Mental Health Beacon: Implementing family inclusive practices in Victorian Mental Health Services

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Report prepared by The Mental Health Program at The Bouverie Centre - Victoria's Family Institute, La Trobe University.

For the Mental Health, Drugs & Regions Division, Department of Health and participating mental health services

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Message from the Director

Mental Health (MH) Beacon (2011-13) is the latest in a series of Beacon projects which aim to implement family interventions in partnership with services, guided by what families and clients want. MH Beacon was an ambitious endeavour that trialled four different family interventions at six sites across Victoria.

The report describes the implementation process and provides a comprehensive account of the impact of this work on the consumers and the families that participated in the different approaches, the practitioners that adopted these interventions and the organisations that partnered with The Bouverie Centre. Recommendations for The Bouverie Centre, mental health services and government to improve the processes for establishing family inclusive practices in services are also presented.

I would like to acknowledge all of the practitioners and managers from the partner services who contributed their creativity, time and energy to an activity that was ultimately about improving the range and quality of services for consumers and their families. I trust that those practitioners and managers will now feel that they belong to a wider network as friends of The Bouverie Centre.

Finally I would like to acknowledge the Mental Health program at The Bouverie Centre for their passionate commitment to the mental health field and their dedication and hard work in *MH Beacon*.

Dr Jeff Young

Director, The Bouverie Centre

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1 Executive Summary and Recommendations

1.1 Executive Summary

This report describes the Mental Health Beacon (*MH Beacon*) Implementation Project undertaken by The Bouverie Centre with Victorian mental health services. The Bouverie Centre worked in partnership with selected adult and youth mental health services to implement evidence based family interventions over a two-year period from 2011-2013. The project aimed to directly improve the quality and range of services offered to families and to contribute to knowledge about effective ways to disseminate family interventions in mental health and related fields.

MH Beacon was a multi-site implementation project informed by the latest research from the field of implementation science. Six partner sites representing metropolitan and rural locations and covering both clinical and Psychiatric Disability Rehabilitation Support Services (now known as Mental Health Community Support Services) were selected through an expression of interest process. Each of the six sites implemented one of three evidence-based interventions. Barwon Health Youth Mental Health Drug and Alcohol Service, together with St Luke's, Anglicare & Mind, Bendigo (in partnership) were successful in their application to implement Multiple Family Groups (MFG) within their respective services. Mid-West Area Mental Health Service and Peninsula Health Mental Health Service were selected to introduce Behavioural Family Therapy (BFT). BFT and MFG sites received training and implementation support in Single Session Family Consultation (SSFC) prior to introducing the other family interventions. Northern Area Mental Health Service and NEAMI (in partnership), along with Eastern Health Adult Mental Health Service, implemented Let's Talk About Children (Let's Talk).

The project employed a 'champion' based approach to implementation whereby three motivated practitioners from each service were nominated, trained and supported to acquire skills in practice development and implementation from The Bouverie Centre. Each partner site also received ongoing support from an experienced family practice consultant from The Bouverie Centre over the course of the two years. Additional components of the implementation strategy included: engaging a nominated management sponsor within each site to help drive the project internally; the development of site-based implementation plans; facilitating site-based project implementation meetings; and providing opportunities for project champions and management sponsors from across the sites to meet and discuss practice and implementation issues through booster sessions which promoted cross service sharing, support and problem solving. Training of program staff at each of the sites was supported by monthly practice development sessions conducted by project champions and in some cases management sponsors.

Key project outputs included: recruitment and training of 19 champions who guided local implementation across the six sites; 65 supervision sessions for project champions facilitated by a family practice consultant; over 50 project site based implementation meetings; 151 practitioners trained in the family interventions SSFC or Let's Talk; and 16 practitioners further trained in BFT or MFG in the second year of the project.

A process and impact evaluation was conducted as part of the project to assess the effectiveness of training and implementation support on the uptake of selected family interventions. This included capturing the experience of consumers and their families.

A significant group of consumers and their families received support and therapeutic intervention as a direct result of *MH Beacon*. In total, 242 SSFC and 111 Let's Talk sessions were conducted and a Multiple Family Group program commenced over the course of the project.

Clients and families who participated in SSFC or Let's Talk found it a positive experience. Both clients and their family members rated various aspects of the sessions highly and this is indicative of a strong therapeutic alliance between practitioners and families. There was also evidence of high levels of satisfaction for those families who participated in the MFG.

There was evidence of significant changes in family related practitioner attitudes and behaviour as a result of the training and support provided. Specifically practitioners reported that on average they were providing more family support twelve months following participation in Let's Talk or SSFC training.

At an organisational level, at all sites a number of significant changes in the operation of teams were made to facilitate and sustain the use of the new practice models. These changes included development of promotional materials for family inclusion, changes to clinical processes and pathways, data collection changes and incorporation of the new practices into training and orientation programs. These changes being confirmed by Let's Talk and SSFC trained practitioners whose ratings of the amount support they received from their organisations for family focused practice increased 12 months following initial training.

In terms of limitations, the rate of uptake could be viewed as modest with 82 practitioners trained in SSFC conducting an average of 2.95 sessions while the average for the 69 practitioners who undertook Let's Talk training was 1.6. Of those trained in BFT and MFG only a small group of practitioners delivered these interventions to a small number of families. However these apparent limitations in uptake outcomes need to be understood in the context that such data is not typically reported and therefore benchmark levels of uptake following training are not available.

There were no specific outcome measures that assessed the implementation of MFG and BFT, although the uptake of MFG and BFT was tracked at each of the sites. There were mixed results across the two MFG sites. Whilst both commenced a multiple family group in the year following their training only one group continued to meet after the education workshop was delivered. Only two practitioners from each site used BFT although some components of BFT such as information sharing and communications skills were incorporated into SSFC at one site.

Champions and management sponsors identified the individually oriented nature of service delivery and the turnover of staff in management sponsor or champion roles as barriers to implementation. Practitioners also reported organisational barriers to use of family interventions, namely burden of work, integration of family work with caseload and other work responsibilities and allowance of time by the service.

A number of positive features of the MH Beacon implementation strategy were identified. The overall partnership between The Bouverie Centre and the participating service where ownership of the project was shared was a valued aspect of the project. The role of the champion was valued highly by all stakeholders and amongst other roles provided on the ground support to individual practitioners and the team. Services appreciated The Bouverie Centre's role as an external implementer with developed knowledge and skills in working with families and in implementation. In terms of other successful components, the selection of the practice models; the EOI process; flexibility in training delivery and the provision of sustained support were generally viewed as positive features of the implementation approach.

In terms of aspects of the implementation approach that worked less well, implementing two different interventions at the same site within a two-year period appeared to be overly ambitious. SSFC proved difficult to establish fully in one year and did not appear to provide a pathway to BFT and MFG as expected. Also, it was difficult for sites to muster the necessary enthusiasm for the implementation of another new practice. Implementation groups operated with varying degrees of success but interestingly their operation did not appear critical to implementation outcomes. Most of the services struggled to make use of existing client registration and contact data.

In conclusion, during the two year period of *MH Beacon* (2011-2013) significant practice and organisational changes in the implementation of family interventions have been observed at participating sites. These changes have had a positive impact on a significant group of consumers and their families, mental health practitioners and on the participating services. While practice change is

undeniably challenging, *MH Beacon* contributed significantly to understanding about how to best implement family interventions in routine care within public mental health services.

1.2 Recommendations

1. Given the high level of satisfaction expressed by consumers and family members who participated in SSFC, The Bouverie Centre should conduct a randomised control trial to further research into the effectiveness of SSFC. This could address whether SSFC is effective in addressing domains such as client outcome, family functioning, distress and burden and the relationships between families and practitioners.

2. The Bouverie Centre should undertake research to better understand the phenomena of why consumers and families decide to participate or decline participation in family interventions. This could include identifying those factors that are amenable to influence by practitioners and services as well as establishing benchmark levels of uptake for different family interventions.

3. The Bouverie Centre explores with mental health practitioners in a suitable forum, the specific difficulties associated with incorporating working with families in their usual work roles. This could include generating strategies to overcome this important barrier to the uptake of family interventions in mental health.

4. Future implementation projects undertaken by The Bouverie Centre should focus on the introduction of a single practice model in order to increase the likelihood of successful implementation of family interventions. If a tiered approach to implementation is adopted then a longer interval between the implementation of the first and second practice model might needed.

5. The Mental Health, Drugs and Regions Division consider options for building the capacity of mental health services including The Bouverie Centre to make best use of currently collected registration and contact data for the purposes of implementation and monitoring service provision in relation to families.

6. Mental Health Services including The Bouverie Centre should engage consumers and family members at the beginning of efforts to implement new practices. This could provide valuable information on how to best promote interventions to consumers and families and ultimately enhance implementation efforts by driving demand for new practices.

