Chapter 4

Involving and Training Professionals

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In Chapter two, there is a description of those family interventions that have been found to be effective. Ensuring that these are delivered to and received by families depends on clinical staff having the willingness, correct attitude, training, skills and competence to do so. Whether or not this happens depends on a range of factors including overall health policy which is covered in Chapter eight and issues in health systems described in Chapter three. Any discussion of the involvement and training of clinicians in providing services to families must take account of these broader factors. For example, if there is an absence of policy relating to the needs of families and how these are to be addressed, it is unlikely that all clinicians will be motivated to deliver services to families. Similarly, if clinical staff are working in a service system that does not give priority to the family, friends and broader social network of those experiencing mental health difficulties, then even those professionals committed to the delivery of services to families will find it hard to do so. Readers concerned with involving and training professionals therefore should take account of the points raised in Chapters three and eight.

While self-help and family support groups play their part in helping families to cope with the situations in which they find themselves, in Western cultures at least, most families will come into contact with mental health professionals and services when a family member experiences mental health difficulties. Most families rely on professionals initially for diagnosis and treatment, and later for support, information, help to know what to do in a crisis, help to cope with the situation in which they find themselves, and information on how to find further help. Not all families receive this type of help and are therefore unsure about how to best help their relative. Thus contact that families have with clinicians can be very limited, or positive and helpful. In some cases where help is limited or non existent, this can be damaging and traumatising. Our aim in this guidebook is to support the development of positive, facilitative and mutually respectful relationships between family members and professionals.

The Historical Context to the Way Families are Treated in Services

For many families, their experience of coming into contact with services is to feel ignored, blamed or criticised by staff. In order to understand this, and to develop effective training for professionals, it is important to understand the factors that have contributed to this response to families from staff.

Mental Health Service Systems

In Western cultures, most professionals work in systems predicated on individual models of care and a focus of the individual with mental health difficulties. Their training has frequently been in hospitals and institutions, where work patterns are designed to ensure that the systems run smoothly rather than meet the needs of individuals and their families. Many patterns drawn from these systems have an impact on how families are treated: visiting times that do not suit families, no access to comfortable areas for children to visit their parents, whether or not families' needs are recorded in documentation and the difficulties that families experience in accessing information from those looking after their relative. All of these issues derive from service needs rather than the current needs of individual families.

There is unequal status and power between those employed in these settings and those who receive care in them. Unfortunately, many of these institutional practices have been transferred into community settings. Professional work schedules and rosters do not always result in services being available to families. e.g. 9-5 working and lack of accessible services at weekends and public holidays. One of the key factors that derives from these systems is the emphasis on the confidentiality of the doctor-patient relationship. This issue is consistently raised by families across cultures as they describe the struggles they experience in attempting to get the information they need to support their relative. It is undoubtedly simpler for professionals to see their remit as only working with the individual. The result is that families do not receive the care and support they need, and frequently end up stressed and frustrated, which in turn creates a stressful emotional environment for the family member who is unwell. Their natural desire to support their loved one and to be involved in their care is frequently pathologized as over involvement, and the natural reactions of family members when a loved one is unwell are erroneously seen as abnormal.

Models of Mental Health Care

The models of mental health care that professionals are exposed to, both in the systems in which they work and in their training have also influenced the fact that families do not receive services. Traditionally, biological and medical are the predominant models in mental healthcare systems, with 'Talking Therapies' in general taking second place. Where psychological therapies are used, these are once again generally focussed on the individual: for example, intrapsychic approaches such as psychoanalytical therapy, or approaches that are predominantly individualistic such as Cognitive-Behavioural therapy. These are perceived as easier to implement in services in that they involve fewer people, and only one person's perspective has to be taken into account. The whole concept of recovery discussed later in this book is not predominant in services as yet – if it was, it is likely that families would be involved more. For most individuals, their recovery is more likely if they have a supportive network around them.

Training of Mental Health Professionals

One of the key reasons why professionals do not deliver family interventions is that their training does not prepare them adequately to do so. The first key fact is that the majority of professionals even up to the current time do not receive training to work with families in their undergraduate or basic professional training. In the Meriden Programme in the UK which has trained well over 2000 therapists to work with families, over 70% of those entering the programme report that they have never

received any training in family work (Fadden & Birchwood, 2002), and these are experienced clinicians. One of the fundamental issues that must change is that professional training courses are not training staff who are 'fit for purpose' in modern mental health services. Many curricula still introduce trainees to outdated theories and views about families, and few involve family members themselves in order to provide trainees with an accurate view of the caregiving experience. Most training still focuses on issues linked with the individual rather than on the importance of people's social networks and environments.

