Best Practice Group

Translating Research to Teaching and Practice

Presentation Plan

- Concise background to family intervention work.
- Problems with implementation.
- Study, data, results.
- Family Intervention Module.
- Transferring findings to practice in Harrogate.
- Questions.

Background to Family Interventions Training

- **Expressed Emotion and schizophrenia**
- **The Stress Vulnerability Model of schizophrenia**
- **Development of validated Family interventions**

Efficacy of Family Interventions

- Many family intervention studies published.
- Have comprised of psycho education training, survival skills and social skills training, CBT and stress management, goal setting, social support and symptom management, single and multiple family groups.
- General findings are less relapse compared to control groups over 9-12 months. Increased relapse at 24months but still less than control groups.

Problems with the implementation of family interventions into routine clinical practice

- **There is further evidence showing that when mental health practitioners have been trained to use these interventions, the mental state and social functioning of people who experience severe mental health problems, does improve (Brooker et al 1992, Brooker et al 1994, Lancashire et al 1996, Pilling, Bebbington, Kuipers, et al 2002).**
- **Despite the efficacy of family interventions and reports recommending the use of family interventions in routine practice they have not been implemented into routine clinical practice by mental health practitioners**
- **The focus of more recent research attention has been whether family interventions can be implemented into routine practice with the same efficacy (Fadden 1997, 2006, Barrowclough et al 1999).**
- **Other developments have included the integration of family therapy techniques with family interventions and the effect this has on the use of family interventions in routine practice, although there is no firm evidence as to the efficacy of this integration (Burbach and Stanbridge 2006).**

Problems with the implementation of family interventions into routine clinical practice

There appear to be three categories of barriers to implementation of PSI's into mainstream practice:

1. **Organisational factors- these include characteristics of the organisation, conflicting pressures on time, lack of organisational and managerial support.**

2. **Attitudinal factors- credible evidence of success and the predominance of the biological model in explaining and treating severe mental health problems.**

3. **Factors relating to the interventions- complexity of the interventions and the absence of appropriate expertise and supervision.**

Research

- Why do this piece of research?

Family Interventions and self-efficacy

- **Data collected by the teaching team and ex-graduates of the course programme suggests that the level of general perceived self efficacy in mental health practitioners also plays a big part in whether family interventions will be used in routine clinical practice after training.**

- **Self-efficacy is a concept introduced by Albert Bandura in 1977 as a core aspect of 'Social Cognitive Theory'. He defines self-efficacy as: "People's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives" .**

- **Self-efficacy relates to the conviction a person holds regarding their ability to achieve goals, in this case supporting families in the management and treatment of their relative's symptoms.**

Collection of data

- **In April 2006 permission was granted from the Department's Research Governance and Ethics Committee to collect data from graduates and those people waiting to come on to PSI courses.**

- **Postal survey of all graduates and those waiting to access the course programme was undertaken.**

Collection of data

- **Participants asked to complete :**
- **General Perceived Self-Efficacy Scale.**
- **Locus of Control measurements (*Locus of Control refers to the extent to which an individual believes an outcome or goal has been determlned by their own actions or by other external factors such as luck, chance , fate, others*)**
- **A list of psychosocial interventions indicating what clinical work they were doing routinely.**
- **206 questionnaires were completed and returned.104 from graduates and 102 from people waiting to come onto the course programme.**

Data analysed by Dr. Jeremy Miles in late summer 2006.

GPSE and individual work

- Those who have had the course score higher than those who have not.
- Statistically significant effect observed.

Summary of data analysis

- **Differences in the state of Locus of control between the two groups.**
- **Both groups had an internal locus of control state but the group that had completed PSI training consistently scored lower and had a greater internal locus of control than the group that were waiting to commence PSI training**

Data analysis

GPSE and family intervention work

- Those who have had the course score higher than those who have not.

- Statistically significantly effect size.

Data analysis

Application of PSI to clinical practice

- Those who have done the course score higher than those who have not done the course.

Data analysis

Locus of control

- Those who have had the course have a lower score on LOC.

