and reablement

Although a relational focus may often be missing from the reablement literature, it is important to see family and other relationships as potentially enabling – but also as potentially in need of enablement in their own right, if they are to provide effective support. As noted in the wider 'Think Family' literature review for the Cabinet Office, while attention may be paid to the needs of individual carers, it is rarer to find genuinely family-inclusive approaches in which relationships with all significant others are acknowledged as important (Morris et al, 2008). For the purposes of this study, a family-inclusive (or 'whole family') approach is defined as 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, 2007 p.30). Within such an approach, family members are included as people in their own right, with multiple roles and relationships inside and outside the family, and there is a flexible understanding of 'family' which includes whoever may be seen as significant others (and not just immediate blood relatives).

At the start of this research project, a scoping study was undertaken which found that, although family-inclusive approaches could appear somewhat marginalised within mental health services, there was nevertheless evidence of significant activity across England (Tew et al, 2014). This revealed four distinct approaches that were being used, which may be characterised as:

Systemic Family Therapy (SFT)

Systemic approaches invite family members to reflect on their relationships and interactions, and their ways of understanding these. Particular difficulties are resolved through finding new ways of perceiving situations and acting towards one another, using techniques such as circular questioning and narrative reframing (Dallos and Draper, 2000). This is a well established approach and can be used for both brief and more sustained periods of intervention.

Behavioural Family Therapy (BFT)

This is a psycho-educational approach which takes the format of a short course (Fadden, 2006). It explores how to manage challenges or stresses more successfully – with a focus on family members learning enhanced communication and problem-solving skills. It is recommended in NICE guideline CG178 for the treatment of psychosis and schizophrenia.

Family Group Conferencing (FGC)

The Conference is an inclusive meeting in which key decisions about care and support are made by the person and their family – with professionals being on hand to provide information and advice, but not to make the decisions (Wright, 2008). Although the main focus is on the Conference itself, the independent facilitator will often undertake preparatory work with family members beforehand and support the follow-up of decisions through convening subsequent review meetings.

Integrated systemic / behavioural approach (ISB)

Also termed a 'cognitive interactional' model, this approach incorporates some of the ideas and practices of BFT within a wider systemic focus. It can integrate psycho-educational components with an emphasis on understanding and improving family relationships (Burbach and Stanbridge, 1998).

The Open Dialogue approach (Seikkula et al, 2006) was not being practiced in England at the time of this study, although it is now being piloted in a number of areas (Carter, 2015). Developed in Finland, this approach has origins in SFT practice, but takes a more radical stance towards family empowerment and inclusive decision making. All conversations take place with the family network and service user present, and it is out of this dialogue that understandings of difficulties, and potential ways forward, are allowed to emerge. In this regard, it shows similarities with FGC processes – although there is no provision for 'family-only' time and,

instead of a one-off Conference, there is a sustained process of regular family network meetings.

Research design and methods

This study used a realist evaluation approach (Pawson and Tilley, 1997), to examine the relationships between context, mechanisms of change, and outcomes. Rather than focus on 'official' theories of change associated with each practice model, we sought to explore what was seen by service users and family members as actually making a difference – and hence deriving theoretical descriptions of change processes, together with indications as to what contextual factors may have supported or inhibited change. In order to do this, we employed a comparative case study design (Yin, 2014), with a nested group of family case studies each forming a unit of analysis around each approach. Within an overall typology of case study research, our analytical approach may be characterised as heuristic (George and Bennett, 2005), aiming to tease out 'typical' causal paths for each approach.

Recruitment was via local sites that were selected as exemplars of each model, based on the initial scoping. For each model, a sample of at least five families was sought, comprising a balance between 'success stories' and those seen by the service as having less favourable outcomes – thereby facilitating within-group comparisons of what may have contributed to (or inhibited) effectiveness. All service users were in receipt of secondary (specialist) mental health services and their summary characteristics are described in Table 1. Interviews were recorded and transcribed. Ethical approval for the study was obtained from the NRES Committee North-West Cheshire (Ref 12/NW/0102).

[Insert Table 1 around here]

After family involvements had been completed, separate interviews were undertaken with service users, family members and practitioners. Narrative accounts were obtained using open-ended questions which focused on the family context, changes and outcomes, and what was seen as helping to bring these about – allowing the opportunity to triangulate between the perceptions of each informant. In order to gain a more systematic overview of outcomes, service users and family members were also asked to complete scorecards based on how they perceived the service user's situation before and after the family involvement. Differences in scores provided a measure of change. Where a participant did not complete a particular scorecard rating, the practitioner was asked to provide a rating on their behalf. Each scorecard contained five-point Likert-scaled questions linking to the following domains:

- personal relationships with family and friends
- reablement (including personal agency and wider social participation).

Although the reliability of 'before' scores could have been compromised by participants' accuracy of recollection, this was compensated, to a degree, by being able to triangulate between the scores provided by service users and family members, and between these and their respective narrative accounts (together with those of practitioners). Ratings of change were also cross-checked against narratives to see if outcomes might be attributable to other forms of service intervention (although this did not, in fact, emerge as an issue). However, in one instance, we found that scores did not fully reflect the degree of change evidenced in

the narrative accounts - as they did not take account of changes that only came to fruition over subsequent months.