7. Given the apparent value of the intentional engagement and support of practice champions as an implementation strategy, The Bouverie Centre should continue to use and refine this

approach. Specific consideration should be given to how to most effectively support practitioners in these roles including the development of appropriate training and supervision.

8. The Bouverie Centre should explore as a priority the use of web-based technologies to improve flexibility in the mode of delivery of training and supervision as well as for data collection as this relates to implementation and research activities.

9. In the light of an increasing emphasis on the cost of interventions and their implementation within mental health services, The Bouverie Centre should seek appropriate research partnerships to measure the cost effectiveness of both family interventions and implementation approaches.

1.3   Acknowledgements

The Bouverie Centre wishes to acknowledge the contribution of the practitioners, managers, family members and consumers who participated in *MH Beacon.* The Mental Health Program at The Bouverie Centre would especially like to thank those practitioners and managers who undertook the roles of practice champions and management sponsors in the project. They demonstrated great leadership, dedication and determination in supporting implementation in their own services and thoughtfully contributed to the generation of ideas about how to best implement family interventions in public mental health services.

2   Background

The efficacy of family interventions in the treatment of mental health conditions is well established with over 50 randomised control studies having been conducted over the last forty years (Pharoah, Mari, Rathbone, & Wong, 2010). The benefits of these interventions include reductions in relapse and readmission rates, improved adherence to medication and improvements in client functioning and symptomology. A unique benefit of family based approaches is that they also address the distress of the primary carer and have been associated with improved family functioning. The strength of the evidence base for family interventions has led to their incorporation in treatment guidelines for conditions such as schizophrenia (Dixon et al., 2010; McGorry, 2004; National Collaborating Centre for Mental Health, 2010). The evidence for the efficacy of family interventions, the recognition of the impact of mental illness on family carers and advocacy by the carer movement have all contributed to the development of government policy and legislation that supports the inclusion of families in mental health care and the funding of services to directly assist carers.

Despite the presence of conditions conducive to the use of family interventions in mental health, attempts to introduce these interventions into services have met with limited success. As such, their use as part of routine service delivery is the exception, not the rule (Haddock et al., 2014; L Magliano et al., 1998). This creates a circumstance in which an intervention known to be effective in the treatment of conditions such as schizophrenia is generally not available to people experiencing mental health difficulties and their families. Studies examining the implementation of family interventions have typically identified difficulties experienced by practitioners in integrating family interventions with their usual work role and a lack of time as constraints (Fadden, 2006; L. Magliano et al., 2005; L. Magliano, Fiorillo, Malangone, De Rosa, & Maj, 2006). However it is also recognised that barriers to the use of family interventions operate at the level of the client and family and at the level of the organisation providing mental health services (Sherman & Carothers, 2005).

As a specialist family mental health service, The Bouverie Centre has a long history of promoting the use of a range of family-based approaches within Victoria's publicly funded mental health services. The centre's strong commitment to helping services achieve real and measurable practice change that delivers improved outcomes for clients and their families, has recently seen it move beyond an exclusive reliance on the delivery of training. Drawing on years of practical experience and knowledge emerging from the field of implementation science about the challenge of realising the potential of family interventions in a variety of service settings (Damschroder et al., 2009; Fixsen, Naoom, Blase, & Friedman, 2005; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2005), The Bouverie Centre has

developed a series of 'Beacon' projects in alcohol & other drugs and Gambler's Help services designed to achieve sector wide change in practice and better understand how to best implement family interventions. Mental Health Beacon (*MH Beacon*) sought to build on the learning from these projects and from our many years of work in the mental health field.

In essence *MH Beacon* involved The Bouverie Centre working in partnership with selected adult mental health services over two years to implement a series of family interventions. The project aimed to directly improve the quality and range of services offered to families in line with practice guidelines and National Mental Health Standards in the selected services. It also aimed to contribute to existing knowledge about the best ways to disseminate effective family interventions in mental health and related fields. The project was launched in April 2011 and concluded in June 2013.

This report describes the key features of *MH Beacon* as an implementation project and provides an account of the delivery of the project. In addition it presents the results of the evaluation conducted as part of *MH Beacon* and identifies key learnings from the project. Recommendations about future implementation and dissemination activities are also provided.

2.1   Project Aims

The overall aim of *MH Beacon* was to build the capacity of Victorian mental health services to constructively include families in care through a multi-site implementation project. This aim would be achieved by introducing evidence-based models of family practice to the participating services. Knowledge gained through the project would also inform The Bouverie Centre's ongoing endeavours to improve the quality of services provided to clients and families within the wider Victorian mental health system.

Specific objectives were to:

- Identify six mental health services through an Expression of Interest process to partner with The Bouverie Centre

- Train and support identified practice champions at each site to guide local implementation

- Identify and engage management sponsors at each service site

- Form local implementation working groups to facilitate changes in team and organisational practice that would enable use of the family interventions

- Train practitioners within the participating teams to provide the selected family interventions and facilitate the provision of ongoing practice support for this cohort, including supervision.

- Evaluate the project in terms of both process and impact including the measurement of uptake by practitioners, changes in practitioner attitudes, and consumer and family satisfaction with the newly introduced interventions.

2.2 The Mental Health Beacon Strategy

2.2.1 An Implementation Framework

Changing practice in health care settings is difficult. Despite the demonstrated value of family interventions and a supportive policy context, introducing and sustaining these practices in individually orientated adult mental health services is challenging (Fadden, 2006). In order to meet this challenge, *MH Beacon* utilised an implementation framework (Damschroder et al., 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Greenhalgh et al., 2005). Implementation frameworks assume that practice change is a complex process operating at a number of levels. As such efforts to change practice need to be multi-faceted rather than relying on a single strategy such as training. This is captured in Figure 1. In practical terms this meant developing comprehensive implementation plans in conjunction with partner services that took account of the unique features of the different organizations, the practitioners involved and the family interventions being adopted.
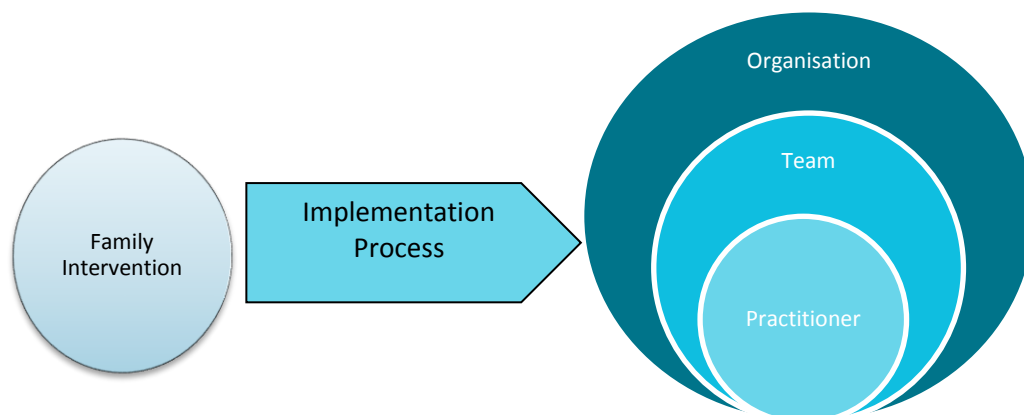

Figure 1. The mechanisms of change within the implementation framework

2.2.2 The Implementation Design

While the implementation plans developed by each site varied somewhat, the *MH Beacon* implementation process had several key components. They are as follows:

- Services interested in participating in *MH Beacon* were required to fill in an online application form which asked them to address a range of key selection criteria. This helped identify which services were best placed to successfully implement each of the three family interventions.

- Implementation was targeted at a program level to avoid dilution of efforts and to improve the likelihood of successful uptake of the new interventions. Services nominated which program or programs (dependent on size) they would like to become implementation sites. In general the EFT of these programs was in the range of 15-25 practitioners.

- In addition to receiving training from The Bouverie Centre, each partner service was assigned a specific Family Practice Consultant. Family Practice Consultants, experienced family practitioners with a background in mental health, actively assisted and supported implementation sites throughout the course of the two year project.

- Three motivated practitioners within each partner service were identified, trained and supported to champion the implementation of the selected family intervention within their programs. After consolidating their own skills, practice champions went on to help train their colleagues in the chosen intervention, co-delivering components of Bouverie's training with family practice consultants.

- Each partner service was required to nominate a management sponsor who would function as the site's primary contact person. Most managers were members of the services' senior leadership group. They worked together with the practice champions to drive implementation.

- An implementation plan was developed by each partner service to help them to identify and manage the complexity associated with achieving real practice change.

