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1 **Title: Improving Family Engagement in an Adult Inpatient Mental Health**
2 **Service using an Action Research Framework**

3
4 **Running head: Family engagement in adult inpatient mental health services**

5
6
7 **Abstract**

8 Family involvement in mental health treatment has been shown to improve outcomes
9 for service users. This project used a whole system focused action research
10 framework and involved service users, family members and healthcare professionals
11 to develop ways to improve family engagement in an adult inpatient mental health
12 service. Focus groups were conducted with two service users, two family members
13 and four healthcare professionals to discuss their experiences of family involvement
14 and develop initial ideas. A problem-solving group involving service users, family
15 members and professionals was used to develop the solutions. The project identified
16 context-specific solutions to improve family engagement which included specific
17 training for professionals working on the inpatient wards, questionnaires to facilitate
18 conversations with families and sharing information about mental health and the
19 inpatient mental health service with families; these may be helpful for other adult
20 inpatient services.

22 **Practitioner Points and Learning Outcomes of the Study**

- 23 • The capacity to work systemically in adult inpatient mental health services may
24 support families, service users and staff to effectively work together.
- 25 • Identifying barriers to families, service users and staff working together can provide
26 helpful insights. Members of the system may be a useful resource for identifying
27 ways to overcome these barriers.
- 28 • Changes such as providing training on systemic skills for non-systemic healthcare
29 professionals and tools, such as questionnaires, to help structure conversations with
30 families may be helpful for other adult inpatient mental health services.

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The Service Context

The project was commissioned by the psychology department within an adult inpatient mental health service in the South of England. The inpatient service consisted of psychiatric intensive care units, acute psychiatric wards and rehabilitation wards for patients aged 18+. The service also included additional wards specifically for older adults over 65. Most service users accessing the service had been sectioned under the Mental Health Act; due to limited bed capacity, few service users were voluntary. Two psychologists within the service were initially consulted to identify the service needs. The psychologists shared the service aims of continuing to improve the involvement of families and carers in care planning, sharing perspectives and decision making in ward rounds, discharge planning, family therapy, and sharing of information to increase consistency and improve the experience of carer involvement. Consultation continued to be woven throughout the project as service users, family members and healthcare professionals, who had been involved in the service, identified the service needs and ways to meet those.

The Authors' Context

I was working in the service as a trainee clinical psychologist when the project was initially conceived and was no longer in the service during the data collection and analysis. I also had previous experience working in the service several years prior. This meant I had a unique position of experience working in the service during the planning of the project, and therefore being part of the system, as well as being somewhat exterior to the system during the delivery of the project. I was completing the AFT intermediate systemic and family therapy qualification while working on the project. Two of the remaining authors worked in the service as psychologists. They were able to support thinking about the service context in the analysis and findings of the project. The final author was a psychologist and course tutor, who was additionally a qualified family therapist, with experience working in an adult inpatient mental health service but had not worked within the service where the research

61 was carried out. The final author helped to broaden the lens in relation to the reflective,
62 planning and action elements of the project in addition to supporting systemic thinking within
63 the project.

64

65

Introduction

66 A 'carer' is a family member or friend who provides unpaid support to someone with
67 a health condition. For family members who take a carer role, they are impacted by the
68 stress of caring for an adult with a mental health difficulty as well as the impact of having a
69 family member with a mental health difficulty. In addition, being a carer can impact on the
70 family relationship. The majority of research has focused specifically on the experiences of
71 family members who are carers. This article will focus on family members as these were the
72 carers involved in this project. Family members are becoming recognised as integral in care
73 for adults with mental health difficulties. Research has shown family involvement in inpatient
74 mental health care can improve relapse prevention and reduce the length of hospital stays
75 (Pharoah et al., 2010; Pilling et al., 2002). The Triangle of Care is an approach developed by
76 Carers Trust in the UK, which involves service users, families, and healthcare professionals
77 working in partnership to promote wellbeing in mental health services (Worthington et al.,
78 2013). The Triangle of Care guidance is best practice and identifies six key standards
79 required for collaboration which include early identification of family members, training for
80 staff, policy and protocols on confidentiality and information sharing, carers lead job roles,
81 information for families about the service and a range of family support services to be
82 available. Whether and how to implement this guidance is the decision of individual services.
83 The Triangle of Care recognises that service users, families and professionals form a
84 system, and when that system is interacting well, it can result in improved outcomes. This
85 links with systems theory, where problems can be understood in the context of different
86 parts of the system and how they interact (Bateson, 1972). This article is written from a
87 systemic lens; within inpatient services, the service users, professionals and family members

88 form a system, and each element of the system can affect the others through the process of
89 circularity (Watzlawick, Weakland, & Fisch, 1974). When the system is interacting and
90 communicating well, it can result in better outcomes, as highlighted by the Triangle of Care.
91 The project uses a whole system action research framework as it aims to use action
92 research, an approach aimed at producing change in a service through participation, with a
93 focus on improving how the system of adult service users, family members and
94 professionals interact and work together.

95

96 Despite recognition of the importance of involving families in mental health services,
97 families' experience of adult inpatient services has been largely negative. Some families
98 report not being involved in their loved ones' care and how this led to vital information not
99 being shared (Forde et al., 2016). Others described feeling distant from their loved ones
100 during their hospital admission and powerless in their care (Ewertzon et al., 2010; Wilkinson
101 & McAndrew, 2008). Wynaden and Orb (2005) found that when family members were
102 excluded due to confidentiality, it impacted their ability to be effective as carers along with
103 their own wellbeing. Within inpatient mental health service contexts, there are clear power
104 inequalities, characterised by restrictions and restraints. Given the challenges families face
105 and the potential benefits of involving them, it is important they are involved in the
106 development of services.