As we were unable to find existing scales for these domains that were appropriate in terms of brevity, content or suitability, we devised and piloted bespoke sets of questions, where possible using or adapting questions from existing instruments, with variants for completion by service users and family members (see Tew et al, 2015). As these scales were purely indicative, no attempt was made to analyse their psychometric properties – and, so as not to give any spurious impression of accuracy, scores for each domain were rounded to the nearest integer. Service users' and family members' ratings of change are presented alongside each other in Tables 2-5 to allow comparison and highlight any significant discrepancies (of which there were surprisingly few). We took the mean score of their respective ratings as the most reliable indicator of change. In reporting findings, all individuals are anonymised and given codes linked to model (SFT, BFT, etc) and status (SU=service user; FM=family member; P=practitioner). To aid interpretation, ratings of change were graded as follows:

-0.5 or less	Negative change
0	No change
0.5 – 1	Small change
1.5 – 2	Substantial change
2.5 or more	Major change

The first stage of analysis was for each family case study to be written up as a 'deep' description using a consistent series of thematic headings derived from the interview questions, with a triangulation between service user, family member and practitioner

narratives, and between these and the scorecard ratings. For each approach, a process of pattern matching and explanation building was used (Yin, 2014) in order to tease out how change occurred in those instances where positive outcomes were reported, and what may have been the factors that militated against change in other instances.

Contexts, processes and outcomes

There were no significant differences between approaches 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. Professionals were routinely invited to the first part of each FGC, but were not included to any significant extent within other approaches, although it was common for care coordinators to be involved as co-facilitators in BFT and ISB approaches.

A consistent finding to emerge across all models was that positive reablement outcomes tended to be associated with starting family meetings (or the preliminary work leading up to this) as close as possible to a time of mental health crisis, often when the service user was still an in-patient. This compares with similar findings from the Open Dialogue approach where family members are fully involved from the point of initial referral (Seikkula et al, 2006). There were no reported scenarios where engagement or success seemed to have been jeopardised by 'getting in early' – and this can be a time when family members may be most receptive to becoming involved. Conversely, offering a family-inclusive approach further down the line –

perhaps when other approaches did not seem to be working – tended not to result in the achievement of positive reablement outcomes.

The duration and intensity of involvement varied considerably both between and within models – with BFT and FGC approaches being briefer. A common success factor seemed to be a relatively intense period of involvement early on - which sometimes could be sufficient in itself for positive outcomes to be self-sustaining. For some, especially for people who were recovering from more profound psychotic breakdowns, the timescale for embedding change could be years rather than months – with a back-drop of ongoing family-inclusive support enabling them to achieve incremental and sustained progress. However, unless a positive engagement around change was achieved early on, longer term involvements did not prove helpful in delivering reablement outcomes.

Systemic family therapy (SFT)

Some of the practice was clinic based, with a reflecting team observing the session through a one-way mirror and offering feedback to both practitioner and family. Other practitioners used a less formal approach with sessions taking place in ordinary meeting rooms or in the family home. Engagement tended to be medium to long term (six months to five years with a median duration of two years) with more frequent meetings initially (weekly or fortnightly) tapering to monthly or three monthly. Within the sample, work with families SFT3 and SFT5 started at a point of crisis, whereas the others were managing more long term experiences of mental distress in the community. Service user and family member perceptions of change are presented in Table 2.

[Insert Table 2 around here]

In most of the families, participants identified deep-seated personal and relationship issues, including violence, abuse and loss – although, in SPT5, family members just seemed to have become more distant from one another. With the presence of practitioner(s) creating a 'safe space', the sessions could provide an opportunity for service users and/or family members to share issues that perhaps could not be aired elsewhere:

> *'I was able to really voice how I felt... It was like a relief to be able to go there and tell them in public how I really felt about [husband] ... and have no volatile situations where [he] would be emotionally vindictive and shout and bully' (SFT1-SU).*

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

In one scenario (SFT1), simply 'getting things out into the open' had not resulted in any significant positive change in any outcome domain. Here, relationship difficulties had predated (and probably contributed to) the service user's mental health difficulties and, although, the family sessions had continued for over a year, they provided more of a forum for mutual accusation than an opportunity for reappraisal and change.

In other instances, questioning and reflective feedback enabled a clearer understanding of feelings and dynamics, which, in turn, led to new ways of relating – both in situations where tensions had predated the onset of mental health difficulties

and where these has had arisen in response to them. Where key relationships had become unhelpfully enmeshed, this opportunity to reflect could allow space for separation as well as getting closer:

> *'My mum sometimes involved me in her life a bit more than she should do and ... 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 seemed to be important in bringing about change was a structured and inclusive conversation in which all participants were invited to reflect on their relationships:

> *'It helped me to take a step back and to think about the rest of my family and for them to see how it was for me. So that we all got to understand one another better... My relationship with my husband has become very strong... I've become very close to my girls now' (SFT5-SU).*

From Table 2, we may see that improvements in relationships did not necessarily translate into more successful engagement with the wider world. However, from the narratives of those who did achieve significant reablement outcomes, some improvement of relationships was seen as the first step towards this. What could then be helpful was an explicit outward focus on life beyond the family – and a systemic understanding could be useful in breaking out of previously self-reinforcing life patterns:

> *'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.... 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' (SFT3-SU).