- Practitioners and management sponsors from the *MH Beacon* partner services were brought together for initial training and subsequent 'booster' sessions to encourage cross service sharing, support and problem solving around practice and implementation issues.

- An e-newsletter was used to enhance communication between the family practice consultants, champions and management sponsors and across implementation sites. There was a strong emphasis on measuring and monitoring the extent of uptake through

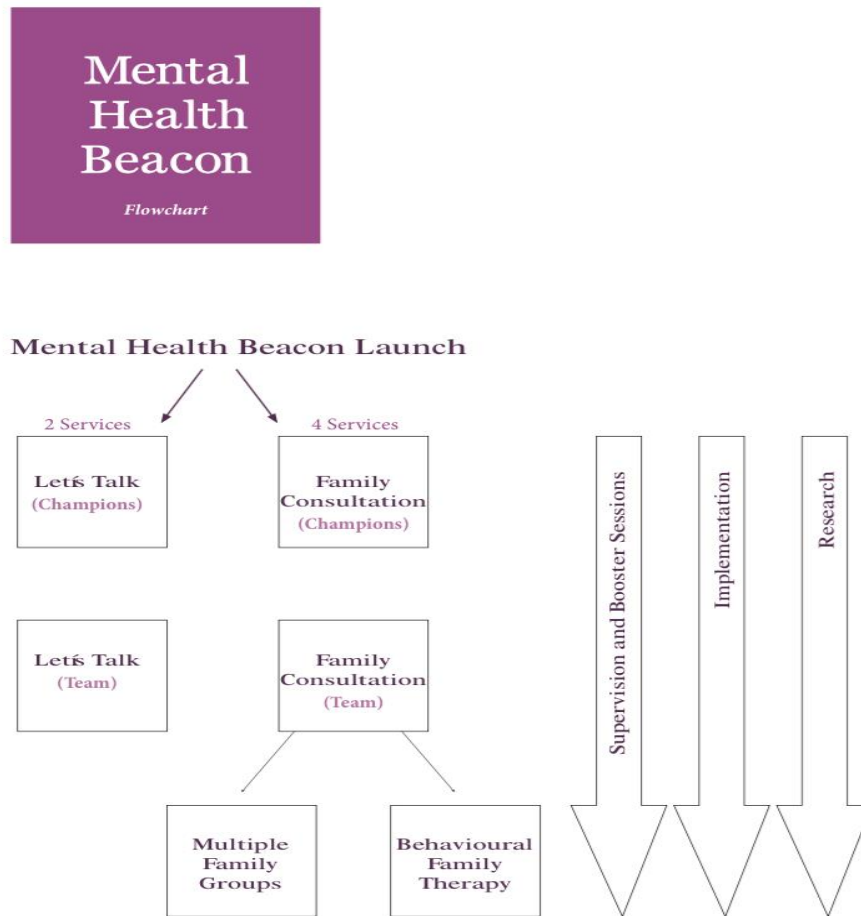the use of existing data collection mechanisms where possible and through additional measures as necessary.

Figure 2. The implementation design of *MH Beacon*

2.2.3 The Bouverie Centre Project Team

MH Beacon was co-ordinated and delivered by The Mental Health Program. The Program comprised:

• Brendan O'Hanlon, Project Manager

• Hanna Jewell, Project Officer

• Rose Cuff, Project Officer, FaPMI State wide Co-ordinator

• Peter McKenzie, Project Officer, Carer Academic

• Melinda Goodyear, Research Officer

All members of the project team aside from the Research Officer undertook the role of Family Practice Consultants with the selected sites.

3   Family Interventions in Mental Health Beacon

Three family psycho-education interventions with demonstrated efficacy in the treatment of mental health conditions were selected for implementation as part of *MH Beacon*. These were: Behavioural Family Therapy (BFT); Multiple Family Groups (MFG) and Let's Talk About Children (Let's Talk). To promote mutual support between sites and create the opportunity for comparison, each evidence-based intervention was implemented at two sites. Single Session Family Consultation (SSFC) was also introduced at the four sites implementing BFT and MFG to increase the level of routine engagement of families prior to the implementation of the evidence-based interventions in the second year of the project (Harvey & O'Hanlon, 2013).

3.1   *Single Session Family Consultation*

Single Session Family Consultation (SSFC) is an intervention developed by The Bouverie Centre that combines concepts and practices from Family Consultation and Single Session Therapy. Family Consultation is a model for engaging with families that was originally developed in mental health services in the United States (Marsh, 2001; Wynne, 1994). In order to facilitate an effective, efficient and responsive meeting process, concepts from single session work have been incorporated into Family Consultation. Single Session approaches recognise that many people ultimately only attend one therapy session even when more are offered yet most still derive significant benefit from this contact. It encourages practitioners to adopt an attitude of making the most of each session and accepts that people may make use of therapy episodically on an 'as needed' basis over time (O'Neill & Rottem, 2012; Young & Rycroft, 2012).

SSFC consists of 1-3 consultative meetings between a mental health practitioner and family (including the consumer). The aim of these meetings is to clarify the nature of family involvement in the work with the consumer and to help the whole family identify and respond to their own needs. The mental health practitioner gives particular attention to negotiating how the family consultation will occur with the consumer to avoid threatening the primary relationship. SSFC is a practice model ideally suited to meeting standard seven (relating to carers) of the new National Mental Health Standards (Australian Government, 2010).

3.2   *Behavioural Family Therapy*

Behavioural Family Therapy (BFT) is a structured psycho-educational model of individual family intervention that aims to equip families with the skills they need to cope with the inevitable difficulties they face on a day-to-day basis (Mueser & Glynn, 1999). Behavioural Family Therapy is an established

family intervention that has been used in numerous outcome research studies across the world. It has been shown to reduce relapse and promote recovery in people experiencing mental health difficulties and improve the well-being of other family members.

Practitioners initially meet with the consumer and then together with available relatives to gain their agreement to participate in BFT. Families are usually seen at weekly or fortnightly intervals for one hour at home or in an office setting dependent on family and practitioner preferences and availability. An assessment that includes meeting with individual family members determines the content of the work with families.

The approach is collaborative and transparent, with the practitioner and family members working together as partners. Beyond the important engagement and assessment phases, BFT has the three main components:

- Information Sharing where the practitioner in conjunction with the consumer helps the family better understand the condition including how to prevent relapse

- Communication Skills training to look at simple ways of improving family communication in order to reduce stress

- Problem Solving/Goal Achievement training to deal with the problems that families face in coping with mental health difficulties

The length of intensive contact varies significantly although existing evidence indicates that overall contact lasting at least nine months is associated with better outcomes.

3.3   Multiple Family Groups

The Multiple Family Group (MFG) is a psycho-educational group intervention that promotes recovery for consumers and their families by providing a forum for mutual support and problem solving and increasing social networks (McFarlane, Dixon, Lukens, & Lucksted, 2003; McFarlane, Lynch, & Melton, 2012). Research on the effectiveness of MFGs demonstrates reductions in relapse and readmission as well as other benefits including improved participation in rehabilitation and employment by consumers. The model was first developed in the United States by McFarlane but has been used in other countries including Scandinavia and Australia (Bradley et al., 2006).

The MFG involves consumers and their family members participating in a group facilitated by two practitioners that meets on a fortnightly basis over nine months or more. The groups utilize the families' lived experiences as well as practitioner knowledge to address the day to day problems experienced by consumers and their families.

The structure of the recruitment process and the group may vary but usually consists of the following components:

- Individual Family Sessions- that usually consist of up to three meetings, including all members likely to attend the group. These sessions provide an opportunity to identify and respond to expressed family needs as well offer the option of participation in a MFG

- An Education Workshop- these are delivered to the MFG either in one whole day or over two half days. Content usually includes topics such as diagnoses, symptoms, medication, early warning signs, understanding the impact of mental health problems on families and relationships and coping skills.

- MFG on-going sessions- these are fortnightly, running 1.5 to 2 hours for 6 to 8 families. Sessions consist of:
  - informal socialising at the beginning and end of sessions
  - sharing of participants' current concerns and progress
  - facilitated group problem-solving of family difficulties using a structured approach

3.4 *Let's Talk About Children*

Let's Talk About Children (Let's Talk) is a two session structured intervention with parents who experience a mental illness that seeks to make talking about children and parenting issues a natural part of the alliance between parents and practitioners. It aims to support healthy parent-child relationships by empowering families to address the impact of mental illness on children. The model was developed in Finland by Solantaus, Paavonen, Toikka, and Punamäki (2010). Let's Talk has an emerging evidence base with families reporting high levels of satisfaction with the intervention, improved understanding between family members and improved working relationships with practitioners. It has been successfully implemented in Finland throughout their mental health services and has attracted interest worldwide.

