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Promoting family inclusive practice in Home Treatment Teams

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Abstract

Purpose

Families play an instrumental role in helping their relatives experiencing mental health issues to stay well. This study aimed to evaluate the feasibility, acceptability and potential benefits of a bespoke one-day workshop for practitioners working with families in crisis.

Design

The study was an uncontrolled evaluation of a one-day workshop for Home Treatment Team practitioners (HTTs) using pre and post-workshop questionnaires.

Findings

Eighty three practitioners participated. Overall, there was strong agreement for the involvement of families in their relative's care, which increased marginally following the workshop. There were significant changes in views about talking to family members without service user consent ($p=0.001$) and keeping them informed of their relative's wellbeing ($p=0.02$).

Qualitative feedback indicated that participants enjoyed the interactive elements of the workshop, particularly the opportunity to practise skills. It encouraged participants to share knowledge and facilitate the integration of family work into their professional role.

Research and practical implications

Support for families can contribute to effective mediation of crisis and continuation of care; factors that are important in reducing admission rates and protecting relationships. Participants' responses suggested that this one-day workshop offered a helpful introduction to a family approach at times of a mental health crisis, which could be routinely offered in HTTs.

Originality/value

A social systems perspective is at the heart of a successful HTT approach to managing mental health crises. This workshop offered a feasible means to address one element of the necessary conditions for family-focused practice; practitioner confidence to talk with families at times of crisis.

Research paper
Key words: Home Treatment Teams; HTT; crisis resolution; workshop; family

Introduction

Home treatment teams (HTT; sometimes known as Crisis Resolution Teams) are specialist teams providing a rapid and intensive home-based response, to people experiencing a mental health crisis, to prevent admission to hospital or provide aftercare following an inpatient stay. HTTs were rolled out across the UK in line with Department of Health (2001) guidance and are now available in most Trusts in the UK (Lloyd-Evans et al., 2016). Key underlying principles include addressing the social systems and environmental triggers within which crises occur; also providing multi-disciplinary interventions to develop crisis coping skills and avoid future relapse. This includes support and education, medication management, practical help with daily living tasks, family/carer support, and advocacy (Carpenter et al., 2013). HTT practitioners work with families at a time when they are extremely distressed and there is increasing evidence that families who manage their stress proactively can help their relative stay well (Bucci et al., 2016).

Family-oriented approaches

Clinical guidelines advocate family inclusive practices in adult mental health services (Care Act, 2014, Worthington et al., 2013). However, reviews have reported some negative patient and carer experiences of HTTs (Care Quality Commission, 2015; Mind, 2011); with the experiences, roles and influence of families often overlooked. Such disempowerment and invisibility can add to the significant impacts associated with providing care. Morant and colleagues (2017) reported that a social systems perspective was recognised by all stakeholders to support a successful HTT approach to managing mental health crises. Carers valued the combination of interpersonal skills (non-judgemental listening, a caring attitude, providing emotional support) and professional skills, but often felt excluded. As family members are often the first to become aware of their relatives' mental health difficulties, it is understandable that they would value having time with HTTs to discuss any concerns privately and to be asked about their own well- being.

Family inclusion is not a straightforward notion, with the experiences, needs and recovery journeys for family members and service users co-existing yet interdependent; both with unique needs and experiences. Morant et al. (2017) suggested that barriers to family involvement include a lack of skilled therapists, who feel able to work therapeutically with

families, and concerns about confidentiality. A commitment to the inclusion of families requires a team culture shift, with widespread leadership and adequate investment of resources. Evidence originating from Finland suggests that a whole system approach - led by the service user and those close to them - can successfully mitigate some of the outcomes following a mental health crisis, with lower use of neuroleptic medication and hospital admission over time (Bergström et al., 2018). Open Dialogue places the social network at the heart of all decision-making and has two distinctive features: (i) a commitment to engaging with service users and their networks, from the point of crisis, in a transparent, shared approach; (ii) a way of engaging in therapeutic conversations known as "dialogic practice". Dialogic practice is underpinned by the value given to hearing the unique voice of each person present; closely attending and responding in the moment, in ways that seek to develop understanding (Olson et al., 2014).

Most HTT practitioners in England are not trained in either family therapy or Open Dialogue, so may lack confidence to work collaboratively with families, with implications for training in these teams. Increasingly, the role that family members and carers can play in the development and delivery of such training plans has been recognised (e.g. Fadden, 2018) as part of a wider culture shift to work more in partnership with families.

This workshop took place in the context of an NHS Trust commitment to meeting the Home Treatment Accreditation Scheme (HTAS) standards (Buley et al., 2017) through a comprehensive training programme. The development and facilitation of a bespoke one-day workshop was commissioned across the South London and Maudsley NHS Foundation Trust. This paper reports its feasibility, acceptability and potential benefits to develop clinicians' skills in working with families in a crisis.