107 There are challenges and barriers to working with families in adult inpatient mental
108 health settings. Eassom et al. (2014) conducted a systematic literature review on the
109 facilitating and hindering factors for implementing family involvement. Although the review
110 focuses on individuals with psychosis, many factors are relevant to family involvement in
111 inpatient mental health services (Rose et al., 2004). In terms of context, the paper highlights
112 practical challenges such as time and structure, lack of skills working with families, and the
113 impact of the system culture and attitudes. When engaging families, they identify that
114 professionals may have reservations about involving families, and there can be difficulties in

115 engaging families. In relation to delivering family interventions, challenges in working with
116 complex needs and maintaining a good working relationship were identified. In addition to
117 the challenges above, Rose et al. (2004) reported that families experienced a lack of effort
118 from healthcare professionals in involving them. The stigma around mental health was
119 another barrier to families engaging. For service users, the main barrier was families' lack of
120 understanding of mental health difficulties and the complexity of family dynamics. This
121 research demonstrates that the system of family members, service users and professionals
122 is complex and challenging. In addition, Stanbridge, Burbach & Leftwich (2009) reported that
123 staff, working in inpatient mental health services, are not typically trained to work with
124 families. There are differences in perspective from different parts of the system as to what
125 the challenges and barriers are. Therefore, in order to develop the most effective solutions to
126 these difficulties, it is important for the different elements of the system to come together and
127 understand one another's perspectives; it also ensures that issues of power and position are
128 considered, when research endeavours to include multiple voices in it (Hoffman, 1993;
129 Watzlawick, Weakland, & Fisch, 1974).

130 As highlighted by Giacco et al. (2017), the majority of research exploring how to
131 improve family involvement in adult mental health services is based on clinician opinions and
132 clinician-led models of family involvement (Eassom et al., 2014; Hsiao & Tsai, 2015;
133 Mottaghypour & Bickerton, 2005; Nurjannah et al., 2014). Giacco et al. (2017) involved
134 service users, family members and healthcare professionals to identify the important
135 components for family involvement in inpatient mental health services. There was a
136 consensus that families should receive information about mental health difficulties and
137 treatment, and families should be involved in care planning and discharge. Participants
138 thought clinicians should adopt a supportive and reassuring approach to families.
139 Furthermore, the family's personal knowledge of the individual should be valued.
140 Kaselionyte et al. (2019) used the findings to develop a one-session carer involvement
141 intervention for adult inpatient mental health settings which improved communication

142 between service users, families, and professionals and provided a steppingstone for carer
143 involvement. Although the intervention was guided by what service users, families and
144 professionals considered important, the specifics of the intervention were developed by
145 professionals. The challenges of involving families in inpatient mental health care can
146 provide insights into what needs to change to support it; therefore, the current study
147 encouraged participants to reflect on the challenges they experienced.

148

149 ***Study Aims***

150 The current project aimed to build on the research by Eassom et al. (2014) and
151 Giacco et al. (2017) to collaboratively explore and develop ways to improve family
152 engagement in an adult inpatient mental health service by involving the system of service
153 users, family members and healthcare professionals. Previous research on family
154 involvement tends to be clinician-led or provides broad recommendations. Although carers
155 include anyone providing unpaid support to someone with a health condition, this project
156 focused on family members as it was easier to define and identify potential participants.

157 This project used an action research framework which involves creating change in a
158 specific context to solve real problems through planning and implementation of ideas and it
159 seeks to include multiple perspectives from various stakeholders (McNiff, 2016). The
160 Triangle of Care framework was used to guide the conceptualisation and development of the
161 study, where the system of service users, family members and professionals worked
162 together. Therefore, the study aimed to develop and implement ideas collaboratively
163 generated by service users, family members and professionals on how to improve family
164 engagement in the context of this South-of-England adult inpatient mental health service. In
165 line with the systemic practice, the study involved understanding the perspectives and
166 beliefs of the different parts of the system and bringing those perspectives together to work
167 together to generate the most helpful solutions within this service context (Hoffman, 1993;
168 Watzlawick, Weakland, & Fisch, 1974).

169 The project aimed to address the following questions:

- 170 • What are the system process issues around family engagement identified by service
171 users, family members and healthcare professionals?
- 172 • What ideas do service users, family members and professionals have on how to
173 improve family engagement in the context?

174

175 **Method**

176 **Study Design**

177 Using an action research framework, the ideas of service users, family members and
178 healthcare professionals were incorporated into the development of family engagement
179 within the service. Action research is a qualitative approach and is commonly used to
180 improve practices in healthcare settings by conducting systematic enquiries (Koshy et al.,
181 2011). The focus is on bringing a change in practice rather than producing knowledge
182 (Hammersley, 2004). Action research lends itself well to service improvement projects due
183 to its focus on participation and problem-solving where those within the system participate
184 and collaborate to bring about change; furthermore, change is one of its' immediate goals
185 (O'Leary, 2004; Waterman et al., 2001). Action research involves a cyclical process of
186 problem identification, reflection, planning, action and evaluation (Waterman et al., 2001).
187 Evaluation can lead to identification of further problems which the same process can be
188 applied to. Action research aligns with systemic thinking due to its focus being context-
189 specific (Ison, 2008). In addition, both systemic practice and action research involve an
190 iterative approach. In systemic practice, hypotheses are generated and explored and refined
191 over time, as well as having an element of self-reflexivity (Anderson & Goolishian, 1992;
192 Palazzoli, Boscolo, Cecchin, & Prata, 1980). In action research, there are cyclical processes
193 where change is developed, implemented, and refined.