The program operates from key principles;

- Not assuming 'good' or 'bad 'parenting but sharing ideas about parenting and mental health with parents as the experts on their children.
- Highlighting what is already going well and what may require additional support.
- Working in partnership with parents to develop a shared understanding of children's development and to promote wellbeing and resilience.
- Building conversational 'tools' that parents may use with their children and family members.
- Offering further assistance where asked for or deemed necessary.

The intervention consists of two x 1-hour sessions between the parent (ideally both parents) and the practitioner. A third session may be necessary if there are more complex issues. Session 1 looks at the overall situation for the children through discussion with the parent(s) about the joys and concerns the parents may have while highlighting the strengths and vulnerabilities of their children. Session 2 looks at how a parent's mental health issues may affect the family and children and provides guidance to parents about how they can best respond. It includes guidance about how parents can talk to children about mental illness. Guidebooks are used for reference.

4   The Evaluation Framework

4.1   Overview

The *MH Beacon* evaluation aimed to address the key question of how to best implement family interventions as part of routine care within mental health teams. There was a particular interest in identifying factors that might be associated with more or less successful implementation that could then inform future implementation endeavours. Secondary research questions related to families, practitioners and the organisation's experience of participating in *MH Beacon*. Partner services were also encouraged to bring additional research questions and resources to the project.

4.2   Ethics approval

Ethics approval to conduct the research at each of the participating sites was sought and granted from Barwon Health Human Research Ethics Committee, Eastern Health Human Research Ethics Committee, Melbourne Health Human Research Ethics Committee, Monash University Human Research Ethics Committee, and Peninsula Health Human Research and Ethics Committee. Approval was also sought from research committees overseeing research at Neami and MIND.

4.3   Research and evaluation design

A mixed methods design was used incorporating both quantitative and qualitative outcome measures. Measures were designed around determining the effectiveness of training and implementation support on the uptake of selected family interventions, including capturing the experience of the mental health client and their families. The Beacon strategy was expected to have an impact in four areas: the organisation, the practitioner, the client, and the client's family and thus various measures were developed to determine impact on these areas. It is also important to note that during MH Beacon, Masters research projects were conducted by Kristy Fennell and Andrea Bernazzoli in relation to uptake of SSFC (Bernazzoli, Fennell, & Gerlach, 2013) at the Barwon and Bendigo sites. The research and evaluation strategy is represented below in Table 1.

Table 1. Summary of MH Beacon research and evaluation strategy

What was measured?	How was it measured?	Why was it measured?	Completed by whom?
The number of SSFC and Let's Talk sessions offered to clients and the number of sessions conducted	Recorded in client log	To help assess the level of uptake of the two interventions	Practitioners
Reasons given by clients and/or their families for declining SSFC or Let's Talk	Recorded in client log	To enhance understanding of consumer/family level factors influencing uptake of interventions	Practitioners
Practitioners' perceptions of their knowledge, skills and attitudes to family inclusive practice	The Family Focused Mental Health Practice Questionnaire (Maybery et al., 2012) - completed prior to training and again 12 months later	To assess the impact of participation in the project on practitioners' knowledge, skills and attitudes to family inclusive practice	Practitioners
Practitioners' perceptions of the extent to which various factors acted as a barrier to working with families	An adapted version of the Family Intervention Schedule (Magliano et al., 2005) - completed prior to training and again 12 months later	To identify what the barriers were to family work and how perceptions of barriers were moderated by participation in *MH Beacon*	Practitioners
Issues families presented with; issues addressed in the SSFC session; strategies used by the practitioner in the session	Session record sheet (adapted from a format developed for Family Consultation by the Family Institute in New York State)	To explore how SSFC was used by each site	Practitioners
Consumers' and families' experience of SSFC and Let's Talk	Client and family feedback forms completed at the end of each session	To evaluate consumer and family satisfaction with the intervention	Consumers/ consumers' families

Organisational readiness for change	A questionnaire constructed for the project which incorporated subscales from the Organisational Readiness Tool (Lehman, Greener & Simpson, 2002) - completed prior to training. Insufficient numbers of questionnaires were returned by participants at the end of the project to permit meaningful comparisons over time	To assess differences in organisational readiness pre and post participation in the project	Project champions and management sponsors
Managers' and champions' experience of participating in the project, including what constrained / facilitated implementation of the new intervention at their site, and what changes they observed as a result of participation in the project	Semi-structured interviews conducted at the conclusion of the project	To explore the nature of each site's participation in the project; to assess the impact of participation on practitioners, the organisation and clients/families; and to evaluate the effectiveness of components of the implementation strategy	Project champions and management sponsors

5   The Mental Health Beacon Strategy in Action

As described earlier, MH Beacon had a number of key implementation components. This section of the report describes how each of these components was enacted in the project. As such this is a form of process evaluation of the project in providing an account of the extent to which the intended processes of implementation were undertaken. The 'roll-out' of the implementation components is described as occurring over four phases:

- Phase 1 - Expression of Interest process and site selection
- Phase 2 - Champion training and support
- Phase 3 - Team-based training and implementation support (SSFC & Let's Talk)
- Phase 4 - Implementation of Behavioural Family Therapy and Multiple Family Groups

5.1   *Phase 1 Expression of Interest and Site Selection*

5.1.1   Expression of Interest

Recruitment of sites to the project occurred through an Expression of Interest (EOI) process. Services interested in taking part *MH Beacon* were required to address several key criteria an online application. Preference was given to:

- Applications that were endorsed and supported by service leadership
- Services that identified a specific program as an implementation site; a program which:
    - Comprised approximately 15-25 staff
    - Permitted practitioners to have ongoing contact with families (effectively excluding acute services)
- Services that had designated specific staff as practice champions and management sponsors
- Services demonstrating an ability to successfully implement a given family intervention.

Site selection was also based on a commitment to achieving a balance in representation of PDRSS & clinical and metropolitan and rural services.

The EOI required that applicants provide information in the following areas:

- Client demographic information relevant to the uptake of family interventions (for example, how many consumers live with family) as well as information regarding the service's current level of engagement with families.
- Service perceptions of enabling and constraining factors in the uptake of family interventions.

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- Proposed mechanisms for ensuring timely decision making and action in relation to organisational changes to support uptake of the new practices.

- An account of how the project would be 'driven' by leadership within the service and nominated program area.

- The numbers and characteristics of the workforce in the nominated area. For example, levels of experience and occupational background.

- Service preparedness to participate and contribute to research and the sharing of emerging knowledge gained through the project.

- Service capacity in relation to web based communication and applications.

- The family based intervention that services intended to implement.

A total of 15 Expressions of Interest were received from clinical mental health and PDRSS as well as from a state-wide service. Both rural and metropolitan sites expressed interest in participating in *MH Beacon* and five of the EOIs were submitted as joint applications between services. It is noteworthy that while the standard of applications was generally high most applications lacked detailed information about family related client demographics (for example, how many clients lived with family members) or the extent of service engagement with families (for example, family related contact data).

5.1.2 Selected partner agencies

Six partner mental health sites listed in Table 2 below were judged as best placed to implement the chosen family intervention, representing a balance of PDRSS/Clinical and metropolitan and rural services.

Table 2. Summary of MH Beacon sites

Sites	Service Type	Nominated Family Intervention
Jigsaw Young Person's Mental Health and Drug & Alcohol Service, Barwon Health	Clinical (Youth)	Single Session Family Consultation/ Multiple Family Groups
St Luke's Anglicare & Mind, Bendigo	PDRSS (Adult)	Single Session Family Consultation/ Multiple Family Groups
Northern Area Mental Health Service & NEAMI	Clinical (Adult) & PDRSS (Adult)	Let's Talk About Children
Mid West Area Mental Health Service	Clinical (Adult)	Single Session Family Consultation/ Behavioural Family Therapy
Peninsula Health Mental Health Service	Clinical (Adult & Youth)	Single Session Family Consultation/ Behavioural Family Therapy
Eastern Health Adult Mental Health Service	Clinical (Adult)	Let's Talk About Children

5.2 Phase 2: Champion training and support

A first stage in the implementation process was to engage, train and support practice champions from each of the six sites. Mental Health program members from The Bouverie Centre were allocated to each of the selected sites to operate in the role of Family Practice Consultant for that site across the remaining three phases of the project. They worked directly with the champions and management sponsors.

5.2.1 Training

Champions received training in the chosen practice models, namely SSFC and Let's Talk, together ahead of the other practitioners in their respective teams. The SSFC and Let's Talk two-day training programs attended by practice champions also included a brief introduction to implementation theory. Management sponsors from each site participated in this component of the training alongside their service's champion. A total of 13 champions attended the SSFC program while six champions participated in the Let's Talk program. Both programs were rated highly by participants.