Workshop development and content

This workshop was developed by two of the authors (MG & JA); both experienced in family work as practitioners, supervisors and trainers. Priorities for the workshop were informed by feedback from families who had experience of using the HTTs, HTT practitioners and managers, as well as reference to key areas of related literature (e.g. Stanbridge et al., 2009). A carer adviser employed by the family service, with personal experience of using

HTTs, contributed ideas for the workshop and recorded a video to be played for participants. The workshop and the evaluation questionnaire were then piloted with an initial group of 10 HTT practitioners, from different professional backgrounds, and refined on the basis of their feedback.

The workshop covered a range of topics, summarised in Table 1. The general approach emphasised the value in the perspectives and experiences of families and the importance of attending closely to their expressed needs. This was combined with introducing conversations on understanding psychosis and communication in the family. Participants were encouraged to recognise expertise they already had and draw on their existing knowledge and experiences of working with families in crisis.

Table 1. Workshop content and associated learning outcomes.

Content	**Learning outcome**	**Supporting literature**
How families and social networks are affected by mental health crises. The benefits of a social network perspective.	Understanding the rationale for working in partnership with family members	Morant et al. (2017) Brennan et al. (2016) Holttum (2018) Worthington et al. (2013)
Video of a family member sharing experiences of HTT	Empathising with the perspectives of family members	Brennan et al. (2016)
Genograms and the value of multiple perspectives	Seeing the service user in context. Understanding that different views in the family can create opportunities as well as challenges.	McGoldrick et al. (1999) Burbach (2018)
Cognitive interactional cycles	Recognising the cycles that family members get into with each other, as well as with staff members. Being able to consider ways of exiting unhelpful cycles of interaction with stressed family members.	Burbach (2018)
Guiding principles for meeting with families including role play exercises	Understanding the value of being led by the family's priorities. Being able to focus on attentive listening as an alternative to providing "expert" solutions.	Olson, Seikkula & Ziedonis (2014)
Information sharing with families	Being responsive to the different ways that family members make sense of things and valuing the expertise of each person.	Burbach (2018) Falloon et al. (2004)
Strategies for managing disagreement and strong emotion	Recognising our own reactions to emotive situations. Knowing how and when to use 'positive re-frames' as a technique to manage critical comments.	Dallos & Draper (2000) Goldenberg & Goldenberg (2012)

The approach taken to evaluating this workshop was broadly informed by the Kirkpatrick four level model; recognising that training impact takes place in four main areas: reaction; learning; behaviour and results (Kirkpatrick, 1996). 'Reaction' to training is understood to be an important starting point, as this may indicate the extent to which participants have engaged in the training event. At the second level, 'learning' reflects the extent to which participants have understood and assimilated new factual or skills-based material that has been covered. Reaction and learning tend to be most easily captured through self-report measures and observations on the day of the training. 'Behaviour' at the third level reflects the extent to which participants translate what they have learnt into behaviour change once they return to the workplace; requiring some kind of follow up after the end of training. The fourth level 'results' refers to the more distal outcomes following training; the extent to which the behaviour changes are seen to lead to desired improvements in target outcomes in the workplace (Kirkpatrick, 1996). It was beyond the scope of the current study to measure changes in behaviour at the workplace and any subsequent results for the organisation, though these were held in mind in the planning and delivery of the workshops, with the involvement of managers and clinical psychologists, who are well placed to support the translation of learning into practice.

Method

Design

The study was an uncontrolled evaluation of a bespoke workshop for HTT practitioners. The questionnaires were given at three time points: pre, post, and at 3-month follow up.

Participants

The workshop was offered to all HTT members across four South London boroughs. The four teams comprised approximately 125 permanent practitioners. At the time of data collection, 97 people (78% of the whole group) had attended the workshop. Attendees at the first workshop (n=10) formed the pilot stage of the study. Eighty-three of the 87 attendees at subsequent workshops participated in this evaluation (see Table 2).

Table 2. Summary of demographic data of participants

Demographic Characteristics	N = 83
Gender	
Male	24
Female	59
Professional Role	
Mental Health Nurse	47
Social Worker	4
Clinical Psychologist	4
Support Worker	7
HTT Practitioner	18
Occupational Therapist	3
Mean years in mental health service (range)	11.5 (1month – 38 years)
Mean years in HTT work (range)	5.7 (1month – 18 years)

Measures

The workshop was evaluated using a locally developed questionnaire that was informed by Kirkpatrick's model, the family work training literature and consultation with colleagues in the HTTs. There was no published and standardised measure that met the service needs for understanding the possible outcomes of this workshop, so adaptations were made to those in the published literature that included the most relevant content, though it was recognised that there would be limitations due to its lack of demonstrated reliability and validity.