A turning point for another service user came when the practitioner showed spontaneous flexibility and, instead of just *talking about* developing confidence in the wider world, actually offered *practical support* at a crucial point:

'She understood about the family and the practical… One time she came to do the shopping with me' (SFT5–SU).

After this, the service user made substantial progress in taking charge of her life, reclaiming positive roles both within her family (as spouse and parent) and in engaging with activities outside the home.

For the SFT cohort, processes of change tended to follow the heuristic schema set out in Figure 1 - with some families progressing to the next stage and others not. Here, positive work on relationships was a necessary but not sufficient condition for reablement outcomes to be achieved – with the latter becoming possible where a wider outward focus was an explicit part of the work.

[Insert Figure 1 around here]

Behavioural Family Therapy (BFT)

BFT offered a relatively standardised course of 8-16 topic-based sessions that were delivered weekly or fortnightly. The family work was often (co-)facilitated by the key-worker or care coordinator, and could therefore be integrated within a longer trajectory of involvement. Sessions took place either at the local service base or in

the family home. Involvement with BFT1, BFT2 and BFT5 commenced at a time of crisis while the service user was still in hospital, whereas involvements with BFT3 and BFT4 came some years into their engagement with mental health services. Service user and family member perceptions of change are presented in Table 3.

[Insert Table 3 about here]

A feature of the BFT approach was an initial focus on psycho-education – helping family members to reach a shared understanding of the implications of a person's mental distress, such as what might be stressful for them, or how to recognise early warning signs of relapse. This could also provide an opportunity to unpick problematic interactions or misperceptions:

> *'I felt rejected… It wasn't their fault, but they didn't understand so they were behaving in a way which made me like – made me frustrated and stuff' (BFT2–SU)*

Although included as part of the course, no-one within the sample made reference to using any problem-solving strategies that they had learned. However, a number valued the focus on communication skills – learning to be clearer with one another and to give positive as well as any negative feedback so as to create '*more of a positive environment to live in' (BFT2–SU)*:

> *'I suppose we became more conscious of how we communicated, and a lot more conscious of giving positive, sort of, feedback … [and] the motivational pat on the back, so that was very useful. (BFT2–FM)*

> *'It's made me more aware of … what I say to people. I just think it's really good' (BFT5-SU)*

Although this was not part of the course as such, all of the families identified significant relationship issues. Some found that learning to communicate more clearly could provide a focus for addressing these, such as family members' over-protective responses to the service user's mental distress:

> 'W*hen you've got people who are ill like that, it's very hard to let them … go'. (BFT1-FM)*

> *'Maybe it did show that the closeness of us could have been the detrimental thing actually to my health and recovery and progress'. (BFT1–SU)*

> *'I think that [family meetings] sort of showed me [how] to ... step off a little bit and I'm sure she used to feel I interfered too much but that was in a way to make her life easier but maybe that showed me I've got to let her stand on her own two feet' (BFT3–FM)*

However, where issues had not simply emerged in reaction to the service user's mental distress, and 'stepping off a little bit' did not lead to much progress, 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)*

As with systemic family therapy, some resolution of relationship issues would seem to have been a pre-requisite for service users to achieve reablement outcomes – which included leaving home (BFT1), starting college (BFT1 and BFT5), and having the '*confidence to make decisions*' (BFT2). However, there was little explicit focus within the model on supporting people to re-engage in the wider world, and

successful reablement could depend on the practitioner adding on '*the afterwards work'* – and maintaining a family-inclusive focus within this:

> *'The family sessions finished … but then I continued working with the family as a family... You're just including them in'. (BFT1-P)*

Although the typical duration of engagement was much shorter than for systemic family therapy, BFT could nevertheless provide the catalyst for relationship change and, if an outward focus was added in to the model, for very significant steps towards reablement -– see Figure 2.

[Insert Figure 2 around here]

Family Group Conferencing (FGC)

As practiced, the FGC model had evolved significantly from its origins in children's services. Instead of the Conference being essentially family-only, it comprised two parts. In the first, relevant professionals were invited into a question-and-answer session where the agenda was driven by the service user and family members - effectively the mirror-image of the conventional process (and power relations) of a Ward Round:

> *'Whatever you had to say, however it would have sounded ... they ... respected that ... and they dealt with those questions that you asked'. (FGC6–FM)*

> *'In that environment ... I did feel much more understood' (FGC2–SU).*

After this, the professionals were invited to withdraw so that the family could draw up their proposals for a recovery support plan.

Substantial work was undertaken with family members in preparation for the Conference and, in practice, subsequent review meetings could function more as part of an ongoing decision-making (and therapeutic) process – with up to four such meetings taking place over a 6–12 month period. The facilitator also worked individually with the service user and family members to support them in carrying through their plans. Meetings took place at any convenient location (including the family home).

Work with FGC1, FGC2, FGC5 and FGC6 started while the service user was in hospital or shortly afterwards (and in one instance while still compulsorily detained). FGC3, FGC4 and FGC7 were referred when the service user had been living in the community for some years.