Two half day booster sessions were conducted at The Bouverie Centre for champions and management sponsors; one in 2011 and the other in 2012. These boosters were designed to facilitate

sharing of information and experiences across sites and to provide additional skills training in relation to practice models and implementation. On both occasions, practitioners particularly valued the opportunity to share their experiences with colleagues from other implementation sites.

5.2.2 Supervision

Champions received regular supervision from a Family Practice Consultant in person or via telephone to assist them with their individual use of the practice model and in their role in promoting the practice within their team. The number of supervision sessions provided to each site over the course of the two years are summarised in Table 3.

Table 3. Number of supervision sessions with project champions per site

Sites	Champion Supervision Sessions
Barwon	9
Bendigo	11
Mid West	14
Peninsula	11
Northern	11
Eastern	10
Total	**66**

5.3 *Phase 3: Team-based training and implementation support*

Once champions were trained, Implementation Groups were convened at each site. Family Practice Consultants continued to provide ongoing consultation to champions and training in the relevant practice model was provided to teams, with the support of local champions.

5.3.1 Implementation groups

Management sponsors or their delegates (typically team leaders) convened an implementation group at each site. The Family Practice Consultant participated in these meetings either on site or via telephone link up. The focus of these meetings was to develop an implementation plan that would

guide local implementation activities. The number of meetings held at each site is summarised in Table 4 below.

Table 4. Number of project implementation group (PIG) meeting per site

Sites	Implementation meetings
Barwon	6
Bendigo	10
Mid West	8
Peninsula	7
Northern	10
Eastern	10
Total	**51**

Implementation groups operated differently across the six sites. Some groups met more frequently than others and were better attended, developing detailed formal implementation plans.

5.3.2 Team-based training

Practitioners from participating programs received training in the chosen family intervention at their workplace over two half-days. The training was delivered by the Family Practice Consultant with the support of local champions, and was well received by participants.

Booster sessions were also conducted at each site to provide further training in relation to the chosen practice model and to encourage uptake of the practice. Booster sessions included; Recognition Awards; interviews with family members about the experience of receiving the intervention; updates on uptake of the intervention; and identifying and problem solving barriers to uptake. Table 5 summarises the number of training workshops delivered to each site during Phase 3 of the project.

Table 5. Number of training and booster sessions and number of practitioners trained per site

Site	Intervention implemented in Phase 3	No. of foundational workshops delivered	No. of booster sessions delivered	No. of practitioners trained in approach
Barwon	SSFC	2	2	16
Bendigo	SSFC	2	1	20
Mid West	SSFC	1	1	22
Peninsula	SSFC	1	1	24
Northern	Let's Talk	2	1	48
Eastern	Let's Talk	1	1	21
Total		**9**	**7**	**151**

Inspection of Table 5 reveals that 16 workshops were delivered in Phase 3 of the project (some spanning over two half days). A total of 151 practitioners from the six sites were trained in SSFC or Let's Talk during this period.

5.4 *Phase 4: Introduction of Behavioural Family Therapy and Multiple Family Groups*

In the fourth phase of *MH Beacon*, BFT and MFG were introduced in four of the six sites. These sites received training and implementation support to embed the two evidence based approaches. The delivery of implementation support for the two Let's Talk sites formally ceased December 2012.

5.4.1 Behavioural Family Therapy

BFT was introduced at Mid-West AMHS and in the adult and youth teams at Peninsula Health. Ten practitioners attended a five-day intensive training program in the intervention in June 2012. This program was very well received with participants appreciating the training process and seeing value in BFT as an intervention model.

5.4.2 Multiple Family Groups

Six practitioners from the Barwon and Bendigo sites attended a two-day training program in Multiple Family Groups in May 2012. They were joined by participants from Inner West and Northern Area Mental Health Services. The training was co-delivered in by a senior practitioner from the Inner West Area Mental Health Service where the MFG has been successfully delivered over the last three years.

6   Uptake and Impact – Single Session Family Consultation

6.1   Uptake of SSFC

A key aim of MH Beacon was to implement family practice models within the participating services. A summary of uptake of SSFC across the four sites is provided in Table 5. (Note: with the exception of Barwon who routinely collected information about the provision of SSFC as part of their broader data capture system, the figures in Table 5 are based on *completed* session records, client logs and client/family feedback forms. This paperwork was not always filled in; therefore the results presented below provide are an estimate of uptake and should be interpreted with caution).

Table 6. Number of family consultations conducted at each site

Sites	Number of SSFC sessions	Number of SSFC offered
Barwon	96	130
Bendigo	36	112
Mid West	42	n/a
Peninsula	68	n/a
Total	242	242

Our data indicates that nearly 250 family consultations were conducted over the two year project period (July 2011-2013). (Readers should bear in mind that practitioners did not receive training until at least two months after the project had commenced and final uptake numbers were supplied well after the active phase of the project concluded. Thus the two year time frame referred to is somewhat misleading.) Table 6 reveals the number of sessions conducted varied by site, with families from the Barwon and Peninsula regions participating in more SSFCs than those in Bendigo and the Mid-West. This may be a reflection of the differences in the numbers of client served and in the demographics of the client group with the Barwon and Peninsula regions including youth teams.

The total number of practitioners trained in SSFC was 82 indicating that overall the mean number of SSFCs conducted by each trained practitioner during the data collection period was 2.95. Once again though, there was variation across sites in the average number of sessions conducted per trained practitioner. Interestingly the two sites with youth teams, Barwon and Peninsula (youth and adult),

differed markedly from the other sites, averaging 6.0 and 2.8 sessions per practitioner respectively compared to Bendigo site (1.8) and Mid West (1.9).

Sites also differed in terms of the proportion of SSFCs conducted relative to the number of invitations made to clients and families. The number of offers was only recorded systematically for two sites. Table 6 shows that 74% of the families and consumers offered SSFC by the Barwon service took up the offer in comparison to only 32% of those invited to participate in the intervention at the Bendigo site.

6.2   Client and Family Feedback - SSFC

As part of the delivery of the intervention, clients and their family members were asked to complete a feedback from at the end of each session. The feedback form included a session rating scale (based on a measure of therapeutic change by (Duncan et al., 2003). Clients and their families were asked to rate a number of characteristics of the session on a visual analogue scale with a numeric range of 1 (representing a negative view) through to 7 (representing a positive view). Feedback on SSFC from clients (n=128) and their family members (n=228) is summarised in the figures below.

6.2.1   Client and Family Feedback

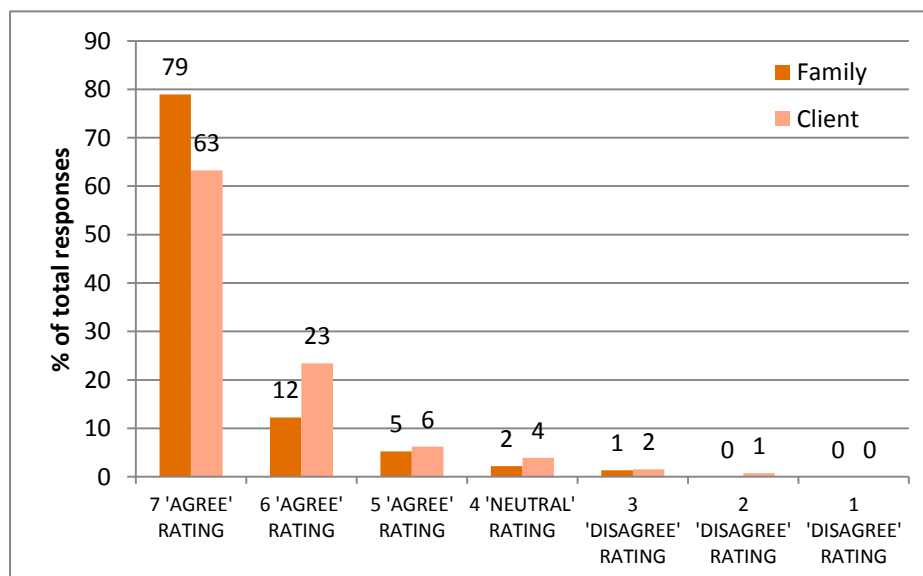#### 6.2.1.1   I felt heard in the session

Figure 3. Client and family ratings (in percentages) regarding feeling heard in the session