Participants first completed some basic demographic information. The spread of demographic information, as well as numbers of participants overall, contributed to judgments about feasibility for this workshop programme.

The evaluation questionnaire included three further sections:

- Section 1 comprised 12 items referring to attitudes to family inclusive practice and beliefs about family involvement in care such as "You should not talk to family without the service user's consent" (see Table 3). All items were rated on a 1-5 Likert scale to indicate the extent of agreement or disagreement with each statement (where 5 represents full agreement).
- Section 2 of the questionnaire referred to participants' self-rated knowledge and confidence in various aspects of family work considered most relevant to their work

context, such as “Using genograms to map out who is in the family and social network”. This section comprised 12 items for knowledge and the same items for confidence except for item 1 for which confidence ratings were considered less applicable (see Table 4). Both were rated on Likert scales ranging respectively from 1 (“know very little”) to 5 (“very knowledgeable”) and 1 (“not at all confident”) to 5 (“very confident”).

- Section 3 referred to participants’ experience of the workshop overall and their views on its likely application to the workplace (e.g. “In my everyday work I will often use the knowledge I gained in the training”). This section was given post workshop, and at follow-up, and consisted of 12 items rated on a 1-5 Likert scale to indicate the extent of agreement or disagreement with each statement (see Table 5). Two open ended items aimed to elicit participants’ views on something from the day that they enjoyed and found useful and something they did not find useful, or that could be done differently.

Scores from the first two sections of the questionnaire were given before and after the workshop and aimed to measure the perceived impact, or potential benefits, based on attitude change subsequent to learning (second level of Kirkpatrick’s model). These sections were adapted from a questionnaire described by Sin and colleagues (2013). The adaptations were introduced to reflect the crisis stage of the teams’ work with families and associated content of the workshop. Table 3 shows the items which were added to section 1 of the questionnaire, following consultation with HTT colleagues about the key intended outcomes. Section 2 followed the same structure and approach to measurement as the Sin et al. (2013) questionnaire, but given that this section was intended to assess fact-based learning (as per Kirkpatrick’s second level) the items were amended to directly reflect the components of the workshop content (see Table 4). Sin et al. (2013) have not validated their questionnaire, therefore these adaptations are not considered to compromise the original status of the measure.

Section 3 was adapted from a questionnaire described in Grohmann and Kauffeld (2013) and aimed to capture participants’ experience of the workshop and perceptions of its likely impact. Along with the qualitative items, this was the primary means of assessing acceptability for participants, with the first four items focusing on Kirkpatrick’s first level (reaction). This questionnaire was chosen because it was designed to assess training in

relation to all four of Kirkpatrick's levels, as indicated in Table 5, though for the immediate post-workshop version the wording of items relating to "behaviour" and "results" were amended to reflect the anticipated future. Other wording changes were introduced either to address translation idiosyncrasies (the original version was in German) or to more closely reflect the HTT context. For example item 12 was reworded from *"Overall, it seems to me that the organisational climate has improved due to the training"* to *"Overall, the team attitude towards families and carers should improve due to the training".*

The limitations to using non-standardised questionnaires were acknowledged, but in consultation with colleagues in the HTTs, these adapted measures were considered to have the best face validity, in terms of their relevance for the service.

Procedure

A manager in each service was responsible for circulating information about the workshop to the different teams and organising the teams' rotas to ensure that people could prioritise attendance. There were 10 one-day workshops delivered between January 2018 and July 2018, including the initial pilot workshop. The workshops were led by two Clinical Psychologists (MG & JA) with contributions from other colleagues experienced in family work. Each workshop comprised a combination of practitioners from across the four teams (mean number of attendees = 10, range = 6-15). Participants were provided with an information sheet about the study and had the opportunity to ask questions on arrival. Informed consent was obtained for their data to be used for publication. The questionnaire was then given to participants immediately before the workshop commenced and immediately after. All participants were emailed a follow-up questionnaire 3-months post workshop.

Data Analysis

SPSS 21 (IBM Corp) was used for data analysis. Paired Wilcoxon signed ranks tests were conducted to assess differences between pre- and post- workshop. To explore if there were any between group differences a one-way ANOVA was conducted. Open text responses were examined to identify aspects participants particularly enjoyed and others where improvements were suggested. All included quotes are verbatim.

Results

Demographic characteristics

Following the initial pilot workshop, 87 mental health clinicians attended over 10 dates (approximately 70% of total), of which 83 completed both pre and post workshop questionnaires, giving a response rate of 95% (see Table 2 for demographics). Any further variation in the number of respondents is due to missing data on certain items as some people missed questions at each time point. Due to a low response rate of 6% (n = 5) at 3-month follow-up, only data for pre and post outcomes are presented.

