

Family work in adult acute psychiatric settings

Alex Reed and colleagues discuss how this form of intervention can help families address the negative effects of admission

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Abstract

Meeting a service user with his or her family in acute care settings to discuss their thoughts, hopes and concerns provides important therapeutic benefits. It can help counter some of the potentially negative consequences of hospital admission for the service user and family. Because people usually enter hospital during a period of crisis, approaches that are flexible and responsive to the specific needs of each client and family are required.

To practise in this way, staff require access to training and continuing supervision that also needs to be delivered flexibly and responsively.

Keywords

Acute mental health inpatients, family work, staff training

DEVELOPING FAMILY work in adult acute psychiatric services can be daunting. Despite an ongoing emphasis in government policy and practice guidance on working with family and carers (Princess Royal Trust for Carers 2010, Department of Health (DH) 2011) and robust evidence (Fadden 2006, National Institute for Health and Clinical Excellence 2009), family-based approaches are not yet widely available in UK services, with one or two notable exceptions (Burbach and Stanbridge 2006, Fadden 2006).

Although there have been inspirational developments in the mental health field, for example, the service-user-led recovery movement, psychiatry's institutional history still exerts a powerful influence in many areas.

Challenges to the implementation of family work are multi-level (Froggatt *et al* 2007). They may include:

- Reservations on the part of the families.

- Staff anxieties about confidentiality and lack of training.
- Organisational factors, such as financial pressures and conflicting priorities.
- Service structures that impede the delivery of family work.

A risk-averse culture can also mean that traditional practices are retained. In acute hospital settings, an orientation towards crisis management (Smith and Velleman 2002) and the complex demands placed on these services, conspire to make delivery of family work problematic.

Institutional work

Despite these many challenges, family work maintains a crucial role in these clinical areas and can help to address some of the deleterious effects of hospital admission (Reed *et al* 1998). Although today's short-stay psychiatric hospitals are quite different from the total institutions that sociologist Erving Goffman (1968) described in the 1960s, admission may still result in some negative consequences. Goffman wrote about a 'stripping process'. This refers to when the individual was stripped of their unique identity and took on an alternative identity – as a patient – which was fabricated when they entered the institutional domain of the hospital. As a consequence, the person's relationships with others and with 'life outside' the institution became weakened.

Similarly, writing in the 1960s and 1970s, the pioneering psychiatrist and family therapist Dennis Scott (1973) described the process of 'closure' or loss of intimacy, which may arise between the person in crisis and their family when hospital admission occurs. The individual's actions are increasingly attributed to the illness rather than as a way of dealing with developmental or relational dilemmas.

More recently, Bridgett and Polak (2003) have argued that psychiatric hospital admission can have adverse 'side effects' linked with a reliance on the medical model and a neglect of the service user's social context. These negative effects may include a process of disengagement from community resources following admission, resulting in delayed discharge from hospital and an increased risk of future re-admission.

The service user and family members can become disconnected from their own problem-solving abilities and depend more on outside experts (Whittle 1996). Family therapy approaches, which value relationship, connectedness and exploration of multiple voices, can be particularly valuable in preventing these processes of closure and disempowerment (Reed 1999).

Modern context

The Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest providers of mental health services in England and its urgent care directorate has a number of adult admissions units, crisis intervention/home treatment services and some acute day care provision. There has been a small amount of family therapy activity in some of these clinical areas for a number of years, (Q HOW MUCH AND FOR HOW LONG?) but more recently there has been an attempt to develop family-based approaches in a more systematic way.

This has led to something of a flowering of activity on several wards and in the acute day services. Although this activity has not yet reached every clinical area, it is spreading. Crucially, even during these times of financial austerity, clinical leads and managers at all levels have given their support. The active local service users and carer leads, who have long called for better access to psychotherapeutic approaches and for more inclusive practices, have also been an important source of support.