194

195 **Participants**

196 As the Triangle of Care highlights the importance of service users, healthcare
197 professionals and families working together, the project recruited service users, family
198 members and healthcare professionals who have been involved with the service. Our
199 intention was to recruit four service users, four family members and four healthcare
200 professionals through voluntary sampling. Family members were recruited through the
201 services' carers forum, community mental health services and current service users on the
202 wards by asking teams to identify potential carers. Service users were recruited through the
203 service user forum and community mental health teams. The professionals were recruited
204 through ward managers and via email. Inclusion criterion for service users and family
205 members was recent experience of the service within the last three years. For professionals,
206 the inclusion criterion was to be currently working in the service for at least six months. Due
207 to challenges in recruitment, the service user and family member focus groups each had two
208 participants, and four healthcare professionals attended the healthcare professionals' group.
209 All participants were invited to the problem-solving group. Of those, two service users, two
210 family members and two healthcare professionals attended. I was a practitioner-based
211 researcher as I was conducting research in the context of where I was working so therefore,
212 part of the action research group.

213

214 **Data Collection**

215 All service users and family members participating were screened by phone to clarify
216 their understanding of the project and assess their ability to participate. Three focus groups
217 were conducted; one for service users, one for family members and one for healthcare
218 professionals (see supplementary material for semi-structured focus group questions). Each
219 of these groups consisted of a reflection phase and a planning phase. This formed the initial
220 stages of planning within the action reflection cycle (O'Leary, 2004). The participant groups

221 were separate for this phase of the research project to minimise the impact of sharing their
222 perspectives with other groups.

223

224 In the first half, participants were asked about their experiences of family
225 engagement in adult inpatient mental health services, both positive and negative. The
226 exploration of positive experiences aimed to help participants identify what works well and
227 the negative experiences helped to identify problems and critically reflect on the difficulties
228 with family engagement. The process of problem identification and critical reflection is part of
229 the action research cyclical process, which helps facilitate planning to achieve solutions
230 (O’Leary, 2004). In the second half, participants were asked to consider ways to improve
231 family engagement, and specifically in the context of withdrawn consent to share information
232 by service users as this is a very common barrier to family and carer engagement within the
233 service. Service users have a right to privacy and can choose to not have information shared
234 with family and friends. However, this can create a dilemma as by respecting service user
235 confidentiality it can mean that families and carers can feel alienated and deprived of
236 important information and effective engagement with the service. Following the generation of
237 ideas, participants prioritised up to four ideas from their group. Using a scoring system of
238 four points for the highest-rated idea, three for the second, two for the third and one for the
239 fourth, the highest-rated idea within each group was identified. Throughout the process,
240 myself and the co-researchers held a curious stance and worked collaboratively with the
241 stakeholders in line with the philosophy of action research, while also being aware that we
242 held some level of expertise (O’Leary, 2004), similar to that of Barry Mason’s authoritative
243 doubt (Mason, 2019)

244 The highest-rated idea from each focus group was taken forward to the problem-
245 solving group to consider the best ways to implement each of the ideas. The researchers
246 had intended to use a problem-solving framework which involved defining the problem,
247 identifying as many solutions as possible then assessing each using pros and cons to

248 identify the best solutions. However, the overlapping nature of the topics made it difficult for
249 facilitators to keep each separate. Therefore, a more general discussion approach was used
250 in the problem-solving group with a discussion of pros and cons from the perspective of all
251 three groups. The problem-solving group provided the opportunity for different elements of
252 the system to understand one another's perspectives and beliefs in relation to what would be
253 effective solutions. The problem-solving group formed the remainder of the planning phase,
254 which was participatory and collaborative in line with action research (Kagan et al., 2008).
255 The final stage of the research involved making recommendations to the service and
256 implementing some of the changes.

257 All groups were audio-recorded except for the healthcare professionals' group due to
258 technical difficulties. Handwritten notes were made during this group.

259

260 **Data Analysis**

261 Content analysis was used as a tool utilised in action research, to gather relevant
262 data from transcripts and notes (McNiff, 2016). The content analysis aimed to illuminate core
263 content themes related to system process issues that hindered family engagement, to add to
264 the knowledge base. I analysed the four transcripts to identify codes by analysing the
265 manifest content of the data. I immersed myself in the data by transcribing the focus groups
266 and re-reading transcripts (Lyons & Coyle, 2016). The data was initially annotated then
267 coded using NVivo (version 12), a qualitative analysis software. Due to the small sample
268 size, quantities of codes were not used to inform the results in detail (Marks & Yardley,
269 2004). I had a unique perspective as they had knowledge of the service but did not work
270 within it at the time of conducting the study. This helped me to hold the service context in
271 mind with a detached, wider perspective. A constructivist approach was adopted as
272 knowledge was created through collaboration with the participants. An inductive approach
273 was used to allow for the identification of novel content themes which had not been identified
274 by previous research. As the first research question involved identifying system process

275 issues, the analysis was conducted with a systemically informed lens with a focus on the
276 barriers and issues within the system which may result in difficulties in families, service
277 users and professionals working together.