[Insert Table 4 around here]

Although the primary focus of the conferencing process was on practical decision-making and drawing up a family-based recovery plan, this could provide a catalyst for other conversations to take place. As with systemic family therapy, meeting together could provide an opportunity for sharing underlying issues, such as experiences of abuse, and for this to be heard by other family members:

> *'I think they got that I wasn't very happy sometimes, but they didn't really understand the extent of what had happened' (FGC1–SU)*

In turn, sharing could bring about change in family relationships:

> *'I found that we got better at being more open and [SU] was far more open about things as well and we were being truly honest about how we felt' (FGC7–FM)*

'I came away feeling really elated ... because I really felt that ... the whole experience had brought all five ... of us together, much closer'. (FGC7–SU)

However, this model was not as effective in dealing with more entrenched relationship issues where there was not a sufficiently robust '*scaffolding'* of support within the family to do this:

'At the surface we put things together... It was the underneath that I felt we really needed [to deal with] – it was just putting another plaster on... We had to plaster it over again' (FGC3–SU).

Perhaps the most distinctive aspect of the FGC process was the explicit protocol of the Conference which placed the family in charge and the service user 'in the driving seat'. This could have an impact in terms of their empowerment, not just in the context of the Conference but more widely:

'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.' (FGC4-SU)

The FGC approach was explicitly geared towards supporting reablement outcomes and in mobilising family relationships in support of this:

*'Family Group Conferencing ... enabled me to access the community and feel part of the community' (FGC1-SU)***.**

'There were all sorts of things that we decided we'd do and we made a really huge effort that we hadn't done before' (FGC7–FM).

In some instances, a practical focus on recovery planning proved sufficient, coupled with support in its implementation from the FGC coordinator, whereas in others, significant relationship change was part of the process:

> *'He's not had to ... reject his family to achieve independence... They've managed to negotiate a way that they can still be supportive and ... see each other.... But he's still feeling he's achieving his own life really' (FGC5–P)*

These alternative routes are described in Figure 3.

[Insert Figure 3 around here]

Integrated Systemic / Behavioural approach (ISB)

Unlike BFT and FGC approaches, there was less of a set format for ISB. It could involve weekly or fortnightly session over a few months which could extend into less intense involvements over months or years. Work with ISB2 was started while the service user was in hospital and ISB3 shortly after discharge; ISB1 and ISB5 early in onset of psychosis before any hospital admission; and ISB4 some years into their involvement with services.

[Insert Table 5 around here]

As with BFT, the ISB approach usually started with developing a shared understanding of service users' experience of mental distress - and others' reactions to this – seeking to dispel misperceptions and build on coping strategies. Typically, the service user would be invited to act as 'psycho-educator':

'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)

'She was suffering a lot of anxiety and intrusive thoughts and, and sort of paranoia, where she would think we were angry with her when we weren't' (ISB3–FM)

'The advantage of the group sessions are that when [SU] has ... coping strategy mechanisms, then we're sort of party to that, so that we can reinforce them' (ISB3–FM).

Positive reablement outcomes were consistently associated with relationship changes (see Table 5). Some relationship changes came about through coming together to organise practical support, whereas others involved the surfacing of underlying issues. As with other approaches, ISB seemed to be better able to help families resolve relationship issues where these focused around family responses to a mental health difficulty – such as conflict between family members around 'illness' behaviours, or over-involvement and the need to let go:

'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)

'It became more about ... how we reacted to her insecurities. And that, I think, has been particularly useful... Because she was constantly asking for reassurance.... But that wasn't the right thing to do… You've got to build up their

own resistance and resilience.... The family sessions sort of helped us do that (ISB3–FM).

Less favourable outcomes tended to be associated with longer-standing issues that affected family relationships, or the refusal of the service user to engage with the process (ISB5).

A consistent theme that emerged from the 'success stories' was how relationship changes had enabled families to provide more of a physical and/or emotional 'secure base' from which the service user was able to explore and engage with the wider world (whether or not they actually lived together) – see Figure 4. This idea has interesting echoes of Bowlby's conception of how an anchoring in secure attachment experiences can facilitate a child's path to independence.

'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 socialise. I felt more comfortable going places after I'd been to family therapy. And that's continued' (ISB1–SU)

'Family therapy was very, very, very instrumental in kind of helping me work through issues of feeling … settled and grounded… [It] helped boost my sense of self and ... my relationships with significant others as well' (ISB2-SU)

[Insert Figure 4 around here]

Conclusions

This is the first national study of how family-inclusive approaches may enable people with mental health difficulties to take more control over their lives and engage with their wider community. The scale of the study provided a sufficient spread of cases to enable a comparison of experience both *within* and *between* particular practice models, including instances where approaches had been less successful. Pragmatically, it was not possible to match the samples in terms of demographic characteristics or severity of presentations – so we were not in a position to make any comparison between the relative effectiveness of each model. Another potential limitation was our reliance on retrospective ratings of change – although the ability to triangulate between different informants' narrative accounts and scorecards was helpful in enhancing reliability. This mixed methods approach was also able to combine a depth of understanding with a more systematic basis for comparison – and we would argue that this added value in making sense of a complex field.