Some of the staff in these acute care services have completed the trust's foundation course in family therapy and/or behavioural family therapy for psychosis. The trust has run a foundation course for many years (Q HOW MANY?) and the benefits of having staff members complete it are being seen. Practitioners are much more likely to deliver family interventions if enough of them are trained in the approach (Fadden 1997).

This number has grown further following a successful bid to the local strategic health authority, made in collaboration with the neighbouring Tees, Esk and Wear Valleys NHS Foundation Trust. This provided funding to buy in training

in behavioural family therapy for psychosis from Meriden, a specialist family interventions training organisation in the West Midlands. These systemic and behavioural family therapy training programmes have helped to create a more supportive culture in the trust, and have encouraged conversations about family work across clinical and managerial spheres. A recent (Q WHEN?) information-sharing event about family work for managers and team leaders in our trust was attended by 34 senior colleagues eager to develop these services in their areas.

Instead of setting up specialist family therapy clinics to which clients can be selectively referred from wards, we have opted for a model in which staff routinely offer family meetings to all service users following admission. If we only tried to identify 'suitable families' to work with there is a risk that the offer of family work would be stigmatising and only seen as relevant for those families who are regarded as 'difficult' or 'failing'.

Similarly, there is a danger in busy services that informal 'exclusion criteria' will gradually develop, such as:

- The person may be judged to be 'too ill' to participate in a meeting.
- The individual may be well known to staff due to previous admissions and the idea of convening the family might seem pointless at this stage.
- The person may have a diagnosis of borderline personality disorder and the team may be wary about offering additional services.
- Often people are admitted 'out of area' and, because of catchment area boundaries, family work might not be thought to be the team's responsibility.

Model used

The approach that we have followed has been based on our readings of the early development of the Finnish Open Dialogue model, which appears to be the most successful example of embedding family-orientated practices throughout a psychiatric system. The Finnish team began by introducing post-admission family and staff network meetings, with these meetings later becoming the hallmark of their entire community and hospital service (Seikkula and Sutela 1990).

In addition to the Open Dialogue literature, we have been inspired by the innovative work of Frank Burbach and Roger Stanbridge and colleagues in Somerset (Burbach and Stanbridge 2006, Carter 2011) and also by Grainne Fadden, Martin Atchison, Peter Woodhams and the Meriden team in the West Midlands (Fadden 2006), who have led the way in showing how family work can become mainstream in services. We also drew on our own previous

experiences of implementing family work (Reed and Hawkes 2007).

The family meetings we offer are usually run by a member of the ward or acute day service team who has completed foundation level or behavioural family therapy training, together with a more experienced colleague with more advanced family therapy training. This co-working model helps those who are inexperienced to gain confidence, increases opportunities for the wider team to participate, and also contributes towards family work being regarded as an ordinary part of service delivery, rather than an elitist activity, which might lead to it being overlooked or ignored.

Those who are working with the family meetings draw on a range of theoretical ideas and techniques from the systemic and behavioural family therapy traditions, according to the particular needs of each family. Our main aim is to create an ethos where all participants feel safe enough to begin to voice their thoughts, hopes and concerns, and where a reflective process of speaking and listening can occur (Anderson 2012) (Q PLEASE INCLUDE IN REF. LIST). Two case studies demonstrate some important aspects of our practice. See panels below and on page 26. The staff enter the meeting with some

themes that families often may wish to discuss, such as:

- The events leading to admission.
- Hopes and fears for the future.
- Family relationships.
- Questions about the professional system.

No particular topic of conversation is imposed, we prefer to be led by the family's concerns.

The meetings may occur on a one-off basis or further appointments can be made according to the needs and preferences of particular families. We also have a weekly team conference to discuss practical arrangements, such as appointments, and to reflect on difficulties in engaging families, what occurred in the sessions and the progress of skills-based training. These fixtures help to maintain a sense of identity and purpose for the project.