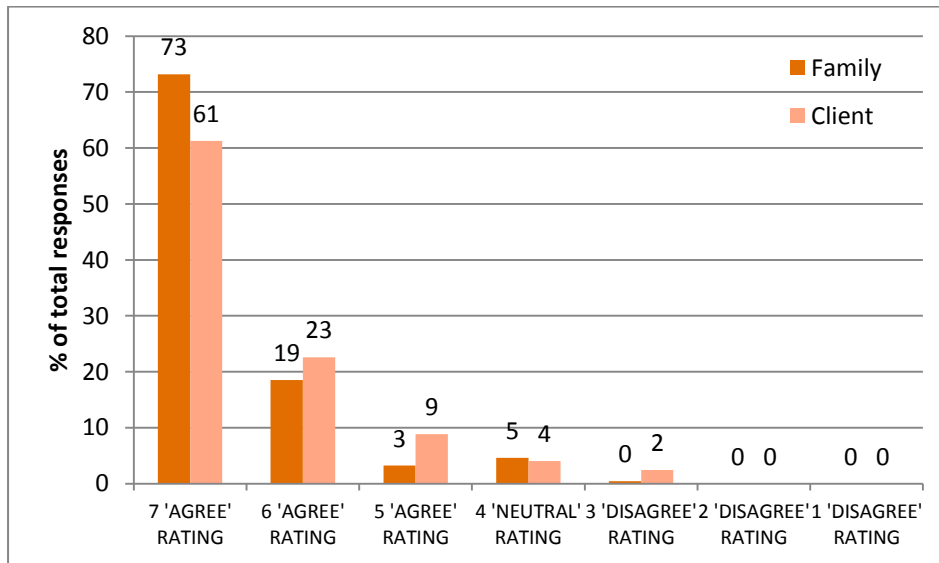## 6.2.1.2 We talked about what I wanted to talk about in the session

Figure 4. Client and family ratings for feeling they talked about what was wanted in the session.
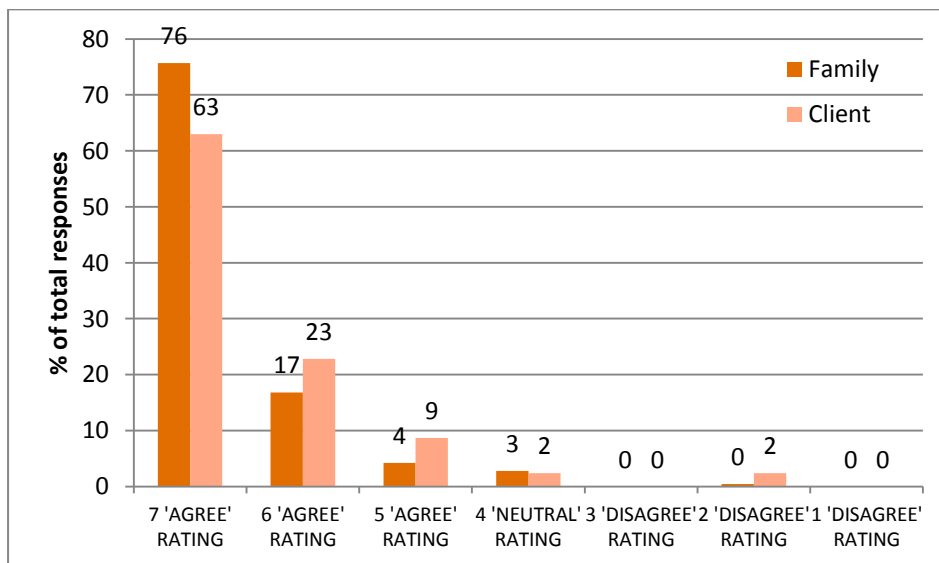
6.2.1.3 The approach was a good fit for me

Figure 5. Client and family ratings for feeling that they approach was a good fit in the session
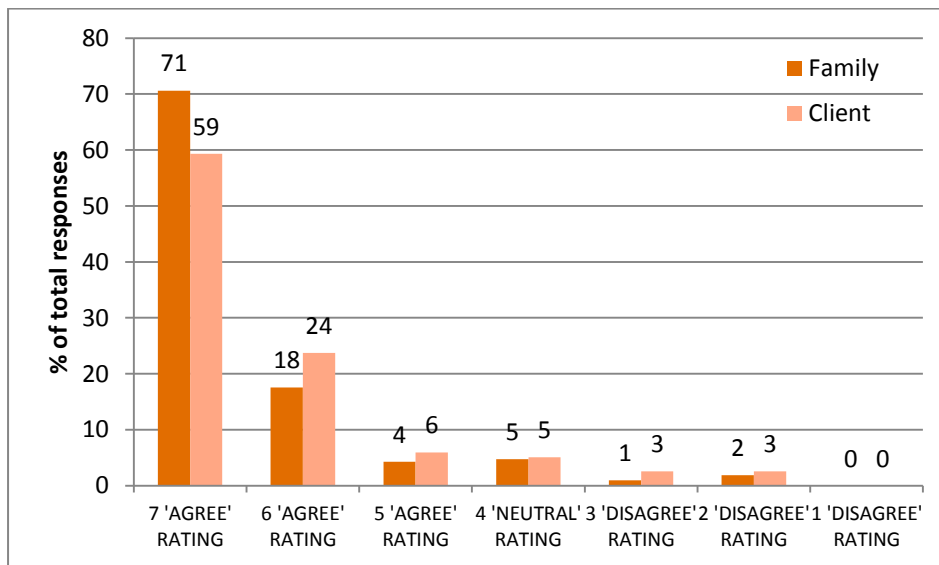
6.2.1.4 The session was helpful

Figure 6. Client and family ratings for feeling that the session was helpful
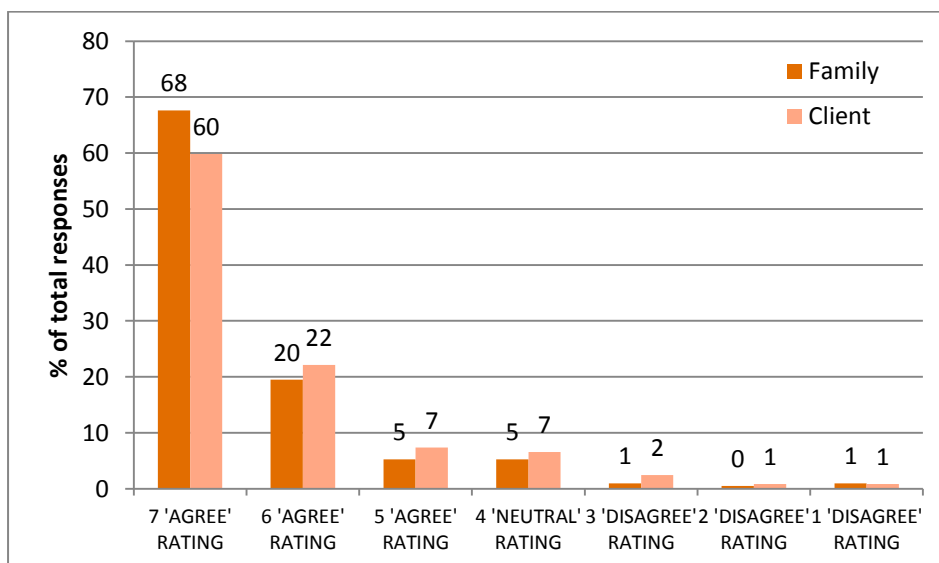
6.2.1.5 The session was right for me

Figure 7. Client and family ratings for feeling that the session was right for them

Taken together, figures 3 to 7 suggest clients and families were highly satisfied with the family consultation sessions delivered by project participants. Over 80% of the clients surveyed reported feeling heard in the session, talking about what they wanted to talk about, that the approach was a good fit for them, the session was helpful, and was right for them. Feedback received from family members was also very positive, with nearly all respondents rating the five components of the session highly. Family members' ratings were on average slightly higher than client ratings.

6.3   Impact on Practitioners

6.3.1   Family focused mental health practice questionnaire

The family focused mental health practice questionnaire (FFMHPQ) was administered to practitioners at the commencement of the training program and again twelve months afterwards. The survey is designed to assess practitioner willingness and capacity to undertake family focused practice as well as perceived organisational supports for this work. It asks respondents to rate a series of statements on a 1 to 7 Likert scale, were 1 equals *Strongly Disagree* and 7 represents *Strongly Agree*.