Summary of data analysis

- **Level of self–efficacy in graduates was much higher**
- **The amount and range of PSI's being used in clinical practice was much higher for graduates**
- **Strong relationship found between the level of self-efficacy and the amount and range of PSI's used in routine clinical practice. Self-efficacy was a strong predictor of the amount and range of PSI's likely to be used in routine practice after completion of the course programme within this sample.**
- **The level of self-efficacy was significantly lower for working with families undertaking family work compared to working with individuals.**

Results

- **No significant difference in the state of Locus of control between the two groups. Indicating that mental health practitioners in the sample generally had internal locus of control, in other words the practitioners in this group all thought that their clinical interventions contributed to a good outcome for their clients.**

- **No significant relationships found between demographic characteristics of the sample and the use of PSI's in routine clinical practice.**

Limitations of the study

- **Unsophisticated study design- Convenience sampling too crude a method**
- **Sample bias those returning the completed questionnaires likely to be the most motivated to using PSI's**
- **55% of questionnaires returned - how representative were the findings?**
- **Design of data collection which promoted respondents to overestimate and respondents who had not undertaken training to underestimate.**
- **Self-report measures were used which could contribute to respondents overestimating.**
- **General perceived self-efficacy meta-analysis (Stajkovic & Luthans, 1998) it becomes less predictive when measuring more complex interventions. What does this mean in relation to family interventions?. Schwarzer & Fuchs (1996) suggested that specific items could be added which the researchers failed to do.**
- **Some of the results could have been contaminated where PSI is embedded in routine practice (Early Intervention, Assertive Outreach)**
- **……**

Stand alone family intervention module

This module has been designed to introduce mainstream mental health practitioners to family interventions but its delivery is designed to improve self-efficacy in order to facilitate the use of family interventions into routine clinical practice. This was done through the use of live clinical supervision and coaching.

Outcomes determined by the measurement of general perceived self-efficacy and the measurement of family satisfaction and improvements in quality of life.