Having an experienced family therapist taking part in the project provides ongoing support and a collaborative form of leadership. It is a two-way exchange: the family therapist brings experience of how to work with families, and the acute care staff have more detailed knowledge of the clinical area and of the service users' circumstances. Because the team members may have training in either systemic or behavioural family approaches, it is important that

Case study one

Joe (not his real name), a 42-year-old married man, was admitted to the ward under Section 2 of the Mental Health Act following an overdose taken while severely depressed. A family meeting took place shortly after he entered the ward, which Joe attended with his wife, Sue, and his parents. Two members of the family team were present to assist the conversation. At the time Joe was extremely agitated, and when on the ward he tended to remain in his room. When his family visited, staff noticed that there appeared to be tensions between Sue and Joe's mum.

The family were eager to take up the invitation to attend a family meeting. The process of arranging the appointment seemed to have helped them reflect on their situation, and they attended with an apparent desire to begin talking about their previously unspoken concerns. Each session begins with a few comments from the practitioners present, indicating that it is the family's time to talk about whatever is

important to them, and this is different for everyone. People often want to talk about what led up to the admission, and about what their hopes and concerns are for the future. At the beginning of this session, Joe looked anxious and said little, but he tolerated being in the room and was able to stay for the duration of the meeting. As the conversation 'warmed up', he was also gradually able to contribute more actively.

The staff aspire to work collaboratively with families to explore previously unacknowledged territory that may be affecting the welfare of the individuals concerned. An ability to contain potentially volatile and conflicting opinions and feelings that can contribute to longstanding family tensions and difficulties, is one of the therapeutic benefits of family meetings. In Joe's case, they (Q WHO – EVERYONE?) wanted to talk about tensions between them that they felt had contributed to his depressed mood. The difficulties that Joe had experienced between Sue and his Mum were examined, and Joe's father was

able to express his own thoughts about this for the first time.

As is common on these occasions, the two leaders explained and asked permission for a reflecting conversation towards the end of the session (Andersen 1990). Here the staff will openly discuss the different thoughts and impressions that occurred to them during the meeting and the family can respond to these reflections (Q PLEASE STATE WHETHER FAMILY ARE ENCOURAGED TO ADD THEIR OWN REFLECTIONS, EG FEEDBACK ON STAFF CONTRIBUTIONS). This approach can help to generate new ideas about responding to problems and people can feel that they have been listened to.

Soon after this (Q: HOW LONG?) Joe was discharged from the ward. The family continued with a further three meetings and he also attended the acute day service and received follow up from his psychiatrist and community psychiatric nurse.

the family therapist has the experience and flexibility to take account of the specific family's needs and the individual professional's level and type of training, and to navigate between different models without unnecessary tensions occurring.

Support for the project from senior figures, such as the team leaders and ward managers from the relevant clinical areas is also important. This should preferably come in the form of direct clinical participation. 'Leading from the front' sends a clear signal to the wider team that family work is a priority, and can encourage more junior staff to engage with the work.

Future plans

The project has seen a high level of take-up in acute settings. An initial six-month audit of two wards and an acute day service showed that 69 family meetings had been offered (Q DO YOU WANT TO MENTION WHAT PROPORTION OF ADMISSIONS THIS IS?), and that more than 70 per cent of those who were offered the service accepted the invitation, or were actively considering it. In their answers to questionnaires seeking feedback about the family work, participants have been extremely positive in their remarks, indicating that the events provide a supportive context in which there is an 'openness of being able to talk about anything' in an 'atmosphere of acceptance and understanding' (Q: DO YOU WANT TO MENTION THE SOURCES OF THESE QUOTES AND

THE FORMAT OF THE QUESTIONS THAT ELICITED THEM).

We have identified several goals. First, having successfully embedded family meetings into some acute care areas in our trust, it is a priority to extend the model to the remaining areas, so that it is a provision that all who are admitted and their families, partners and friends can expect.