Although arriving there by significantly different routes, all the approaches demonstrated a capacity to deliver substantial reablement outcomes. Where family-inclusive approaches were least successful, key factors tended to be a difficulty in engaging with relationship issues that predated the onset of mental distress and/or introducing family work as an 'afterthought' after other interventions had been tried. As delivered, FGC and ISB approaches were more consistently geared towards developing the family as a resource to support the service user's reablement, whereas SFT and BFT approaches could focus more on the internal dynamics of family life – although some practitioners were able to graft in a more outward-looking orientation with considerable success.

Across the approaches, there were somewhat different strategies for establishing a baseline of shared understanding and commitment between the participants. There is no clear evidence from this study that any starting point was inherently better than any other, although a number of families seemed to appreciate the more practical focus of either a recovery planning meeting (FGC) or a 'psycho-educational' sharing of knowledge about how best to manage experiences of mental distress (BFT and ISB). Central to achieving this baseline engagement was an inclusive and democratic approach in which all perspectives were valued, and in which the experience and expertise of the service user and family members was central.

A key element of reablement 'success stories' was the opportunity for service users to take control and exercise initiative for themselves within the context of their families. This was perhaps most explicit within the FGC approach, which placed the service user in the 'driving-seat' of the family's recovery planning process, able to negotiate with other family members the forms of support (or freedom) that would be most helpful. Each of the other approaches also provided examples where a focus of the work had been to achieve space for service users to set more of their own independent direction.

An interesting area of difference both between and within approaches was the degree to which the surfacing and resolution of relationship issues was seen as a prerequisite for mobilising family support. While an explicit focus on relationships was central to the SFT and ISB approaches, it was something that was allowed to emerge within BFT and FGC approaches – and, in some instances, substantial change could be brought about, even when this was not a core part of the 'official' practice model. However, where relationship issues were more deep-seated and intractable – and particularly where they may have predated the onset of mental

distress - a failure to provide sufficient (and sustained) support within the approach could result in a lack of progress.

Whether or not any resolution of relationship issues was part of the process, the achievement of reablement outcomes depended on the establishment of the family network as an outwardly focusing ‘secure base’ – a safety-net and jumping-off point which fostered service users’ personal agency and from which they could negotiate specific forms of support as they accessed wider opportunities. This has a somewhat different feel to a more inward-looking ‘safe haven’, which may be warm and accepting, but may offer less encouragement to move on and engage in wider community life.

In providing an overview of the mechanisms that underpin the achievement of successful reablement outcomes, we have brought together key elements of the heuristic schemas for each approach into a composite schema that charts how different starting points, singly or in combination, may, by various routes, lead to the construction of a secure and empowering base from which a service user may reconnect with a wider social world (Figure 5).

[Insert Figure 5 around here]

From this, we would suggest that best practice may need to embrace elements from all the approaches studied, in order to

(a) offer flexibility in terms of starting points, and engage service user and family members in ways that give them power to set their direction, with the service user in the ‘driving seat’

(b) provide support in as much depth as is needed to help family members resolve relationship issues, if they emerge

(c) maintain an outward looking focus and a 'secure base' that enables negotiation of support, letting go and moving on.

These findings add an important dimension that complements the more clinically focused research base on family interventions – and has particular relevance as new family-inclusive approaches, such as Family Group Conferencing and Open Dialogue, are now being introduced in many countries. There is a growing recognition that recovery from mental health difficulties involves more than just the control of symptoms, and this research establishes that family-inclusive approaches can play a key role in supporting the development of people's agency and social capabilities. Beyond this, by examining processes as well as outcomes, we have been able to isolate some of the core principles that can make such approaches effective – thereby establishing the foundations for family-inclusive practice for social workers and other mental health practitioners.

These findings have immediate relevance for policy and practice. Family-inclusive approaches can still be the exception rather than the rule, and the growing evidence base as to their effectiveness has particular relevance for social work. In England, recent draft guidance on the implementation of the Care Act now emphasises a 'whole family' approach (DH et al, 2015) and the Knowledge and Skills Statement for Social Work in Adult Services argues for a relational approach in which 'social workers need to be able to work directly with individuals and families … to build purposeful, effective relationships underpinned by reciprocity' (DH, 2015 p.4). The findings of this study provide valuable pointers as to how to do this effectively within the context of mental health, highlighting the importance of joining with families in

ways that are empowering and respectful of their expertise; finding the right balance between the practical and a sometimes necessary focus on relationship issues; and enabling families to provide an outward-looking ‘secure base’ from which people may reclaim control over their lives and (re)engage with wider social, educational and economic opportunities. In turn, this suggests an agenda for social work education where the teaching of family-inclusive models of practice may currently have insufficient emphasis.