Views on working with families

Measured change on these items contributed to assessment of "learning" as described in Kirkpatrick's second level. Overall, mean total scores for pre- versus post-workshop (after adjusting for reverse scored items) were 4.3 (SD 1.0) and 4.4 (SD 0.6) respectively, reflecting strong agreement for the involvement of families at the start of workshop which slightly increased. Table 3 shows the scores for all items before and after workshop. There was a statistically significant change in participants' expressed views on talking to family members without the service user's consent (Z=-3.268, p=0.001). Pre-workshop, the participants were more likely to "neither agree nor disagree" with this statement (mean reversed score 3.2). Post workshop, participants were more likely to slightly disagree with the statement "You should not talk to family without the service user's consent" (mean reversed score 3.8) suggesting that post-workshop participants were more likely to advocate talking to family members.

There was also a significant difference in mean scores on item 4 (Z=-2.328, p=0.020). Pre-workshop, the participants slightly agreed (mean score 3.6) with keeping family members informed of their work with their relative, however, post-workshop mean scores increased to show stronger agreement (mean score 3.9) with informing family members. There were no other significant changes on items pre- and post- workshop. An ANOVA to examine if there were any differences and changes pre- and post- workshop according to professional

role, years in mental health service and years in HTT work did not reveal any significant between group differences.

Table 3. Pre and post ratings of views on working with families.

Item	Pre-Training Mean[1]	Post-Training Mean[1]	Standard deviation	Significance (2 tailed)
1. You should not talk to family without the service user's consent*	*3.2*[2]	*3.8*[2]	1.51	**0.001**
2. It is a luxury to attend to the needs of family members	*3.9*	*4.0*	1.15	0.255
3. You should not talk to families unless you have specialist training	*4.7*	*4.5*	0.87	0.206
4. You should keep family members informed about work with their relative	3.6	3.9	1.45	**0.02**
5. You should avoid distressing conversations with family members*	*4.0*	*4.2*	1.21	0.24
6. Family involvement should take lower priority when time is short*	*4.2*	*4.4*	0.88	0.174
7. We have a duty of care to service users but not to their families	*4.5*	*4.6*	1.16	0.188
8. Family involvement in decision-making is a high priority in a crisis*	4.3	4.4	1.09	0.686
9. Supporting families and carers should be a core part of HTT work	4.7	4.6	0.64	0.306
10. You should always ask about service users' family situations	4.8	4.7	0.60	0.145
11. It is a team issue to ensure that we support family members*	4.6	4.6	0.94	0.64
12. It's our job to involve families and carers in discharge plans*	4.8	4.7	0.65	0.401

*Indicates new items added to adapt the questionnaire for the HTT context

[1] Means shown to one decimal place

[2] Italics indicate scores after adjusting for reversed score

Knowledge and confidence in working with families

These items also reflected Kirkpatrick's second level of training evaluation (learning). There were statistically significant changes in participants' ratings of their knowledge ($p<0.05$), in that all participants rated their knowledge as higher post-workshop on all 12 items (Table 4). There were also statistically significant changes on all 11 items related to confidence in offering support when working with families ($p<0.05$) (Table 4). All participants rated their confidence levels as higher post-workshop.

Table 4. Pre and post scores for self-rated knowledge and confidence.

Item		**Knowledge**		**Confidence**	
		Pre	Post	Pre	Post
1	Understanding the rationale for involving carers and family members	2.5	2.8	N/A	N/A
2	Empathising with the perspectives of those close to a service user in crisis	2.5	2.8	2.4	2.8
3	Using genograms to map out who is in the family and social network	1.7	2.5	1.7	2.7
4	Identifying carer/family strengths and contributions to care	2.3	2.7	2.2	2.7
5	Sharing ideas about how communication might be affected by stress in the family	2.3	2.5	2.3	2.6
6	Involving carers in care planning at different stages of the care episode	2.4	2.8	2.3	2.8
7	Supporting carers to look after themselves	1.5	2.9	1.5	2.4
8	Guiding principles for holding a family meeting	1.6	2.6	1.6	2.5
9	Managing difficult family interactions in the moment e.g. conflict, distress	2.4	2.8	2.4	2.8
10	Using a co-worker relationship to support a family focused meeting	2.7	2.9	2.5	2.8
11	Sharing information about mental health problems with families	2.2	2.7	2.1	2.6
12	Ensuring that everyone in the family feels heard	2.6	2.8	2.4	2.7

Workshop experience

The average score across items on section 3, and across participants, was 4.6 (range = 1-5) indicating agreement with all items relating to their experience of the workshop and its perceived impact on their work (see Table 5). Section 3 was designed to reflect all four levels of Kirkpatrick's model, though in the absence of follow up data, items relating to "behaviour" and "results" indicated outcomes anticipated by participants rather than actual change.