A second goal is to strengthen the relationship between the family meetings and main clinical decision-making processes in our acute services. We are working towards shorter admissions and being more focused on specific goals, and there are clear opportunities for family meetings to contribute to this process.

Third, we aim to focus more on parenting and to become more active in inviting younger family members to the meetings. Many of the people who are admitted have children or may have younger siblings who have been affected by the situation (Smith *et al* 2009).

There are several reasons why the inclusion of younger people has been slower to develop. Traditionally, child and adolescent mental health services are separate from adult services, so many staff in adult psychiatry have little experience of working with children (Hunt 2012, Reimers 2012). In addition, many service users who are parents may not want their children to visit to protect them from this potentially unsettling environment.

Case study two

Esther (not her real name), a 54-year-old woman, was admitted under Section 3 of the Mental Health Act following a recurrence of psychosis. She was offered a family meeting, together with her husband, Jonathon. The couple had no close relatives living nearby, and no children. The first session took place a few days after Esther's admission and two of the family team attended.

Before admission, Esther had been experiencing intense paranoid ideas directly relating to her husband, but these unusual ideas were affecting her less by the time of the family meeting. Jonathon appreciated the opportunity to discuss his concern for his wife, and also expressed a wish for her to remain in hospital and recover.

Although she was angry with her husband for taking steps to have her admitted, she began to speak more reflectively in the session about the powerful feelings she had been experiencing. She also regretted the

worry Jonathon had experienced, and talked about her own hopes regarding her future care and recovery.

The couple were able to reflect on their 30-year marriage and the strengths in their relationship, which had enabled them to cope in hard times. It was apparent that they had endured several major life events together and a theme around identity emerged, stemming from Esther's childhood relationships with her parents, and experiences of separation and loss. A family tree was drawn and this illustrated the complex family history and helped them to make sense of their experiences within the context of their wider family network.

The couple have continued to attend family meetings since Esther's discharge from the ward. She has had no further episodes of psychosis to date (Q AFTER HOW LONG?). The family work is drawing to a natural close after ten meetings, in keeping with the guidelines on schizophrenia from the National Institute for Health and Clinical Excellence (2009).

Two initiatives have helped us deal with this. We have been inspired by a DVD made by our trust's Patient and Carer Engagement Team (Northumberland, Tyne and Wear NHS Foundation Trust 2012), which addresses the impact of parental mental illness on children and calls for a more satisfactory service response than safeguarding processes alone can offer. Also, visits to the area by family therapists Bernadette Wren and Gwyn Daniel to present their innovative therapeutic work at the Tavistock Centre on parental mental illness (Daniel and Wren 2005) have helped to build our confidence and determination to better support these young people.

(Q: MENTION OF LIMITATIONS OF, OBSTACLES TO AND NEGATIVE FEEDBACK ABOUT THE FAMILY WORK WOULD BE INSTRUCTIVE)

Conclusion

Despite the many challenges encountered when implementing family work in acute care settings, these strategies offer important therapeutic benefits and can help to counter some of the negative consequences of admission experienced by service users and families. Because people usually enter these settings during a period of crisis, approaches that are flexible and responsive to specific needs are required. Shotter (2011) has termed such approaches 'witness practices', because they are attuned to the specific and changing needs and responses of each client and family.

To work in this way, staff require access to training and continuing supervision; these also should be delivered flexibly and responsively. Co-working arrangements in which practitioners can work alongside more experienced colleagues seem to be particularly effective in building confidence and capacity for working collaboratively with families (Reed 2012).