278 A process not dissimilar to content analysis occurred within the groups in relation to
279 identifying priorities and solutions. The group co-facilitator wrote down the ideas and
280 solutions as they arose then participants decided which were the most important; therefore,
281 further analysis of the data was not required. The process and its findings are summarised in
282 the results sections because the outcome of action research is the identification and
283 implementation of solutions (O’Leary, 2004).

284

285 **Ethical Considerations**

286 Ethical approval was sought and granted from the University’s Health and Social
287 Care Ethics Committee, the NHS Agency’s line manager, the Department of Research and
288 Development at the NHS Hospital and Foundation Trust, where the study was conducted.
289 The ethical considerations included participants’ comfort to share experiences, participant
290 wellbeing and managing potential distress.

291

292 **Findings**

293 **Demographic information**

294 The demographic information for participants demonstrates the diversity of the
295 sample, see Table 1. Both family members were mothers. All the service users and service
296 users of family members had accessed the working age adult wards. All professionals
297 worked on working age adult wards, except one who worked on an older adult ward.

298

299 [Insert Table 1]

300

301 **Reflection Phase**

302 During the reflective section, participants discussed the challenges they had
303 experienced regarding family engagement. Seven key themes about system process issues
304 arose through the content analysis; see Table 2 for summary of themes and number of times
305 each were mentioned.

306

307 [Insert Table 2]

308

309 1. Communication difficulties between service users, families and professionals.

310 Families found it challenging to share all necessary information with professionals.
311 One family member reported that a combination of a late-night admission, heightened
312 emotions and professionals not asking direct questions impacted on the communication
313 between the family and professionals.

314 Family member 1: *“You can’t remember everything you want to get out. And with [my*
315 *daughter] every admission ends up being two or three in the morning, you’re upset,*
316 *she’s upset but you’ve also got loads of things you want to say but you can’t*
317 *remember it all at that time.”*

318 Sometimes it was difficult for families to feel heard, and it seems this led families to
319 feel frustrated. Similarly, professionals found it difficult to communicate with families,
320 particularly when there were concerns about confidentiality.

321 Professional 1: *“... it’s that sort of fear and lack of confidence that they’re going to*
322 *say either too much or the wrong thing or their consent to share is not to mum or-*
323 *you can see like people freeze on the phone.”*

324 When professionals and families did communicate, this could be challenging for
325 service users if they were not made aware of the extent of the communication. This may be
326 impacted by staff concerns about breaking confidentiality and practicalities of time. One
327 service user said she did not want her family involved as not knowing what had been shared
328 led to difficulties in her relationships with family.

329 Service user 1: *"I wanted to know exactly what everyone was saying to my family at*
330 *all times because, when I didn't know, it like made me so much worse because my*
331 *mum would come in and say oh you didn't tell me that this happened and I'd be on*
332 *the spot thinking oh my goodness, how do I respond to this?"*

333

334 2. Complexities in gaining consent to share information.

335 Communication difficulties were exacerbated by issues surrounding confidentiality,
336 as mentioned above. Most family members and service users acknowledged that service
337 users had reasons for deciding to withdraw consent to share information; however, if
338 professionals were able to explore this with them, it may have led to increased confidence in
339 information sharing.

340 Family member 2: *"I mean he actually told me that the only reason he signed those*
341 *papers was because he's growing up and he's a man now and he didn't want to*
342 *worry me. So that for me was quite disheartening because no one had taken the care*
343 *to have a conversation with him as to why he's signing these papers."*

344 Both family members reported that when their loved one decided not to consent to
345 share information with them, they felt excluded from their care which impacted their
346 emotional wellbeing.

347 Family member 1: *"I find that really upsetting and disheartening. You've gone*
348 *through that journey for weeks, if not months, to get to that point and you're the only*

349 *person around supporting her and suddenly you're excluded from knowing anything.*

350 *And it's hell, absolute hell."*

351

352 3. Challenges of collaborative care planning.

353 Families reported that they found it difficult to be collaboratively involved with care
354 and discharge planning. One family member found it particularly difficult to be included in
355 meetings.

356 One service user said they were not asked if they wanted their families involved so
357 were not given the opportunity to decide whether they wanted it.

358 Service user 1: *"...they [my family] weren't involved in any kind of ward rounds or*
359 *anything. Um I don't actually know why, no one asked them um I don't think anyone*
360 *asked if I wanted them involved in those meetings."*

361 When one of the professionals talked about family engagement, they acknowledged
362 that in busy and quickly changing services families who are not proactively involved or those
363 that present a greater challenge to services can be forgotten.

364

365 4. Impact of family differences and dynamics.

366 Family engagement was more challenging when families had complicated dynamics
367 or different structures. Service users, families and professionals all acknowledged this. One
368 service user acknowledged that the difficult dynamics in her family made it challenging for
369 her family to spend time all together, which at one point resulted in staff on the ward
370 stepping in to separate her family.

371 Service user 2: *"...it wasn't a good relationship between my husband and my family*
372 *so it was really spend time, so the staff it was a very quick reaction to separate and*
373 *just my family leaving hospital because it really wasn't a good time to be together."*

374 Sometimes families may not be able to provide the support. One service user spoke
375 about how her family was not able to offer much support, however, professionals assumed
376 that they could.

377 Service user 1: *"I remember people saying, "you should really talk to your family,*
378 *they'll really be there for you and support you and they're really important to you" and*
379 *it's like well I know that that wouldn't be the case. Like I don't that that they can't,*
380 *rather than that they wouldn't want to.*

381

382 5. Family understanding of mental health difficulties.