Qualitative Feedback

These comments were an additional means of assessing Kirkpatrick's first level of "reaction" to workshop. Sixty-one people responded to the open ended questions (73% of all respondents). In reference to the first free-text item ("Please tell us something from the day that you enjoyed and found useful") participants reported enjoying the interactive element of the workshop (group work and role play) and the opportunity to learn new theoretical material. In particular 32 people commented on finding the role play helpful. This was reported to provide the opportunity to practice skills, share information and learn more about integrating family work into professional roles.

> *"The whole course was quite useful, particularly the role play. It helps you think about how you interact with families. Very good course."*
>
> *"Very enjoyable and fruitful day. New skills, more confidence in interacting with family. Well delivered, more confident in working with the family."*

Many participants also enjoyed the opportunity to learn about new concepts (e.g. use of genograms, a nuanced understanding of expressed emotion and tools for understanding interactional cycles) and developing some new skills in positive reframing.

> *"Group discussions, listening to different perspectives learning new skills I could incorporate different styles or interaction with client."*
>
> *"Very useful to have knowledge about how to hold an open dialogue meeting and role playing, along with interactional cycles."*
>
> *"Attending this training has given me insight as it's how my approach and communicating with client is very useful, I will surely practice this."*

Of the 61 people who responded to the open-text element 23 responded to the second free-text question ("Please tell us something from the day that you did not find useful, or we could do differently". Six people (9.7% of the total sample) reported that too much was covered for a one day workshop, recommending spreading the workshop to allow for assimilation and discussion. Two participants noted that some material was not directly relevant to crisis HTT work such as using genograms, or questioned the emphasis on listening to families rather than being action-oriented:

"Genograms - the concept is extremely useful but too much focus isn't as it is not something we would get time to prioritise."

"There was limitations to family meetings that were not realistic."

Table 5. Workshop impact and experience (adapted from Grohmann & Kauffeld, 2013).

Item	Mean score (range 1-5)
I will be able to remember this training[1]	4.5
I enjoyed the training very much[1]	4.7
The training will help me in my work[1]	4.7
Participation in this kind of training is very useful for my job[1]	4.7
After the training I know substantially more about working with families than before[2]	4.4
I learned a lot of new things in the training[2]	4.4
In my everyday work I will often use the knowledge I gained in the training[3]	4.4
I feel able to apply the training contents to my routine practice with families[3]	4.4
The training will help me to feel more content with my work[4]	4.2
My job performance should improve through application of this training[4]	4.3
Overall, the application of the training content will facilitate the work in my team with families[4]	4.3
Overall, the team attitude towards families and carers should improve due to the training[4]	4.6

[1] *Kirkpatrick's level 1 - Reaction*

[2] *Kirkpatrick's level 2 - Learning*

[3] *Kirkpatrick's level 3 - Behaviour*

[4] *Kirkpatrick's level 4 - Results*

Discussion

Including the initial pilot workshop, 97 practitioners (78% of the whole group) attended the workshop over a period of seven months and 10 one-day workshops. All teams released practitioners from different professional groups, suggesting that this is a feasible means of providing a routine workshop to HTTs. The only professional group not represented here was psychiatrists indicating that an alternative means of recruiting their participation might be required.

With regard to the benefits of this workshop, beforehand participants reported favourable attitudes towards the involvement of families in HTT work, so there was limited scope for change in this respect. Nine of the 12 items in Section 1 obtained a mean score of 4 or higher before the workshop, reflecting agreement with family involvement. This is

consistent with a previous study in the same Trust which also noted the difficulties measuring change in attitudes towards families (Kowalski et al., 2017). The two items which did show significant change related to sharing information and talking to families in the absence of the service user's consent. The difficulties experienced by mental health practitioners in managing the boundaries of confidentiality with families are well documented as a barrier to social systems oriented care (Morant et al. 2017; Holttum, 2018) so a significant change on these two items was considered a good outcome from this workshop. The workshop aimed to help practitioners to feel confident listening to carers' concerns and offering support, which could involve sharing general information (about the service for example) without breaking confidentiality. Although this can feel like an ethical challenge, a little change may make a big difference for families.

Further workshop benefits were suggested by the significant increase in self-rated knowledge and confidence on all items. These results reflect the second level of Kirkpatrick's model, suggesting that learning did take place, although this could have been assessed more reliably with the use of an objective test of factual knowledge. The significant increase in rated confidence on almost all items may indicate that people considered that they would be able to use this learning and that the practice-based elements of the workshop had enabled them to try things out in a helpful way. Having an opportunity to practise new skills with colleagues, away from the pressure of the usual work environment, may be more likely to influence practice than purely theoretical learning (Kowalski et al., 2017). This was encouraging with regard to intended benefits and learning, but in the absence of a follow-up no conclusions can be drawn about whether this led to more attuned and confident actions with families back in the workplace.