Another key factor is that much training is not skills-based, and therefore professionals do not have the skills they need to conduct meetings with families and to help the family to develop coping skills. Most training courses nowadays do not provide their participants with training in group work skills which are fundamental for family work, for example, the basics of how to ensure that everyone has a say, that all group members are treated equally, and how to deal with conflicts that arise, how to manage over-talkative members, and so on. This results in a lack of confidence on the part of professionals in dealing with more than one individual.

It is clear that many professionals struggle with knowing how to deal with the complexities that family work commonly gives rise to. Therefore they avoid these situations if they can, or hide behind what are perceived as binding rules, because of their lack of confidence in handling these situations.

Finally, there is sometimes a professional arrogance that professional training instils, that leads clinicians to think that they alone know what is right for an individual with mental health difficulties. This leads to a lack of respect for the views of the family who are sometimes perceived as not acting in the best interests of the individual.

What Qualities do Mental Health Professionals Need?

Table 1 lists the knowledge, skills and attitudes that professionals need in order to work effectively with families. The broad range of qualities required for this complex area may go some way towards explaining why many clinicians shy away from getting involved in family work. Without the right attitude, however, none of these skills will be translated into services for families. Family members are highly sensitised towards how they are perceived by professionals, and pick up immediately on any hint of criticism from those they come in contact with. It is striking that in the Meriden Programme, the aspect of family work that professionals say they find hardest is how to engage with families.

To make the task more manageable for those concerned with the involvement and training of professionals, it may help to divide training into three different categories:

1. Basic family work skills

Under this heading come those skills listed in Table 1 as general counselling skills: how to listen to the family's story and experiences, how to express warmth and empathy and to show that you are interested and care. This may seem very basic, but in the experience of those of us involved in training people in family work skills for many years, many professionals lack these basic skills. It is almost as if their professional training prevents them from responding in the way they would have responded instinctively as human beings. It should be noted that it can be hard to get many

clinicians to acknowledge that they need training in basic skills, especially if they have been working for a number of years and perceive themselves as having senior status.

Table 1: Knowledge, skills and attitudes needed to work with families

- Positive, understanding attitude towards families
- Use of Rogersian principles: empathy, warmth, positive regard
- Good general counseling skills: ability to listen, reflect back and summarise
- Ability to engage with families and gain their confidence
- Ability to deal with a range of intense emotions: trauma, distress, hopelessness, helplessness, grief and loss
- Good communication skills
- Experience in group work: managing groups, ensuring everyone has a say, dealing with conflicts, managing the over talkative, encouraging the reticent
- Transference/ countertransference issues – how a particular family impacts on them and they impact on the family. What issues from their own family of origin or current family does contact with a particular family trigger for them?
- Knowledge of systems
- Knowledge of biopsychosocial theories of mental health difficulties
- Ability to plan and structure sessions
- Understanding of the life cycles that all families go through as part of their development
- Knowledge of the evidence base for family work
- Knowledge of key components of family interventions
- Ability to deal with complex issues such as confidentiality conflicts
- Behavioural/cognitive therapy skills
- Knowledge of local carer support systems
- Familiarity with government policy
- Awareness of the rights of families in legislation: rights to benefits, respite care
- Ability to reflect on their own practice and use supervision

Each element in these basic skills can be broken down into separate components, and those receiving training can be given practice in acquiring these skills and practising them until they reach levels of competence. An example of this in relation to the skills of engaging families is given in Table 2. Therapists often find this stage of family work difficult, and successful engagement requires a range of therapist qualities such as basic humanity, openness, seeing the family as being like oneself, and flexibility in approach (James et al, 2006). While many of these can be seen as qualities or attitudes, it is possible through training that involves clinicians reflecting on themselves and their own practice to help people to become aware of approaches that will be most effective in engaging with families in a positive therapeutic alliance.

It is also crucial that clinicians understand developmental stages and cycles common in all families so that they are able to normalise the reactions of families faced with coping with highly stressful situations.