383 Some families were thought to lack knowledge about mental health difficulties and
384 how to help which impacted on service users. One service user spoke about how her family
385 appeared insensitive about her mental health difficulties, this meant she no longer wanted
386 them involved.

387 Families and service users identified that it would be helpful to provide more
388 information about mental health and ways to help to families.

389 Service user 1: *"I'm not sure how much was explained to my family um it was kind of*
390 *about the situation, where I was found, um and then um kind of- and therefore that's*
391 *why I was sectioned but there wasn't really any other explanation like um I don't*
392 *know, she's been struggling with this or this would be helpful for you to do or things*
393 *like that..."*

394 When families disagreed about a mental health diagnosis, one professional spoke
395 about finding it challenging to work with them.

396

397 6. Need for emotional support for families.

398 Family members described how visits to the wards could be upsetting and that they
399 had coped with the distress of this on their own afterwards; they saw this as a time when
400 support could be provided by professionals.

401 Family member 2: *“...the amount of carers that I’ve met, including myself, that have
402 sat in the car afterwards...”*

403 Family member 1: *“...and sobbed and sobbed...”*

404 Family member 2: *“and hour, two hours and you’re just sobbing your heart out.”*

405

406 7. Impact of limited service provisions.

407 One family member described how her family felt compelled to provide activities during
408 an admission as they saw a gap in the service.

409 Family member 1: *“Nothing to do all day long, me, her dad and her sister worked all
410 the time and we’d go in, taking her to dancing and take her in activities. Nothing to
411 do, absolutely nothing, no activity co-ordinator, nothing really.”*

412 The same mother discussed the impact of limited funding and resources on what
413 services can offer and how this might impact the length of admissions.

414 These themes within the reflection phase set the context for participants to think
415 about the potential ways to improve family engagement.

416

417 **Planning Phase**

418 The second half of the focus groups initiated the first stages of planning ways to
419 improve family engagement. The ideas generated by the service user group and the scores
420 for each can be seen in Figure 1. The highest-rated idea from the service user group was to
421 have support from professionals during visits with family to act as a mediator and advocate.

422 This was because conversations with family could be tricky and service users struggled to
423 answer all the family's questions.

424

425 [Insert Figure 1]

426

427 The ideas generated by the family members and scores for each are shown in Figure
428 2. The family members group rated staff "investing time with the family to find out about the
429 service user" highest. Family members reported having information about their loved ones
430 but were either too overwhelmed to remember to share it or not asked.

431

432 [Insert Figure 2]

433

434 The ideas generated by the healthcare professionals and their scores are shown in
435 Figure 3. Healthcare professionals prioritised staff training on working with families. This was
436 due to some professionals not feeling confident in working with families.

437

438 [Insert Figure 3]

439

440 Based on the ideas generated from the initial focus groups, solutions related to how
441 to implement the ideas were generated in the problem-solving group. At the end of the
442 problem-solving group, each participant voted for two or three of their most important
443 solutions which they thought should be taken forward to be implemented by the service.
444 Table 3 summarises each of the solutions and the number of votes. The importance of how
445 professionals phrase conversations about consent and information sharing was highlighted
446 in this group. Participants talked about the importance of professionals approaching

447 conversations in a way which demonstrated the importance of family involvement and
448 allowed greater depth of information to be gained. Furthermore, the benefit of having
449 questionnaires to initiate and help structure conversations with families and service users
450 was emphasised.

451

452 [Insert Table 3]

453

454 **Action Phase**

455 Three of the highest-rated solutions, solutions one, two and three, were incorporated
456 into training, which included building systemic informed skills to support working with family
457 members (including carers more broadly), which one of the authors was involved in
458 developing. The systemic skills training included use of an eco-map to create a visual
459 representation of the system, to help healthcare professionals have a conversation with
460 service users about their social network (Hartman,1978). The training involved role-play
461 exercises to practice challenging conversations with families, guidance on how to manage
462 consent to share information and encouraging professionals to explore and understand
463 decisions not to share information with family members. In addition, the training involved
464 guiding professionals to use a questionnaire called "This is the Person I Know" to have
465 conversations with family members about their loved ones. This training is for healthcare
466 professionals working on the adult inpatient mental health wards. The remaining solutions
467 were summarised and shared in a meeting with key stakeholders in the service to consider
468 implementing. There had been some recent changes in the service which aligned with the
469 recommendations from the project. These included developing a process to monitor how
470 often consent to share information is discussed with service users to encourage
471 professionals to revisit. The other change involved developing the Carer Champion role;
472 these were individuals working in the inpatient mental health service with an interest in
473 working with families. The Carers Champions had identified the need for a resource pack to

474 help skill them to work with families (and carers more broadly). The group discussed the
475 idea of training Carers Champions to support their teams in working with families in order to
476 meet some of the recommendations identified by the project, such as offering support with
477 visits between families and service users. A number of ward activity co-ordinator roles were
478 created to help with activity provision, which will hopefully be more fully funded by the extra
479 funding provision for healthcare staff to provide therapeutic activities on wards in the NHS
480 Long Term Plan/Mental Health Implementation plan (NHS, 2019). The group arranged
481 further meetings to take these ideas forward. In addition, the group discussed working with
482 the community mental services on advanced care plans and carers letters were influenced
483 to have more salient information and adapted to the needs of families.