Of the 83 people who completed both a pre- and post- workshop questionnaire only five (6%) returned the follow-up questionnaire three months later. This stage was excluded from the analysis due to this poor return rate, so the extent to which learning translated into behaviour change (Kirkpatrick's third level) could not be determined.

Discussions with participants over the course of these workshops confirmed that practitioners were routinely in contact with families and carers whilst on home visits; often

encountering highly charged and demanding situations and at times feeling ill-equipped to respond. Training HTT practitioners in basic skills for family work should be given high priority, given that a social systems perspective is recognised to be so important to a successful home treatment approach to managing mental health crises (Morant et al., 2017).

The shared planning for these workshops was key to ensuring that the content would address the skills gap experienced by team members. The emphasis throughout the day's workshop was placed on empathic understanding of the experience of stressed relatives, along with the skills required to be attuned to families' concerns at times of high distress. The exercises built into the day (e.g. role play) were intended to increase peoples' confidence in making sense of difficult situations and responding helpfully. Participants rated both knowledge and confidence to be higher in these areas after the workshop.

With regard to acceptability of the workshop, in the final section of the questionnaire, participants indicated a high level of enjoyment of the workshop, as well as endorsing statements to reflect its general utility. This met Kirkpatrick's first level criterion of 'reaction' and suggested that the necessary foundations were in place for learning to happen (Kirkpatrick, 1996). Items addressing the translation of learning into practice were also rated positively, suggesting that people had found the workshop relevant and accessible. Arguably this section would have had the most value at follow up as participants would have had the opportunity to indicate whether they thought actual changes in practice had occurred since the workshop, allowing some attempt to judge Kirkpatrick's third element of 'behaviour' following workshop (Kirkpatrick, 1996). The absence of meaningful follow up is a concern because the difficulties implementing changes in practice following workshop are well documented (Smidt et al., 2009) particularly with regard to working with families (Fadden, 2006; Bucci et al., 2016).

Facilitators' reflections on the workshop

The final item of section 3 of the questionnaire, relating to less helpful aspects of the workshop elicited comments from three people about the constraints on HTT visits to put some of these skills into practice. Lively discussions were had on this subject during the

course of the workshop. People generally agreed that it would be beneficial to spend longer on visits in order to listen to the concerns of family members but felt that their ability to do this was compromised by high caseloads and pressing agendas relating to such things as risk assessment and medication management. This is consistent with Morant et al. (2017) who found that such pressures constituted threats to the original HTT model and its social systems perspective.

The role play exercise was informed by the principles of dialogic practice (Olson et al., 2014) with the intention of encouraging participants to practise a different way of being with a family, that was focused on listening and following, rather than being focused on their own agenda or practical solutions. Although this was not reflected in the written feedback, participants commented on how challenging it was for them to put their agendas to one side to focus on the family's expressions of distress. This may reflect an attempt to find ways of coping with their own anxiety in the face of frequent high distress that they feel powerless to resolve. Being overly structured or action oriented can become a defence against anxiety (Hyde & Thomas, 2002) particularly when there is insufficient time to reflect on difficult situations as a team. The Open Dialogue approach offers an alternative model for crisis intervention that is wholly led by the service user and the network around them rather than any service driven agenda (Olson et al., 2014) but this involves whole service change rather than changes made at the level of individual practitioners.

Strengths and limitations to the study

A strength of this study was the large sample contributing feedback on the workshop, with a good response rate on the day, which perhaps also reflected the high level of engagement people had with the workshop overall.

The study took a pragmatic approach as it was built into the routine work of a service. Consequently there are limits to the conclusions that can be drawn, for example the measures used were non-standardized but adapted from relevant examples found in the literature, therefore no conclusions can be made about validity or reliability of different sections of the questionnaire. There is a possible risk that social desirability affected answers on some scores, with questions relating to attitudes perhaps being the most

vulnerable to this kind of bias. The attempt to follow up after three months was unsuccessful with only five people returning the follow up questionnaire. This would have enabled more commentary on retention of learning over time and any behaviour change.

Although a carer was involved in the planning and delivery of this workshop, the extent of this involvement was limited and could usefully have been extended. Services should aspire to move beyond an involvement role for carers and towards co-production, where boundaries between professionals and those with expertise born of lived experience are blurred in favour of a more equitable, shared approach to training and service development (Martin et al., 2017). This workshop might have looked quite different had it been directed from the outset by those with experience of using the HTTs; both service users and carers.