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Tables

Table 1 Characteristics of service user sample

Gender	*Male*	*Female*		
	7	15		
Ethnicity	*White UK*	*Other*		
	19	3		
Age	<20	20-29	20-39	40+
	1	5	8	8
Living unit	*Alone*	*With parent(s)*	*With parent(s) and siblings / others*	*With partner and / or children*
	3	6	5	8
Diagnosis	*Psychosis*	*Depression*	*Other*	
	12	7	3	

Table 2: Systemic Family Therapy sample: perceived outcomes

		Perceptions of change across each domain			
Family	Respondent	**Relationships**	*Personal agency*	*Social participation*	**Reablement***
SFT1	SU	**0**	*-1*	*0*	**-0.5**
	FM	**1**	*0*	*1*	**0.5**
	Mean	**0.5**	*-0.5*	*0.5*	**0**
		Small	*Negative*	*Small*	**None**
SFT2	SU	**2**	*1*	*0*	**0.5**
	FM	**2**	*1*	*1*	**1**
	Mean	**2**	*1*	*0.5*	**0.75**
		Substantial	*Small*	*Small*	**Small**
SFT3	SU	**1**	*2*	*2*	**2**
	FM	**2**	*2*	*3*	**2.5**
	Mean	**1.5**	*2*	*2.5*	**2.25**
		Substantial	*Substantial*	*Major*	**Substantial**
SFT4	SU	**2**	*1*	*1*	**1**
	FM	**2****	*1***	*1***	**1**
	Mean	**2**	*1*	*1*	**1**
		Substantial	*Small*	*Small*	**Small**
SFT5	SU	**2**	*2*	*2*	**2**
	FM	**1****	*2***	*2***	**2**
	Mean	**1.5**	*2*	*2*	**2**
		Substantial	*Substantial*	*Substantial*	**Substantial**

* Average of *Personal Agency* and *Social Participation* scores
***Rating by practitioner*

Table 3: Behavioural FamilyTherapy sample: perceived outcomes

		OUTCOMES Perceptions of change across each domain			
Family	Respondent	**Relationships**	*Personal agency*	*Social participation*	**Reablement***
BFT1	SU	**1***	*3*	*2**	**2.5**
	FM	**1***	*3*	*2**	**2.5**
	Mean	**1***	*3*	*2**	**2.5**
		Small	*Major*	*Substantial*	**Major**
BFT2	SU	**2**	*3*	*1*	**2**
	FM	**2**	*2*	*0*	**1**
	Mean	**2**	*2.5*	*0.5*	**1.5**
		Substantial	*Major*	*Small*	**Substantial**
BFT3	SU	**0**	*0*	*0*	**0**
	FM	**1**	*0*	*0*	**0**
	Mean	**0.5**	*0*	*0*	**0**
		Small	*None*	*None*	**None**
BFT4	SU	**0**	*1*	*0*	**0.5**
	FM	**2**	*1*	*0*	**0.5**
	Mean	**1**	*1*	*0*	**0.5**
		Small	*Small*	*None*	**Small**
BFT5	SU	**2**	*3*	*4*	**3.5**
	FM	**1**	*2*	*2*	**2**
	Mean	**1.5**	*2.5*	*3*	**2.75**
		Substantial	*Substantial*	*Major*	**Major**
** Significant mis-match between Likert scores and narratives, with the latter evidencing a greater degree of change*					

Table 4: Family Group Conferencing sample: perceived outcomes

		OUTCOMES Perceptions of change across each domain			
Family	Respondent	**Relationships**	*Personal agency*	*Social participation*	**Reablement**
FGC1	SU	**1**	*3*	*3*	**3**
	FM	**0**	*2*	*2*	**2**
	Mean	**0.5**	*2.5*	*2.5*	**2.5**
		None	*Major*	*Major*	**Major**
FGC2	SU	**1**	*2*	*3*	**2.5**
	FM	**1**	*2*	*2*	**2**
	Mean	**1**	*2*	*2.5*	**2.25**
		Small	*Substantial*	*Major*	**Substantial**
FGC3	SU	**1**	*1*	*0*	**0.5**
	FM	**1**	*1*	*1*	**1**
	Mean	**1**	*1*	*0.5*	**0.75**
		Small	*Small*	*Small*	**Small**
FGC4	SU	**1**	*3*	*1*	**2**
	FM	**3**	*2*	*2*	**2**
	Mean	**2**	*2.5*	*1.5*	**2**
		Substantial	*Major*	*Substantial*	**Substantial**
FGC5	SU	**1**	*2*	*3*	**2.5**
	FM	**2***	*2*	*2**	**2**
	Mean	**1.5**	*2*	*2.5*	**2.25**
		Substantial	*Substantial*	*Major*	**Substantial**
FGC6	SU	**0**	*3*	*4*	**3.5**
	FM	**0**	*2*	*2*	**2**
	Mean	**0**	*2.5*	*3*	**2.75**
		None	*Major*	*Major*	**Major**
FGC7	SU	**2**	*2*	*2*	**2**
	FM	**1**	*2*	*2*	**2**
	Mean	**1.5**	*2*	*2*	**2**
		Substantial	*Substantial*	*Substantial*	**Substantial**
**Rating by practitioner*					