484

485

Discussion

486 This action research study involved the collaboration of service users, family
487 members and professionals, mirroring the Triangle of Care, in identifying and prioritising key
488 solutions to improve family engagement in an adult inpatient mental health service. A
489 training programme delivered to front line staff working in the service incorporated several
490 key solutions; this aimed to develop systemically informed skills. Although the solutions
491 generated are context-specific, they may be applicable to other adult inpatient mental health
492 services.

493 The reflections, although not the main outcome of action research, provide further
494 insights into the system process issues in family engagement. There are similarities between
495 the system process issues identified in this study and those identified in previous research.
496 Challenges with communication, challenges to collaborative care planning, family dynamics,
497 family understanding of mental health difficulties, the impact of confidentiality and need for
498 emotional support for families were identified in both this study and previous research (Forde
499 et al., 2016; Rose et al., 2004; Wynaden & Orb, 2005). The impact of service provision on
500 family engagement appears to be a novel finding, with one family member describing

501 stepping in to provide activities that they believed the inpatient service should offer. The gap
502 in funding provision for therapeutic activities has been recognised as a UK national issue,
503 and additional funding has been allocated as part of the NHS Long Term Plan/Mental Health
504 Implementation Plan to address this (NHS, 2019). Although previous research considered
505 the impact of family dynamics, this research highlights how not all families can provide the
506 support professionals might expect or hope for. Research, policies, and guidance appear to
507 assume that families/carers have the skills and resources to be able to provide support
508 which may not be the case for everyone. It seems that there can be a difference in beliefs
509 and perceptions between services and families and service users in terms of what support
510 families can provide (Palazzoli, Boscolo, Cecchin, & Prata, 1978). The expectations which
511 professionals have, of the care families can provide, may shape their approach to engaging
512 them, which in turn may contribute to some of the difficulties in family engagement. The
513 findings further suggest that professionals' assumptions about family support can prevent
514 exploration of the family circumstances. Within inpatient settings, healthcare professionals,
515 including systemic practitioners, could support staff to think about how their own experience
516 of family, and the messages received through research and guidance, shape their beliefs of
517 the level of involvement family members of service users can provide.

518 Through understanding the different perspectives within the system, the participants
519 primarily focused on solutions to improve communication and interactions between different
520 elements of the system. The solutions mostly focused on improving the communication and
521 interaction between family members and professionals. Based on systems theory, it is
522 expected that intervening at one point in the system can have ripple effects to other parts
523 (Bateson, 1972). When comparing the solutions from this project with the recommendations
524 from the Triangle of Care and other research, several themes were similar (Giacco et al.,
525 2017; Worthington et al., 2013). As recommended by other research, the need to ask for
526 family members views and knowledge, training staff on working with family members
527 (including carers), provide training around information sharing procedures and provide

528 information about the service, mental health conditions and ways to help were highlighted.
529 The overlap increases the credibility of the findings of this study along with providing specific
530 ideas of how to implement these recommendations. The findings from this project suggest
531 that having ways to structure conversations may help support professionals to feel more
532 confident having discussions about or with families. This project additionally highlights that
533 training for staff should include guidance on having phone conversations with family
534 members, how to facilitate difficult conversations with service users and family members and
535 how to manage consent and information sharing issues. Although the solutions were
536 focused on a family perspective, they may also be useful for carers more broadly. As the
537 solutions were generated collaboratively with the participants, I aimed to balance the power
538 differential between themselves and the participants. Having the participants involved in the
539 analysis and dissemination of findings would have further aided the balance of power. The
540 co-researchers and I, therefore, held some of the power and privilege over the interpretation
541 of the analysis which may have led to a bias in the interpretation coming from the
542 perspective of a healthcare professional.

543 Surprisingly, some solutions linked to problems highlighted in the reflection phase
544 received very few votes from participants in the problem-solving group. This may be
545 because alternative solutions, such as staff training, may have met the need in a better or
546 more feasible way. Alternatively, hearing from other groups may have influenced some
547 participants' perspective on what is most important. The need for emotional support for
548 family members was highlighted in the reflection phase but did not appear to be directly
549 related to any solutions. This may be because it was considered less important, which is
550 supported by evidence of it only being mentioned five times. Alternatively, other solutions
551 may have been perceived to have an indirect effect on family's wellbeing.

552

553 Self-Reflexivity

554 I took the lead in analysis and as I was not working in the service at the time, this
555 may have allowed me to have an awareness of the service context, while balancing the
556 views of the three groups of participants. My previous experience of the service may have
557 shaped the way in which I interpreted the findings as my experience was that families may
558 be involved but, due to the busy nature of the service, this was not a priority. I was likely
559 influenced by my own family background, coming from a family with supportive parents, I
560 was drawn to the stories shared by the parents who worked hard to be involved. This may
561 have led to reflections being biased towards the perspective shared by family members.
562 Another author, who supported analysis and worked within the service, helped to balance
563 this bias, particularly by bringing in the healthcare professional perspective, which led to
564 themes being adjusted in both their labels and the interpretations.