Twenty-eight SSFC trained practitioners completed both pre and post questionnaires. Pre and post evaluation data was analysed using SPSS for Windows. A mixed design ANOVA was conducted to compare SSFC trained participants' responses to the survey at Time 1 and at Time 2, and to explore how implementation or non-implementation of the intervention moderated responses. The average pre and post ratings obtained from SSFC trained respondents are presented in Figure 8 and Table 7.
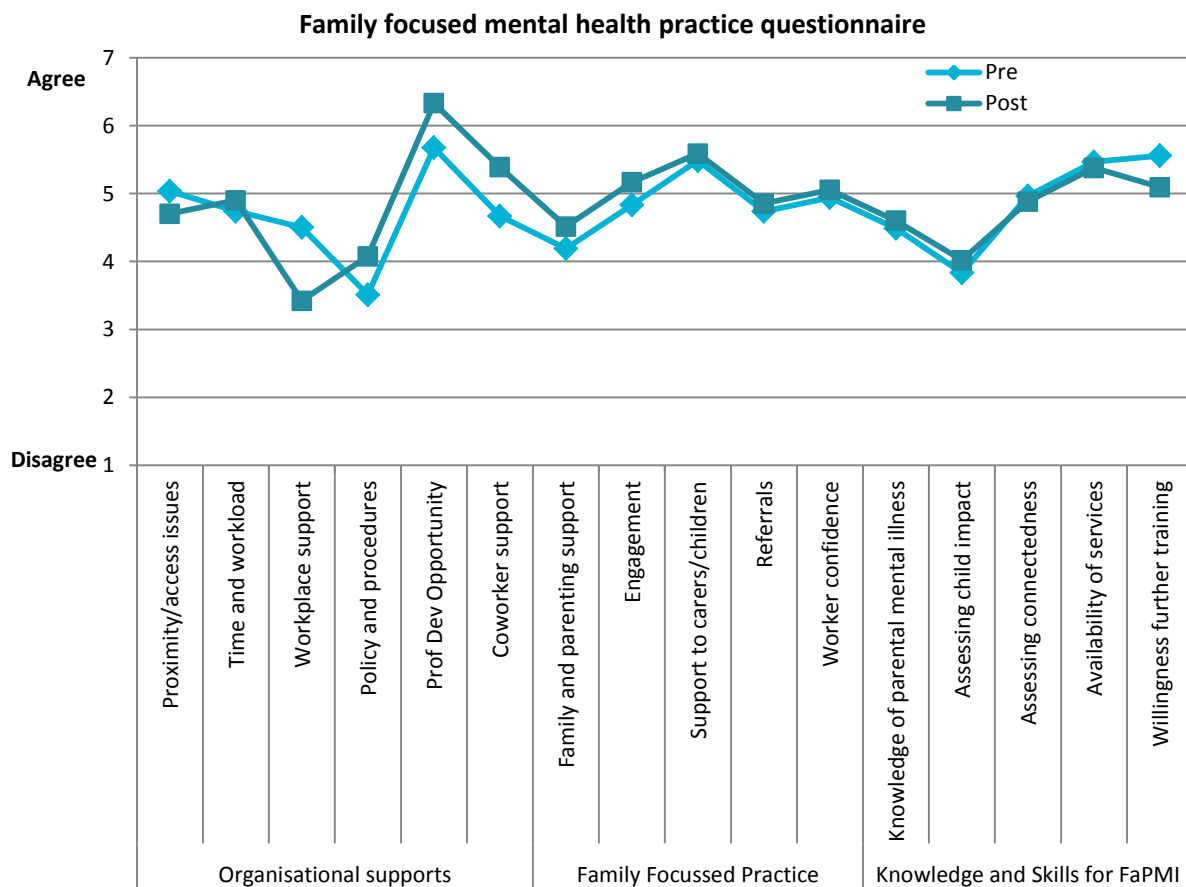

Figure 8. Mean pre-training and 12-month post scores on components of family focused mental health practice survey from SSFC trained practitioners

Table 7. Mean, standard deviation, and p values of ANOVA comparisons of subscale scores

MH Practice Questionnaire	Subscales	Pre mean (standard deviation, n=28)	Post mean (standard deviation, n=28)	Statistical significant difference (2x2 Mixed design ANOVA)
Organisational supports	Proximity/access issues	5.04 (1.27)	4.70 (1.16)	
	Time and workload	4.74 (1.03)	4.90 (1.20)	
	Workplace support	**4.50 (1.44)**	**3.42 (1.54)**	p=.024 pre to post diff
	Policy and procedures	3.51 (1.50)	4.08 (0.98)	p=.053 pre to post diff
	Prof Dev Opportunity	**5.68 (1.45)**	**6.33 (0.96)**	p=.018 pre to post diff
	Co-worker support	**4.67 (1.25)**	**5.39 (0.86)**	p=.014 pre to post diff
Family Focussed Practice	**Family and parenting support**	**4.19 (0.98)**	**4.52 (0.83)**	p=.038 pre to post diff
	Engagement	4.83 (0.89)	5.17 (0.93)	p=.099 pre to post diff
	Support to carers/children	5.48 (0.98)	5.59 (0.76)	
	Referrals	**4.74 (1.37)**	**4.85 (0.84)**	p=.003 interaction effect
	Worker confidence	4.94 (1.28)	5.05 (0.99)	
Knowledge and Skills for FaPMI Practice	Knowledge of parental mental illness	4.49 (1.00)	4.60 (0.98)	
	Assessing child impact	3.83 (1.14)	4.02 (1.01)	
	Assessing connectedness	4.97 (0.84)	4.88 (0.74)	
	Availability of services	5.47 (1.11)	5.38 (1.13)	
	Willingness further training	5.56 (0.93)	5.09 (1.10)	p=.064 pre to post diff

Comparisons of overall pre and post responses show mixed results. On average, SSFC trained practitioners' ratings of the clarity of policy and procedures in place at their organisation to support family work, the opportunities available for family work related professional development and the level of support received by co-workers in working with families rose 12 months post training. By contrast, average ratings of the support provided by the workplace dropped significantly over time. Twelve months on, practitioners were also more reluctant to undertake further family focused training – which may be an indication that respondents felt sufficiently confident in their skills and did not require further training or that they needed more time to consolidate their skills before partaking in any further professional development in the area. Practitioners were more likely to perceive families as willing to engage with services and were more inclined to provide family and parenting support at Time 2, suggesting trained practitioners were offering more support for families one year in to *MH Beacon*.

There were few statistically significant differences in the patterns of responses displayed by respondents who implemented SSFC within the 12 months and those who did not. There was one exception - referrals of family members to support services. On average respondents who had not conducted a SSFC session in the twelve months following training were *more likely* to refer family members at Time 2 in comparison to Time 1, whereas respondents who had run at least one session were *less likely* to provide a referral. These results may suggest that SSFC training alone serves to raise awareness of the needs of family members; however, when SSFC is actually put into practice, outside assistance to help meet families' needs may no longer be required.

6.3.2 Family Intervention Schedule

Practitioners were given an adapted version of the Family Intervention Schedule (FIS) to fill out immediately prior to (pre) and 12 months following (post) participation in training. The FIS asks respondents to use a 1 to 5 scale (where 1 represents not at all difficult and 5 represents extremely difficult) to rate the extent to which a series of barriers increase the difficulty associated with working with families, with higher scores representing greater perceived difficulty. Twenty-seven SSFC trained participants completed **both** the pre and post questionnaires. Paired-samples t-tests were conducted to compare overall responses to the survey at Time 1 and at Time 2. Table 8 presents the mean pre- and post-ratings across the 15 barriers.

Table 8. Mean, standard deviation, and p values of paired samples t-test comparisons of perceived barriers to family work

Family Intervention Schedule - Perceived barriers	Pre mean (standard deviation, n=27)	Post mean (standard deviation, n=27)	Statistical significant difference (Paired samples t-test)
Burden of work	2.96 (0.94)	2.63 (1.04)	
Clash of client needs	2.81 (0.83)	2.37 (0.79)	$p < .05$
Keeping discussions on track	2.78 (1.05)	2.08 (0.68)	$p < .001$
Integration of family work with caseload and other responsibilities at work	2.59 (0.93)	2.63 (1.25)	
Allowance of time	2.54 (0.89)	2.26 (0.94)	
Working outside hours	2.53 (1.23)	1.95 (0.52)	$p < .05$
Available families to work with	2.34 (1.00)	2.50 (1.01)	
Lack of familiarity with approach	2.26 (0.98)	1.56 (0.68)	$p < .001$
Concerns about conflict	2.15 (1.06)	1.96 (0.65)	
Anticipating hostility from family members towards worker/service	2.07 (0.83)	1.69 (0.61)	$p < .05$
Non-applicability of approach to client/family need	2.05 (1.06)	1.82 (0.77)	
Lack of confidence	2.04 (0.94)	1.62 (0.68)	$p < .05$
Lack of collaboration work with colleagues	1.57 (0.74)	1.28 (0.44)	$p < .05$
The travel	1.54 (0.69)	1.28 (0.41)	
Lack of manager/colleague support	1.53 (0.92)	1.23 (0.51)	
Total	33.77 (7.27)	28.87 (6.78)	$p < .001$

Inspection of Table 8 reveals several differences in the ratings of barriers to family work over time. Family work clashing with client needs, keeping family discussions on track, having to work outside hours, a lack of familiarity with family approaches, anticipating hostility from families, a lack of confidence and a lack of collaboration for the work from colleagues were on average perceived as less of an impediment to working with families by SSFC trained practitioners at the 12 month follow up. These pre-post differences were statistically significant. By contrast, there was a statistically significant increase in average ratings of the difficulty associated with integrating family work with one's caseload and other responsibilities, and the availability of families. These two barriers, along with the burden of work, were among the top rated barriers to family work at both Times 1 and 2. Taken together, the findings suggest that despite perceiving themselves as being better equipped to work with families and initiating more of this type of work, SSFC trained practitioners continued to struggle somewhat with the integration of family work within current practice, the demands of their workload and finding suitable families to work with.