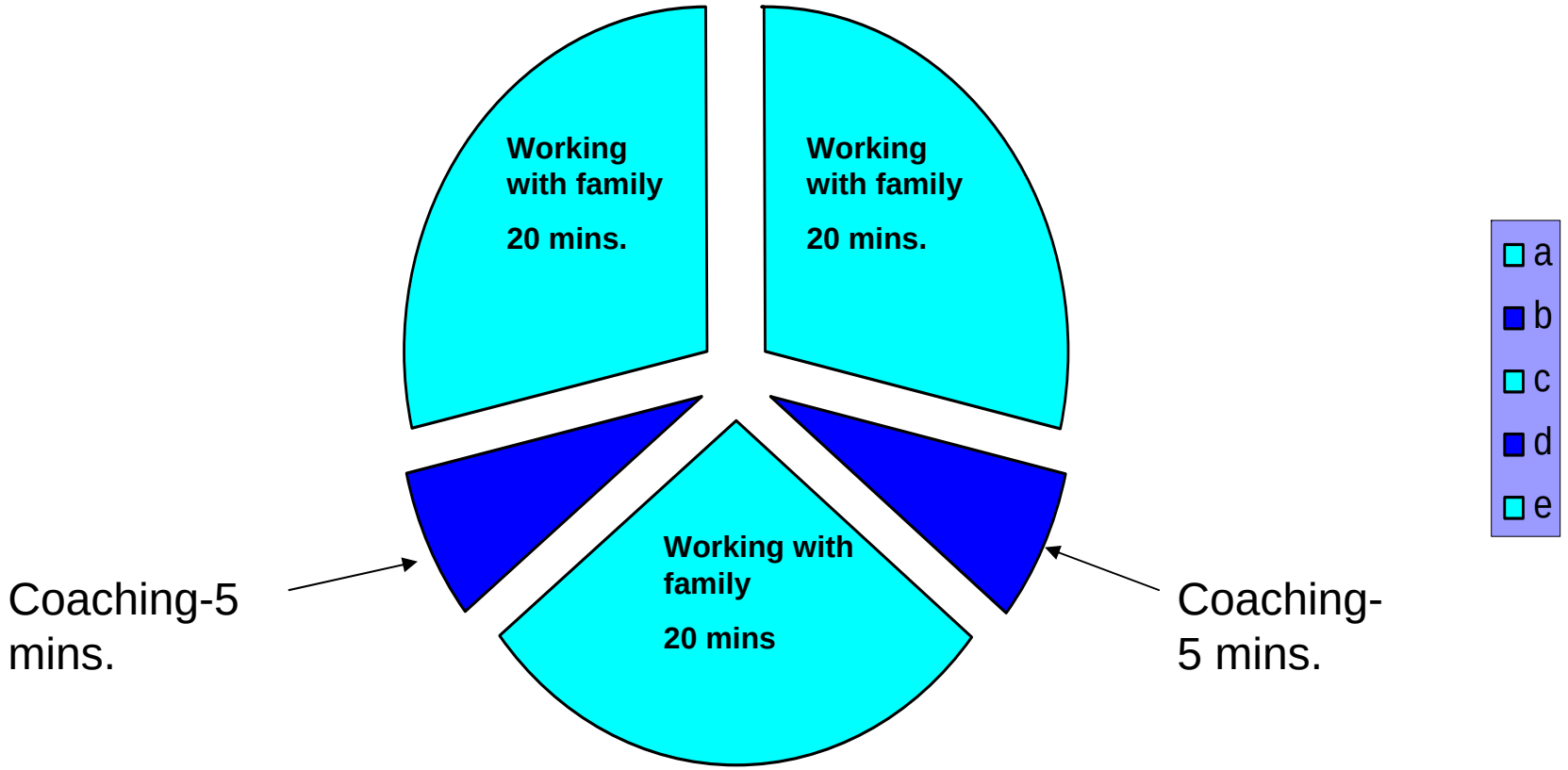
Course structure/delivery

As per course handbook

Study day	Study day	4 week block to work with families	Study day/working with families	4 week block to work with families	Study day/working with families	4 week block to work with families	Study day/working with families	Follow up study day

Family Intervention Module Coaching

Each family session = 70 mins/3x20 mins work sessions/2x5 mins coaching sessions



Coaching agreements with the family

- **Families need to agree to presence of clinical supervisor in the family sessions. Students also need to agree structure of 70 minute family session to include breaks for the family whilst 5 mins. Coaching takes place.**
- **This can be arranged through preliminary meetings where students discuss the role of the clinical supervisor with families. Or to include clinical supervisor in the initial meeting for introductions.**
- **Clinical supervisors to remain silent through 3x20 mins. sessions with families.**
- **Clinical supervisor can also be PSI trained local practitioner (Rick Allan)-the students trained up and the local practitioner then work at developing a local family intervention service as per NICE (2002) guidelines.**

Clinical supervision

- **As well as coaching within the session each of the two pairs of co-working students should receive one hours of clinical supervision for every family session. This clinical supervision session should follow immediately after the family session Clinical supervision documents are included in the course handbook and these should be completed after each clinical supervision session. They should then be detached from the course handbook and submitted along with the assignment.**

FAMILY INTERVENTION SCALE for Psychotic Disorders (modified)

McGovern, Barrowclough & Bradshaw

Core session items

1. Giving rationales
2. Opening/brief review of the week
3. Planning the session with the family
4. Review of between session tasks-last session
5. Pacing of session
6. Control of session-content
7. Control of session-participation orchestration*
8. Rapport, warmth and positive feedback
9. Participation of co-therapists
10. Planning of between session tasks
11. Closure

FAMILY INTERVENTION SCALE for Psychotic Disorders (modified)

McGovern, Barrowclough & Bradshaw

Specific interventions

1. Identification of problems/needs
2. Education
3. Communication Training
4. Problem Solving Training
5. Stress management and coping
6. Goal setting and planning
7. Staying well