Table 2: Engagement with families: content of engagement sessions

- Non-blaming attitude
- Establishing a relationship with each family member
- Listening to the family's story
- Dealing with feelings about past experiences of services/professionals
- Staying with a range of feelings – anger, disappointment, helplessness, resignation, lack of hope
- Giving the family an experience of a reasonable professional who is interested, approachable, and a positive image of services
- Dealing with immediate crises
- Leaving the family with content to reflect on

2. Specific family work skills

The key common components of successful psychosocial interventions for psychosis have been listed in chapter 2 and in other publications (Lam, 1991; Fadden, 1998). Models of family work in which professionals need to be trained are the models that were originally described by Leff et al (1982), Falloon et al, (1982), and Tarrier et al, (1988), with McFarlane et al (1995) delivering versions of these approaches in multi-family group contexts. These models commonly include the following features:

- A stress-vulnerability model of mental health difficulties
- The sharing of information with families, and reaching a shared understanding of what is wrong
- Development of relapse prevention or 'staying well' plans
- Knowledge of what to do in a crisis
- Development of communication skills
    - Expressing positive feelings
    - Listening skills
    - Asking for what you want
    - Expressing difficult feelings
- Development of skills to deal with problems that arise
- Maintenance of realistic expectations
- Encouragement of interests outside the family for all family members
- The concept of recovery and the holding of hope

Anyone delivering these approaches needs to be familiar with all these aspects, and have the ability to introduce these to family members in a way that is respectful and acceptable to them.

3. Complex family work skills

Some families for a variety of reasons may present with more complex difficulties. This may be because of issues in the evolution of their families, because there is more than one person in the family experiencing mental health difficulties, or because there are conflicts in the family about how to handle the situation. There can be issues relating to confidentiality, especially when the person experiencing difficulties does not want their family involved in their care. Clinicians need the skills to deal with these more complex issues without becoming defensive, while remaining sensitive to the family's position. This is quite a challenge for those who do not feel confident in family work skills. A section in Chaapter 9 discusses this issue.)

Who to Train?

There are four core groups that need to be trained if family work is to be effectively delivered: direct clinical staff, middle or team managers, senior managers, and family members themselves.

Direct Clinical Staff

The evidence suggests that there is little point in training one or two individuals from a service or a team. The experience of the Thorn training schemes in the UK has demonstrated that those who leave a service to complete training and return as a couple of individuals attempting to implement change experience great difficulty (Brooker et al, 2003) They are frequently not facilitated in being given the time they need to implement the skills learned, and eventually give up. It seems preferable therefore that training is available to all clinicians in a team rather than just one or two clinicians from several teams or work sites. Not all clinicians may receive exactly the same training. A good model would seem to be one where everyone receives awareness training relating to the needs of families, a large number receive training in the family work skills listed above, and a small number develop more sophisticated skills to enable them to deal with complex family issues.

Difficulties seem to reduce if training is team-based (Corrigan & McCracken, 2003). This is the model used by Stanbridge and Burbach (2004). Multidisciplinary professional team-based training with subsequent supervision (Quarry and Burbach 1998) enables the required changes in culture and practice for service development (Burbach et al 2002).

McFarlane(1993) also reported that training a critical mass of clinicians followed by the encouragement of 'mutually supportive networks…..through conference calls and site visits:

> 'served to counteract any feelings of isolation that involvement in a special project with a sometimes-controversial viewpoint might inadvertently have fostered. These social networks were useful in dealing with the compatibility issue, by making psychoeducation congruent with the preferences of many public-sector clinicians for more supportive and team-based work environments.'

The concept of a critical mass is also discussed by Fadden (1997) who found that those areas where a critical mass of people were trained were those where family work was implemented. She also discussed concepts of multidisciplinary training – it appears that professionals from all disciplines can deliver family work equally well, provided they have the motivation and commitment to do so. Co-working also seems to help some clinicians, especially just after they have received training when they describe feeling more confident if they have another clinician with them. It is obviously most advantageous as a learning approach if someone who is less experienced works with a more experienced worker, though this is not always feasible because of service issues.

Team Managers

The experience of the Meriden Programme is that family work is unlikely to be implemented unless training is provided for those who manage teams and those in split management/clinical roles (Fadden, 2006). These are the people who facilitate clinicians in having the time they need to deliver family work, who prioritise family work, and who manage issues that impact on the delivery of family work such as caseload size. If they are not familiar with what family work is about and are not on board, then services to families are unlikely to develop. In terms of what training should be offered to team managers, they are unlikely to have the time to devote to lengthy training but will attend shorter courses covering the evidence base for family work, current policy and the basics of family work skills.

Senior Managers

It is key that senior managers and those in authority in services are familiar with family work and why it is essential in services (Smith & Velleman, 2002; Kelly & Newstead, 2004). They will not attend lengthy training, but it is important that they attend introductory or summary sessions which provide them with the core relevant points. It is important also that we remind them of the cost savings for services of implementing family work.

Carers and Family Members

It is important to ensure that some family carers are also trained**.** Thought must be given to what special help and support they will need in order to feel comfortable in being trained alongside clinicians. Similarly, it is important for staff to understand and accept that the presence of carers in the training adds a dimension that will help them understand and appreciate the benefits of the family work model in which they are being trained. Information sharing of this kind is invaluable.