Online archive

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Conflict of interest

None declared

References

- Andersen T (Ed) (1990) *The Reflecting Team: Dialogues and Dialogues About the Dialogues*. Borgmann, Broadstairs.
- Bridgett C, Polak P (2003) Social systems intervention and crisis resolution. Part 1: Assessment. *Advances in Psychiatric Treatment*. 9, 432-438.
- Burbach F, Stanbridge R (2006) Somerset's family interventions in psychosis service: An update. *Journal of Family Therapy*. 28, 1, 39-57.
- Carter K (2011) Family liaison in an adult acute inpatient ward. *Mental Health Practice*. 14, 8, 24-27.
- Daniel G, Wren B (2005) Narrative therapy with families where a parent has a mental health problem. In Vetere A, Dowling E (Eds) *Narrative Therapies with Children and Families*. Routledge, London.
- Department of Health (2011) *No Health Without Mental Health*. Department of Health, London.
- Fadden G (1997) Implementation of family interventions in routine clinical practice following staff training programmes: A major cause for concern. *Journal of Mental Health*. 6, 6, 599-612.
- Fadden G (2006) Training and disseminating family interventions for schizophrenia: developing family intervention skills with multi-disciplinary groups. *Journal of Family Therapy*. 28, 1, 23-38.
- Froggatt D, Fadden G, Johnson DL et al (2007) *Families as Partners in Mental Health Care: A Guidebook for Implementing Family Work*. World Fellowship for Schizophrenia, Toronto Canada.
- Goffman E (1968) *Asylums*. Penguin, Harmondsworth.
- Hunt L (2012) Front line staff urged to take 'whole family' approach. *Mental Health Practice*. 15, 5, 8-9.
- National Institute of Health and Clinical Excellence (2009) *Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (update)*. National Clinical Practice Guideline No. 82. NICE, London.
- Northumberland, Tyne and Wear NHS Foundation Trust Patient and Carer Engagement Team (2012) *Shy Bairns Get Nout: A Glimpse into the Ordeal of Children living with Parental Mental Illness*. angela.glascott@ntw.nhs.uk (Q: NOT FOUND. PLEASE CHECK - WHY IS THIS EMAIL ADDRESS HERE?)
- Princess Royal Trust for Carers and National Mental Health Development Unit (2010) *The Triangle of Care - Carers Included. A Best Practice Guide in Acute Mental Health Care*. www.carers.org (Last accessed: December 15 2012.)
- Reed A (1999) Psychiatric hospital admission and interpersonal 'closure': Network meetings as a means of countering closure. *Human Systems*. 10, 1, 35-48.
- Reed A (2012) Therapist attentiveness and negative capability in dialogical family meetings for psychosis. *Journal of Family Therapy*. In press (Q: PLEASE UPDATE).
- Reed A, Hawkes K (2007) Supporting systemic thinking in an early intervention in psychosis team. *Context*. 93, 3-5. (Q: NOT FOUND. PLEASE CHECK AND ADD ISSUE NUMBER)
- Reed A, Stevenson C, Wilson M (1998) Social network meetings ease trauma of psychiatric admission. *Nursing Times*. 94, 42, 52-53.
- Reimers S (2012) What's the difference between children and adults? Conflict, cooperation and indifference in relationships between adult and children's therapeutic services. *Journal of Family Therapy*. 34, 2, 157-171.
- Scott RD (1973) The treatment barrier: Parts 1 and 2. *British Journal of Medical Psychology*. 46, 45-67.
- Seikkula J, Sutela M (1990) Co-evolution of the family and the hospital: The system of boundary. *Journal of Strategic and Systemic Therapies*. 9, 2, 34-42.
- Shotter J (2011) *Getting It: Witness-Thinking and the Dialogical in Practice*. Hampton Press, New York NY.
- Smith G, Velleman R (2002) Maintaining a family work for psychosis service by recognising and addressing the barriers to implementation. *Journal of Mental Health*. 11, 5, 471-479.
- Smith J, Fadden G, O'Shea M (2009) Interventions with siblings. In Lobban F, Barrowclough C (Eds). *A Casebook of Family Interventions for Psychosis*. Wiley-Blackwell, London.
- Whittle P (1996) Causal beliefs and acute psychiatric hospital admission. *British Journal of Medical Psychology*. 69, 4, 355-370.