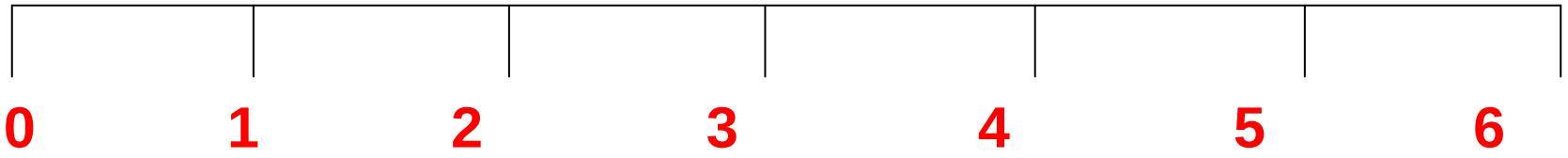
Skills/Family intervention scale

FAMILY INTERVENTION SCALE

(modified) McGovern, Barrowclough & Bradshaw

Guidelines for Scoring

The range of possible scores for each item is 0 - 6 although there are only item specific behavioural descriptors for even numbers (i.e. 0, 2, 4 & 6). In cases where you are of the opinion that the students level of skill for a particular item is in between the even numbers, then the item should be scored with the odd number in the middle of these.



Results

- 5 of the 6 students completed the training module the sample size was too small for any real rigorous analysis of data
- Evaluative data showed same patterns of change that were evident in the larger sample-increases in GPSE, changes in LOC to lower scores within internal dimension and large increase in reported likelihood of using family intervention skills in practice

Themes identified from focus group data

- Increasing self-confidence (low level of self-confidence and anxiety relating to seeing families at start of the course), initially perceiving coaching and supervision as intrusive but as confidence increased this changed to supportive.

- Skills learning-the family intervention scale provided a clear structure and series of skills that students were able to focus upon. They are considering how to generalisIng these skills out to other families they may work with.

- The ongoing problems with organisational difficulties associated with demands on time, priorities and the lack of line management support for the students family work (students noted a disparity between senior managers who supported the work and line managers who had a limited team rather than service orientated outlook.

- Fears about having the time to use and practice post-training.

Translating Research and Training to Practice in Harrogate

FAMILY INTERVENTION SERVICE FOR PSYCHOSIS

REFERRAL PROCESS

TELEPHONE CONTACT TO DISCUSS REFERRAL WITH
F.I. SERVICE LEAD, RICHARD ALLAN

SEND WRITTEN REFERRAL IF APPROPRIATE
F.I TEAM WILL SEND LETTER ACKNOWLEDGING RECEIPT OF REFERRAL

REFERRAL DISCUSSED AT F.I MONTHLY BUSINESS MEETING

- •OFFER FULL F.I
- •OFFER CO-WORKER FROM F.I SERVICE

REFERRAL PLACED ON WAITING LIST

TELEPHONE CONTACT

TO FURTHER EXPLAIN TO FAMILY

REFERRAL ACCEPTED

F.I SERVICE WILL MAKE

WITH FAMILY AND OFFER
BRIEF OVERVIEW

F.I ASSESSMENT VISIT BOOKED

SERVICE THROUGHOUT 2007 TO APRIL 2008

4 FAMILIES SEEN THROUGH COURSE OF F.I. TEAM TRAINING:

- 2 FAMILIES COMPLETED F.I.
- 2 FAMILIES DROPPED OUT

2 FAMILIES CURRENTLY BEING SEEN BY P.S.I BSc STUDENTS WITH CO-WORKER FROM F.I. SERVICE

1 FAMILY CURRENTLY BEING SEEN BY SERVICE

NO WAITING LIST AND SPARE CAPACITY WITHIN THE SERVICE

Supervision Group

- Present a current family to group
- Any stage of work
- Formulation
- Problem solving
- Supportive
- Educational

Business meeting

- New referrals
- Current families
- Update on development plans
- Feedback from implementers group
- Literature and articles
- Feedback on training

FINALLY

- Any questions???

Evaluation and Planning

- Split into groups and discuss how you think the day has gone.
- Take 15 minutes to do this.
- Consider what was good, what could be better, the venue, future speakers or topic areas, anything else.
- Each group write your ideas on a flip chart and allocate a spokesperson to feedback to main group.

Finally

- Next Best Practice day is September 12th .
- Room AEW 104 at University of York.
- Start at 10.30.