565

566 **Limitations**

567 There was an under-representation of family members and service users, which may
568 have impacted the variety of perspectives and ideas generated. Despite this, the
569 experiences described in the reflections were similar to those identified in previous research
570 (Eassom et al., 2014; Rose et al., 2004). As the participants were self-selecting, the sample
571 may be biased towards staff with a particular interest in the area and service users and
572 family members who felt services needed to change. Therefore, the reflections may not be
573 representative of the experiences of all. Similarly, the solutions generated may be suited to
574 participants' experiences and may not fit for everyone. The literature highlights that families'
575 voices can often go unheard (Forde et al., 2016) and while this project intended to voice the
576 experiences and ideas of family members, this group were under-represented. The difficulty
577 of engaging family members in this project mirrored the difficulties in engaging and involving
578 family members and carers more broadly, in adult inpatient services. The groups were held
579 during standard working hours, making it difficult for those in employment to be involved,
580 which may have particularly impacted family members. In addition, the forums and services

581 used to identify family members for the project may struggle to identify family members. The
582 project did not include the experiences and views of carers more broadly; those who are not
583 family members may have different experiences, which may require different solutions which
584 were not captured by this project.

585 Only one male participated in the study, who was a healthcare professional;
586 therefore, males are under-represented in this study, especially among family members and
587 service users. Any specific challenges males may experience have not been captured by
588 this study, and there may be particular solutions required to address this group's needs. The
589 service users and healthcare professionals were of a similar age, as they are at similar
590 stages in their life, their perspectives may be influenced by their experience of being a family
591 member at this stage of the life cycle. Given they were in their 20s and 30s, they may be
592 more likely to consider the position of a sibling rather than a parent. The study only included
593 two non-white participants; therefore, the project recommendations may not be
594 representative for all ethnic groups. This is particularly important given evidence of those
595 from minority ethnic groups having distrust in mental health services (Henderson et al.,
596 2015). Research has demonstrated barriers to recruiting individuals from minority ethnic
597 groups into mental health research; future research on family engagement would benefit
598 from finding ways to overcome these (Brown et al., 2014). In some cultures, stigma around
599 mental health or mental health not being openly discussed in families may influence family
600 engagement in services (Memon et al., 2016). The data on reason for admission, number of
601 admissions and whether service users were sectioned was not collected. This additional
602 information may have helped contextualise the data on experiences and the solutions
603 generated.

604 Another limitation was that the healthcare professionals' group was based on
605 handwritten notes from the meeting. Therefore, some of the detail was not captured.
606 However, no key information was lost as the focus of the research was to identify and
607 implement solutions rather than explore experiences. In terms of methodology, action

608 research may be considered less precise in comparison to other forms of research (Parkin,
609 2009). The findings from action research are potentially less generalisable as the focus is on
610 being context-specific. Despite this, the findings may be applicable for other similar services
611 as mentioned above. Some research suggests that individuals may be less likely to discuss
612 sensitive topics in focus group settings in comparison to individual interviews (Kaplowitz,
613 2000). Therefore, the participants in this study may not have felt comfortable sharing
614 sensitive information. However, Guest et al. (2017) demonstrated that focus groups can
615 result in more sensitive topics being discussed compared with individual interviews.

616 In addition, there was no measurement of quantity or quality of family engagement
617 before and after the project as this was beyond the scope of this project. Therefore, it is not
618 possible to empirically investigate whether the project impacted family engagement. Finally,
619 taking a systemic approach can involve focusing on enablers and disablers in a system and
620 the analysis of this project focused only on disablers. Including what worked well in the
621 service within the analysis may have highlighted additional information. However,
622 participants drew on what works well when generating solutions.

623

624 **Conclusion**

625 This paper highlights the need for systemic thinking and practice in adult inpatient
626 mental health services and family therapists and systemically trained practitioners would be
627 well placed to lead on and provide this. This project involved service users, family members
628 and professionals exploring the challenges and identifying solutions to improve family
629 engagement in adult inpatient mental health services. The findings suggest that family
630 engagement can be difficult because of the approach, skills and resources of professionals,
631 family ability to engage and their knowledge of the mental health and service context. The
632 solutions generated were aimed at ways to improve communication and interactions within
633 the system. A training programme for frontline staff to develop their systemic practice skills

634 was used to implement some solutions, and the remainder of the recommendations
635 generated during the project were shared with stakeholders in the service.

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Tables749 **Table 1.**750 *Demographic Information*

		Service Users	Family Members	Healthcare Professionals
Age (mean, SD)		31.5 (5.5)	51.0 (3.0)	28.5 (4.3)
Age range		26 - 37	48 - 54	23 - 34
Gender	Female (n)	2	2	3
	Male (n)	0	0	1
Ethnicity	White British (n)	1	1	3
	White Polish (n)	1	0	0
	Mixed (n)	0	1	1
Years in job role (mean, SD)		1.75 (0.83)		

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753 **Table 2.**754 *Summary of key content themes.*

Themes on system process issues related to challenges in family engagement	Number of quotes
1. Communication difficulties between service users, families and professionals.	26
2. Complexities in gaining consent to share information.	9

3. Challenges of collaborative care planning.	10
4. Impact of family differences and dynamics.	7
5. Family understanding of mental health difficulties.	10
6. Need for emotional support for families.	5
7. Impact of limited service provisions.	5

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760 **Table 3.**

761 *Solutions generated in the problem-solving group and number of votes.*

Solutions	Number of votes
1. Training for professionals involving specific guidance on how to answer phone calls with family members, how to have difficult conversations with service users and family members and guidance on how to manage consent and information sharing issues.	5
2. Professionals to have conversations with the family about who the service user is using a questionnaire to help facilitate the conversations.	4
3. Professionals to share information with family on mental health, sections, ward information and process of what happens on the ward.	2