Clinical and research implications

Workshops of this kind can help address the risk of losing sight of a social systems orientation in routine HTT practice (Morant et al., 2017). Skills-based training offers one element of the necessary conditions for family-focused practice but must be supplemented by organisational support for this way of working, in order to sustain changes in practice (Fadden, 2006). When practitioners feel confident to talk with families at times of crisis, this has the potential to mediate the crisis more effectively by enabling the family to continue caring (Brennan et al. 2016), potentially reducing the need for admissions (Norman et al., 2005). It could also improve the chances of protecting the relationship between service user and family as well as service providers and family, both of which can be threatened by poorly handled crises (Brennan et al., 2016). A review by Martin et al. (2017) highlights issues which contribute to the exclusion of families and social networks, noting that significant culture change is required to address outdated views which locate service users' difficulties in family members. Further research is needed to better understand the current experiences and attitudes of mental health professionals in this regard.

There is evidence in the literature to suggest that implementation of formal family approaches can be hard to sustain following training (e.g. Fadden, 2006). Less is known about the impact of shorter workshops such as this on family-inclusive approaches, though Stanbridge et al. (2009) reported some increase in family involvement following their 3-day

workshop for inpatient staff. Further research could usefully explore how training can support a sustained change in HTT experience for families, particularly after a short workshop such as this one. Objective assessment of observed behaviour change would be particularly useful to include, for example, the frequency with which genograms are used in HTT case discussions.

Conclusions

Although the evaluation methodology had some limitations, overall the consistency of the responses obtained from participants suggested that this workshop offered a helpful introduction to approaches for working with families at times of a mental health crisis. Feasibility was demonstrated through reliable and widespread attendance, whilst high acceptability and possible benefits were reflected in the positive scores and comments from participants, particularly with regard to the skills practice elements of the workshop. The Kirkpatrick model (1996) provided a broad framework to evaluate the workshop. The first two levels of 'reaction' and 'learning' were considered to be met, whilst those pertaining to 'behaviour' and 'results' could not be demonstrated in this methodology.

The HTTs welcomed the initiative and reported more confidence in having some tools for understanding and interacting with families in more helpful ways. Given that this workshop is currently planned to continue on a rolling basis it would be prudent to develop more robust ways of supporting and measuring changes in practice that will demonstrate the application of learning in routine practice. In this way, the actual – as opposed to reported - benefits of the workshop should become clearer.

References

Bergström, T., Seikkula, J., Alakare, B., Mäki, P., Köngäs-Saviarob, P., Taskilab, J., Tolvanene, A. and Aaltonen, J. (2018). The family-oriented open dialogue approach in the treatment of first-episode psychosis: Nineteen–year outcomes. *Psychiatry Research*, 207, 168 – 175. doi.org/10.1016/j.psychres.2018.09.039

Brennan, A., Warren, N., Peterson, V., Hollander, Y., Boscarato, K. and Lee, S. (2016) 'Collaboration in crisis: Carer perspectives on police and mental health professional's responses to mental health crises', *International Journal of Mental Health Nursing,* 25(5), pp. 452-461. doi: 10.1111/inm.12233.

Bucci, S., Berry, K., Barrowclough, C. and Haddock, G. (2016) 'Family Interventions in Psychosis: A Review of the Evidence and Barriers to Implementation', *Australian Psychologist,* 51(1), pp. 62-68. doi: 10.1111/ap.12172.

Buley, N., Copland, E. and Hodge, S. (2017). '*Home Treatment Accreditation Scheme (HTAS): Standards for Home Treatment Teams*.' Third Edition. Royal College of Psychiatrists.

Burbach, F.R. (2018) 'Family therapy and schizophrenia: a brief theoretical overview and a framework for clinical practice', *BJPsych Advances,* 24(4), pp. 225-234. doi: 10.1192/bja.2017.32.

Carpenter, R.A., Falkenburg, J., White, T.P. and Tracy, D.K. (2013) 'Crisis teams: systematic review of their effectiveness in practice', *The Psychiatrist,* 37(7), pp. 232-237. doi: 10.1192/pb.bp.112.039933.

Care Quality Commission (2015). Right here, right now. Retrieved from: https://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf (accessed on 24th June 2019).

Dallos & Draper (2000). '*An Introduction to Family Therapy: Systemic theory and Practice*.' Third Edition. Open University Press: New York.

Department of Health (2001). 'Crisis Resolution/Home Treatment Teams.' The mental health policy implementation guide.

Fadden, G. (2006) 'Training and disseminating family interventions for schizophrenia: developing family intervention skills with multi-disciplinary groups', *Journal of Family Therapy,* 28(1), pp. 23-38. doi: 10.1111/j.1467-6427.2006.00335.x.

Fadden, G. (2018). Are we there yet? Commentary on Family Therapy and Schizophrenia. *British Journal of Psychiatric Advances*. 24, 235–236 doi: 10.1192/bja.2018.11

Falloon I, Mueser K, Gingerich S, et al. (2004) '*Family Work Manual*.' The West Midlands Family Programme.