Table 5: Integrated Systemic/Behavioural sample: perceived outcomes

		OUTCOMES Perceptions of change across each domain			
Family	Respondent	**Relationships**	*Personal agency*	*Social participation*	**Reablement**
ISB1	SU	**3**	*2*	*4*	**3**
	FM	**3**	*2*	*4*	**3**
	Mean	**3**	*2*	*4*	**3**
		Major	*Substantial*	*Major*	**Major**
ISB2	SU	**3**	*3*	*3*	**3**
	FM	**2**	*4*	*3*	**3.5**
	Mean	**2.5**	*3.5*	*3*	**3.25**
		Substantial	*Major*	*Major*	**Major**
ISB3	SU	**1***	*2*	*1**	**1.5**
	FM	**3**	*2*	*3*	**2.5**
	Mean	**2**	*2*	*2*	**2**
		Substantial	*Substantial*	*Substantial*	**Substantial**
ISB4	SU	**0**	*2*	*1*	**1.5**
	FM	**1**	*1*	*1*	**1**
	Mean	**0.5**	*1.5*	*1*	**1.25**
		Small	*Substantial*	*Small*	**Small**
ISB5	SU	**0***	*0**	*0**	**0**
	FM	**1**	*0*	*0*	**0**
	Mean	**0.5**	*0*	*0*	**0**
		Small	*None*	*None*	**None**
**Rating by practitioner*					