The concept of professionals receiving training from family members is growing and has recently been made mandatory in relation to the training of psychiatrists in the U.K.(Fadden, Shooter & Holsgove, 2005). In our experience in the Meriden Programme over the last five years, the most effective way of changing staff attitudes is to ensure that they receive training directly from family members.

How to Deliver Training

Training programmes should use the elements of successful training as identified by Joyce and Showers (2002) incorporating presentation of information, demonstrations, and opportunities to practise key skills. Training is often most effective in small groups with low participant to trainer ratios. For example, the Meriden Programme uses ratios

of 1:5 in all of its training, and a facilitator is with trainees during all practice and role-play exercises, enabling them to get detailed feedback on their performance of all skills.

Staff need to understand at the outset that they will be expected to put this training into practice immediately, but that they will be supervised and supported from the outset. Evidence shows that those who delay in putting their skills into practice soon after training are less likely to do so at all. Some services now make training in family work mandatory, and include in the job descriptions of staff that they must deliver services to families following training.

There is often a question of whether training should be delivered in a block, or spaced out. Each has its advantages. Block training allows trainees a concentrated period of time to focus on their learning without the distractions of their clinical commitments. Shorter periods of time over several weeks is more manageable for services in terms of releasing staff for training while continuing to provide a clinical service. There does not appear to be much difference in terms of outcome of training whatever method is used, provided the space between training days is not too long.

The question of accreditation for training should be addressed as this gives status to the training and is an important motivator for many staff.

The Importance of Supervision

Ongoing supervision is crucial once training has been completed in order to ensure the development of skills. It is also important to have regular update and refresher days to keep therapists up to date with developing practice, and to maintain competence in the relevant skills. This also helps to build the confidence which is crucial in implementing family services. There are different methods of supervision that can be used. Group supervision maximises learning from a group of peers who are facing a range of issues that can be discussed and solutions found. Some clinicians prefer one to one supervision, especially if they are not feeling very confident, and are reluctant to discuss their work in front of a group. Ad hoc supervision where clinicians have access to a supervisor whenever they need it is important for dealing with crises that arise or issues that need to be discussed before the next planned supervision session. Overall therefore it is best to have a range of supervision options available.

Once again, managers play a key role in relation to supervision in terms of facilitating staff in attending supervision, and becoming involved if those who are trained and practicing family work do not attend supervision.

Conclusion

It will be clear that training is a crucial element in the effective delivery of family work. Staff who lack confidence and skill will be unlikely to take on what many of them perceive as a difficult and complex area of work. With training and crucially on-going supervision to support their learning, clinicians can be encouraged to begin this work which then becomes rewarding in its own right.

Meriden – the West Midlands Family Programme

The Meriden Programme has been described elsewhere (Fadden et al, 2002, Fadden et al, 2004). The Programme was established in 1998 with the aims of ensuring that

services sensitive to the needs of families were delivered, and that evidence-based family approaches were available to families in the West Midlands region of the U.K. This area has a population of 5.5 million, with both urban and rural areas and a diverse cultural mix, particularly in Birmingham and the surrounding cities.

The programme has employed two main strategies – a detailed programme of staff training and on-going supervision, and an extensive range of organisational strategies aimed at ensuring that services make the necessary changes to ensure that family work is delivered routinely. The programme was funded initially through regional training funds for the first six years, after which funding has been provided by the participating health organisations. The cost of the programme over a nine year period has been a million pounds sterling, so it has been very cost-effective, given its scale.

The programme operates a cascade training system whereby therapists are trained and then go on to train and supervise others within their services. Cascade systems of training can face difficulties if those trained as trainers do not receive support, monitoring and on-going supervision to ensure fidelity to the model of training. The Meriden Programme has been effective because the trainers/supervisors receive monthly supervision, and regular on-going training days to ensure that they are applying the model correctly and that their skills are constantly updated. There are currently 130 trainers/supervisors within the programme within the 13 participating organisations, and almost 2500 people have been trained to deliver family work over the nine years the programme has been running. Those trained are drawn from both statutory and voluntary agencies, and also include service users and carers.

The programme addresses a number of specialist areas including the needs of children where parents have a mental health problem, the needs of families in in-patient settings, and the needs of carers from black and minority ethnic groups. It is influential in guiding national policy on carers and guidance documents such as those relating to confidentiality and information-sharing with carers. Further information on the programme can be found on the Meriden website, www.meridenfamilyprogramme.com

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