<p>4. Professionals to support family visits on the ward by offering to join conversations between service users and their family to help answer questions and offer support to the service user.</p> <p>Professionals to check in with service users and families at the end of a visit to see how it went and check on their wellbeing.</p>	1
<p>5. Develop a peer mentorship scheme to provide service user and carer support in an informal way.</p>	1
<p>6. When there is communication between family members and professionals, share that with the service user. If possible, offer the service user to be present for the conversation or have a conversation with the service user to agree what they are happy to be shared.</p>	0
<p>7. If possible, have advanced care plans completed in the community to provide information on the service user.</p>	2

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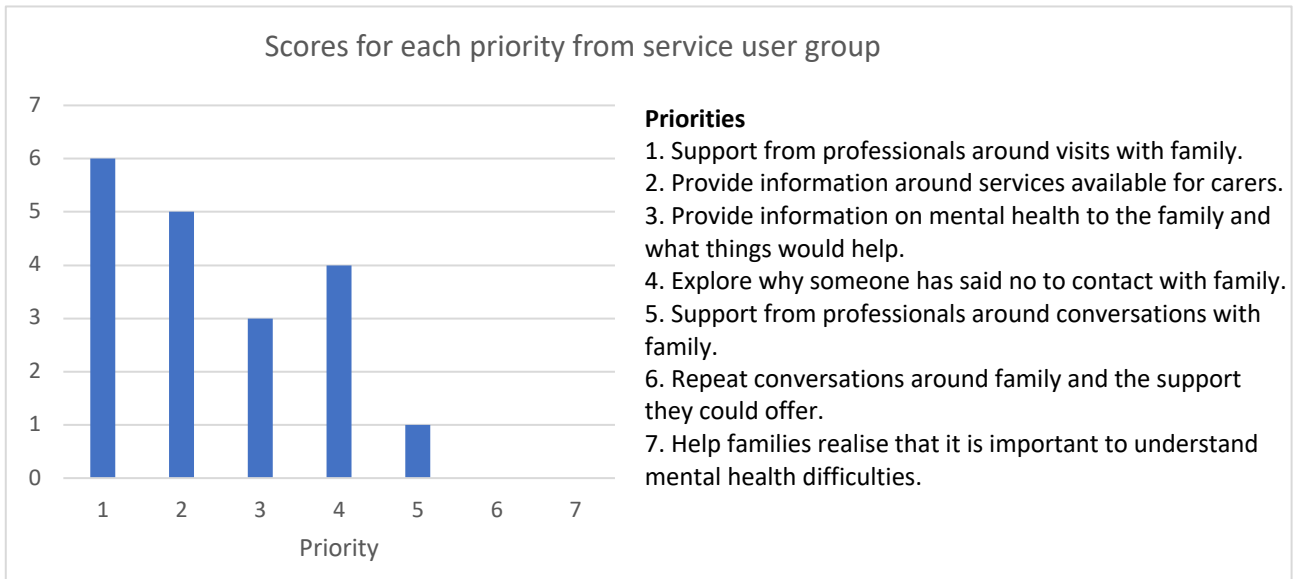
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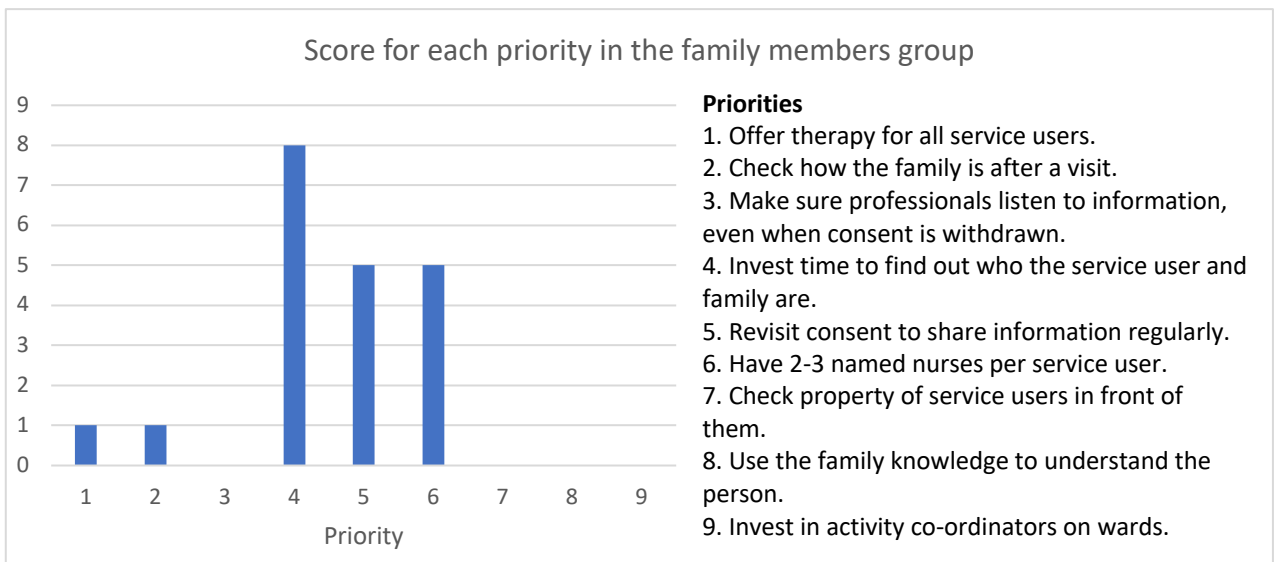
768 **Figure 1.** Priorities generated by the service user group and score.



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771 **Figure 2.** Priorities generated by the family members group and score.



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779 **Figure 3.** Priorities generated by the healthcare professionals' group and score.



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