Figures

Figure 1: Routes to reablement: Systemic Family Therapy

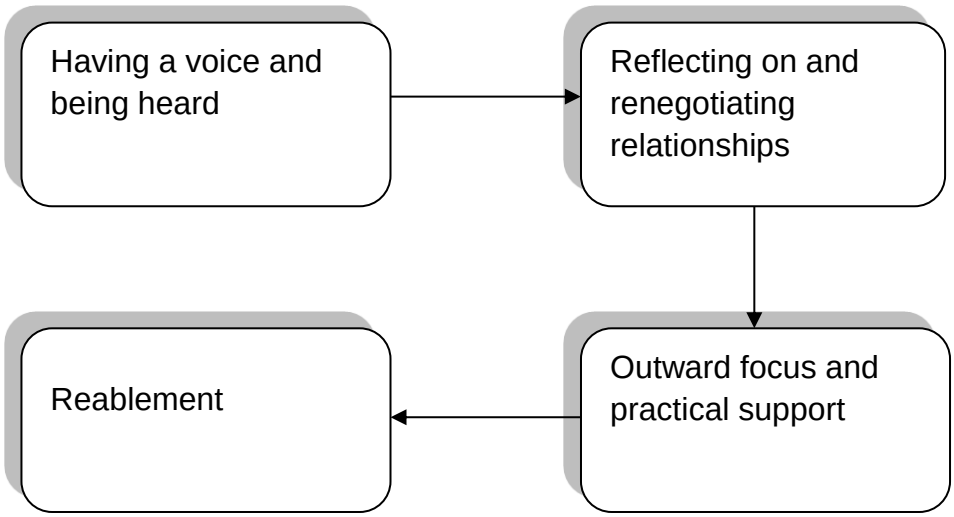

Figure 2: Routes to reablement: Behavioural Family Therapy

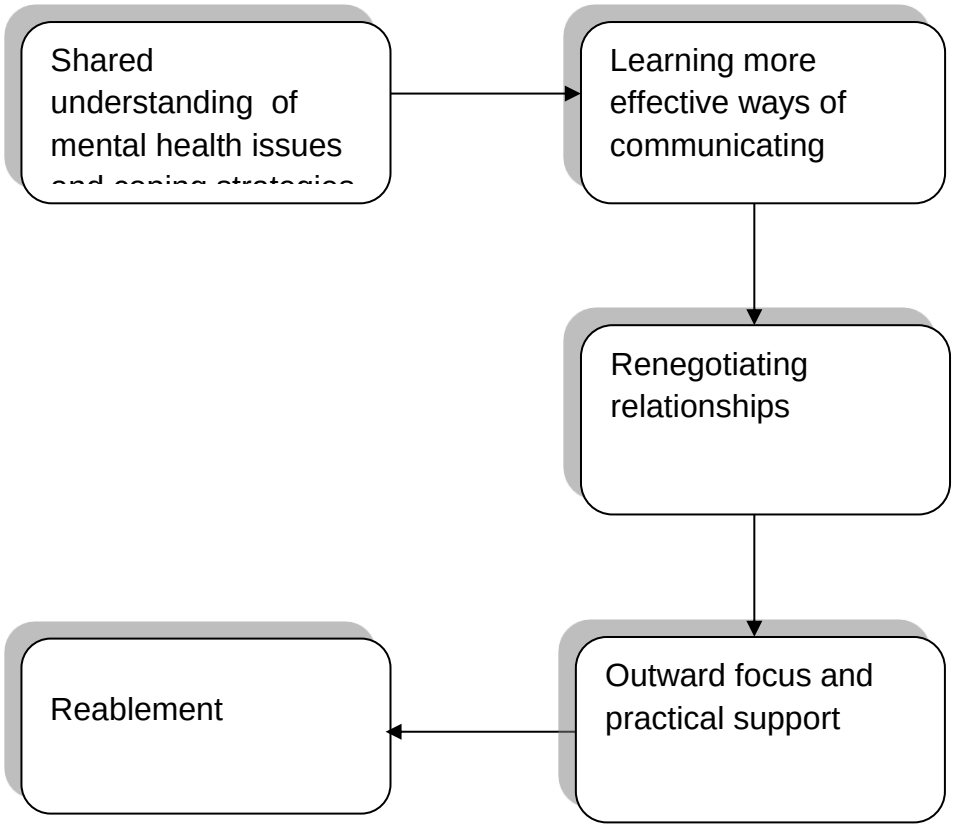

Figure 3: Routes to reablement: Family Group Conferencing

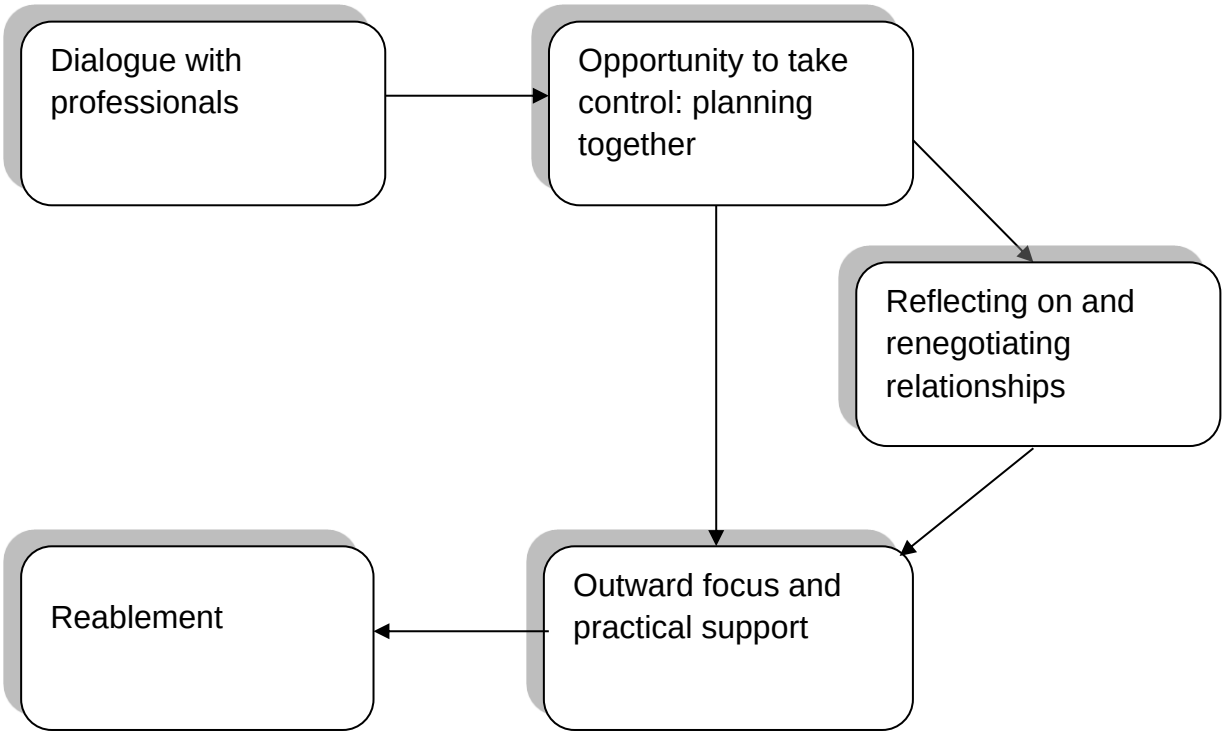

Figure 4: Routes to reablement: Integrated Systemic/Behavioural

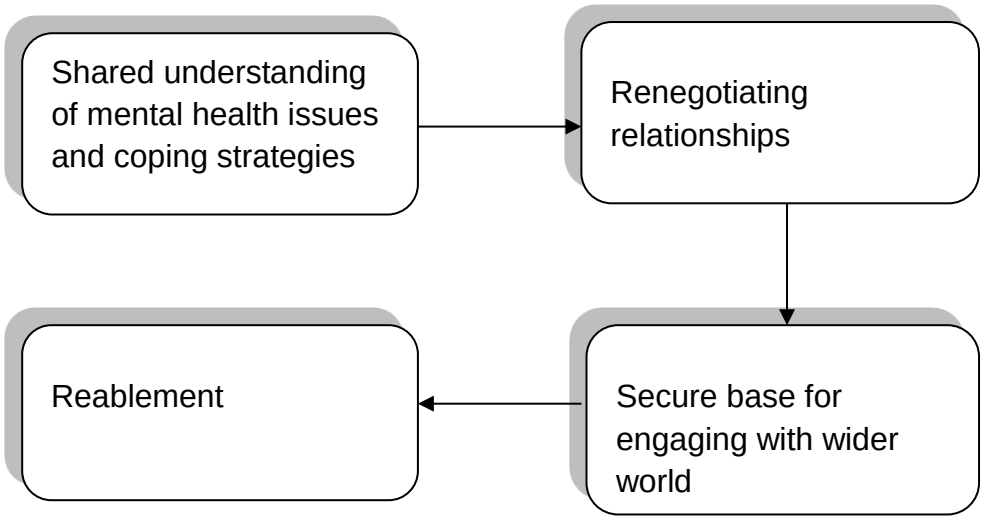

Figure 5: Routes to family-based reablement