Goldenberg, H. and Goldenberg, I. (2012) '*Family therapy: An overview*.' Cengage Learning.

Grohmann, A. and Kauffeld, S. (2013) 'Evaluating training programs: development and correlates of the Questionnaire for Professional Training Evaluation', *International Journal of Training and Development,* 17(2), pp. 135-155. doi: 10.1111/ijtd.12005.

Holttum, S. (2018) 'Inclusion of family and parenthood in mental health recovery', *Mental Health and Social Inclusion,* 22(3), pp. 114-120. doi: 10.1108/MHSI-04-2018-0014.

Hyde, P. and Thomas, A.B. (2002) 'Organisational defences revisited: systems and contexts', *Journal of Managerial Psychology,* 17(5), pp. 408-421. doi: 10.1108/02683940210432646.

IBM SPSS Statistics for Windows, Version 21.0. (2013) IBM Corp. Armonk, NY: IBM Corp.

Kirkpatrick, D. (1996) ‘Great ideas revisited. Techniques for evaluating training programs. Revisiting Kirkpatrick’s four level model’ *Training and Development*, 50, pp. 54–59. Doi: EJ515660.

Kowalski, C., Attoe, C., Ekdawi, I. Parry, C., Phillips, S. & Cross, S. (2017) ‘Interprofessional simulation training to promote working with families and networks in mental health services.’ *Academic Psychiatry, 2(5), pp. 605-612.* DOI: 10.1007/s40596-017-0840-z

Lloyd-Evans, B., Fullarton, K., Lamb, D., Johnston, E., Onyett, S., Osborn, D. … Johnson, S. (2016) 'The CORE Service Improvement Programme for mental health crisis resolution teams: study protocol for a cluster-randomised controlled trial', *Trials*, 17, pp.158. doi: 10.1186/s13063-016-1283-7.

Martin, R.M., Ridley, S.C. and Gillieatt, S.J. (2017) ‘*Family inclusion in mental health services: Reality or rhetoric?*’ London, England: SAGE Publications.

McGoldrick, M., Gerson, R., & Shellenberger, S. (1999). ‘*Genograms: Assessment and intervention’*. New York: W. W. Norton & Company.

Mind. (2011) ‘Listening to experience: an independent report into acute and crisis mental healthcare.’ London: Mind.

Morant, N., Lloyd-Evans, B., Lamb, D., Fullarton, K., Brown, E., Paterson, B., Istead, H., Kelly, K., Hindle, D., Fahmy, S., Henderson, C., Mason, O. and Johnson, S. (2017) 'Crisis resolution and home treatment: stakeholders’ views on critical ingredients and implementation in England', *BMC psychiatry,* 17(1), pp. 254-13. doi: 10.1186/s12888-017-1421-0.

Norman, R.M.G., Malla, A.K., Manchanda, R., Harricharan, R., Takhar, J. and Northcott, S. (2005) 'Social support and three-year symptom and admission outcomes for first episode psychosis', *Schizophrenia Research,* 80(2-3), pp. 227-234. doi: 10.1016/j.schres.2005.05.006.

Olson, M., Seikkula, J. & Ziedonis, D. (2014) '*Key Elements of Fidelity to Dialogic Practice in Open Dialogue: Fidelity Criteria*.' The University of Massachusetts Medical School. Worcester, MA.

Seikkula, J. (2011) 'Becoming Dialogical: Psychotherapy or a Way of Life?' *Australian and New Zealand Journal of Family Therapy,* 32(3), pp. 179-193. doi: 10.1375/anft.32.3.179.

Sin, J., Livingstone, S., Griffiths, M. and Gamble, C. (2014) 'Family intervention for psychosis: Impact of training on clinicians' attitudes, knowledge and behaviour', *Psychosis,* 6(2), pp. 128-142. doi: 10.1080/17522439.2013.806569.

Smidt, A., Balandin, S., Sigafoos, J. and Reed, V.A. (2009) 'The Kirkpatrick model: A useful tool for evaluating training outcomes', *Journal of Intellectual and Developmental Disability,* 34(3), pp. 266-274. doi: 10.1080/13668250903093125.

Stanbridge, R.I., Burbach, F.R. and Leftwich, S.H. (2009) 'Establishing family inclusive acute inpatient mental health services: a staff training programme in Somerset', *Journal of Family Therapy,* 31(3), pp. 233-249. doi: 10.1111/j.1467-6427.2009.00467.x.

The Care Act 2014. [online] Available at: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted (accessed 26th June 2019).

Worthington, A., Rooney, P., Hannan, R. (2013) '*The Triangle of Care. Carers Included: A Guide to Best Practice in Acute Mental Health Care in England (2nd Ed).*' Carers Trust, London.