6.4 How practitioners used the Single Session Family Consultation Model

As part of their completion of the session record forms, practitioners were asked to note what issues clients and their families presented with and to categorise the strategies used in responding to families. A thematic analysis was conducted on the issues that were discussed in each of the sessions (from 145 session record forms) and the 12 major points of discussion are reported in Table 9 below.

Table 9. Topics and issues addressed using the SSFC model

Understanding their family member's diagnosis and condition	Discussing professional and community support options
Improving communication and problem solving within the family	Relapse Prevention: Understanding of the trigger points of illness and what the family can do to help
Plans for particular symptoms of the illness when they emerge	Information about the treatment plan
Planning for discharge from the service	Planning for the transition from supported to independent living
A better understanding of each family member's experience with the illness	A better understanding of each family member's worries and concerns
Understanding the perspectives of the whole family about the impact of illness	Informed on new treatment options/initiatives available

The topics and concerns identified through the analysis suggest that the SSFC sessions were addressing issues relevant to the treatment and care of clients and to the needs of families.

6.4.1 Perceived client and family barriers to engagement in SSFC

As was evident in the uptake data, not all clients or family members offered a SSFC were willing to participate in sessions. Practitioners recorded the reasons that SSFCs were declined on log sheets while project champions and management sponsors also expressed their views about the circumstances under which the offer of an SSFC appointment was refused.

6.4.1.1 SSFC Log Sheet Data

The most common reasons cited by clients for declining SSFC as noted by practitioners in their client logs were as follows:

- Already involved in therapy for family relationship issues
- Relationship with family too fractured
- Family not living close by
- Client believes family member would not be interested/willing to come
- Client feels over-serviced/therapized
- Children of client declining
- Not identified as a need as supportive relationships exist outside family
- Unstable mental health or not articulating a reason

6.4.1.2 Interviews with champions and management sponsors

Interviews with project champions and managers suggest differences in client demographics influenced receptivity to SSFC. Those reported as *harder* to engage in SSFC included the following groups:

Existing clients

"The existing clients often didn't want the family involved – they knew this process was something new and therefore optional to them."

This suggests that for existing clients the option of participating in a SSFC was seen as additional and optional in contrast to new clients who may have seen SSFC as part of usual practice and were therefore less likely to decline participation.

Clients living in rural regions

"As a regionally based service, a lot of our clients had no families in the area (which we didn't know until this project). About 40% of the people that declined had no family in the area."

The acute context

"The use in CATT/acute area was more challenging – it was time limiting, of a short duration and it is acute care so the clients were very unwell. Some consideration needs to be made to see how best to make family consultation work in that setting."

Adult versus youth clients

"..They tended to want the support and were willing to try new things. Might be because they are young and want to repair those relationships, whereas adult clients may be thinking that the damage is done over the last five or ten years, and can't really repair it so they are not interested. These are young adults who want to better their relationships and develop their skills, they help bring family members in and learn about the program."

However engagement of the client base was also heavily dependent on the understanding of the SSFC model, which included both how the practitioner would explain the model and how the family and client came to understand what the family consultation was actually about.

"Also remembering that it's what they need to call it as well – families who have had some pre family work done would say 'they've already had a family meeting and we speak to you on the phone, so why do we need that'. Family consultation was presented as a formal family meeting and sometimes families would think that we already get that, so they would decline another one. That was the message to families rather than it being explained as an intervention for the client and this is about talking with the client about what might be helpful to talk about with your family."

6.5   Impact of SSFC on the service

As part of the interviews with project champions and managers, participants were asked to reflect on the impact of each of the interventions on organisational processes. They were also asked to consider what changes needed to be made to procedures and policies to support the implementation of family interventions in the service. Themes from these interviews are presented below.

6.5.1 Changes to service operation

Several organisational systems and processes were modified to accommodate the implementation of SSFC locally at each service. These included:

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- The provision of client and family education – development of a brochure explaining SSFC as 'Get Togethers'
- Changes to intake processes to offer SSFC early in the clients contact with the service
- Embedding SSFC check-ins at team meetings to monitor practitioner's uptake and encourage continued use of the practice – featured as a regular agenda item
- Monitoring use of SSFC was incorporated within line supervision
- Incorporating information about SSFC (PowerPoint adapted from the training) during staff orientation processes
- Intake and assessment protocols modified to involve families and explain about SSFC at the beginning of a client's engagement with the service

6.5.2 Uptake of SSFC by practitioners

During the interviews, project champions and managers indicated that several practitioner characteristics influenced adoption of SSFC. Practitioner-level factors that facilitated or hampered/slowed implementation are discussed below.

6.5.2.1 Early adopters: 'Some practitioners just ran with it'

Project champions and management sponsors observed that early adopters of SSFC were in general more willing to try new things and were flexible. Some further added that this openness to new experiences was not modified by age, experience or professional background.

> *"In our team I would say there was an overwhelming enthusiasm for it, but then I suppose the uptake was interesting – there were clinicians that picked it up and ran with it immediately and had an easier time running with it than others, and I don't know that it was that there was any less enthusiasm or acknowledgement that it was a good idea or a good therapy, I think it was more that it's something new and that it's that some clinicians just have a little more sense of capacity to be flexible and change to take on new things…"*

> *"It wasn't about age or experience, and I couldn't see any discipline related effect in my team – but the allied health staff did pick it up a bit more easily in the adult team. Perhaps it was just more around adjusting to a new style of approaching a very key therapeutic intervention and it being prioritised early on in the clients journey with us, and I think the clinician's confidence and capacity to take that on is just different based on their own personality styles and capacity to cope with change."*

6.5.2.2 Later adopters - 'Some practitioners took a while to get going'

. Practitioners were often quite hesitant to put their training into practice and conduct an SSFC session. Practitioner anxiety about conducting SSFC was expressed in a number of different ways.

> *"There was also a fear at the personal clinician level – it's not our job, it can open a can of worms or thinking that clients and families will say no."*

Uncertainty in practitioners minds about how they were meant to practice under the framework of an SSFC and the applicability of the model to different client circumstances were also constraining factors in adoption.

> *It was confusing at first – not sure what it is was – therapy or mediation – and we had difficulty training staff. Some workers didn't implement the model appropriately after training – didn't follow the steps or the preparation processes. Other people found it scary and didn't want to use it when there might have been other things going on.*

Similarly, while practitioner discipline background did not seem to be related directly to willingness to use the model, there were some differences in how practitioners from different disciplines operationalised the model.

> *Each of the four disciplines approached the training differently as they have different background training in how to approach and work with families. Some did use some of the ways they work in how they implemented the model and didn't implement the model as completely as you would if you were just implementing this model.*

There was recognition that some practitioners simply needed more time to take on a new practice. Co-working appeared to be important in supporting cautious practitioners to undertake SSFC.

> *"…it just takes some time to get used to something new and put themselves out there."*

> *"We tried to pick those ones up by encouraging the joint work with the champions. And not even with their own clients – just to get some exposure."*

6.5.2.3 Workload getting in the way

Project champions and managers noted that when there were other pressing work demands, practitioners tended to revert to a focus on their core role to the exclusion of practices such as SSFC.

> *"People were really busy – there were group programs to run, a reduction in staff, staff who had too many demands with their client load and they just shut down to basics."*

Some practitioners had difficulty negotiating the challenges associated with having to change their practice and some also found it difficult to see the value of the approach for particular types of clients.

> *"It can be about the process of change, or introducing slightly different ways of approaching clients and their clinical care that's a challenge, others that are just too old maybe, or they felt that their client group were so chronic or old that there was no family around and that there wouldn't be much point. I think in all those instances there could be challenges to that."*

7   Uptake and Impacts – Let's Talk About Children

7.1   Uptake of Let's Talk

The two participating Let's Talk Beacon sites recorded the number of Let's Talk consultations delivered from July 2011 until July 2013. Table 5 presents the final numbers by site.

Table 10. Number of Let's Talk sessions conducted at each site and number of parent-clients (families) seen.

Sites	Number of families that received LT	Number of LT sessions conducted	Number of clients who declined LT
Northern Area Mental Health Service & NEAMI	27	81	Neami: 14 declined out of 32 offers
Eastern Health Adult Mental Health Service	10	30	N/A
Total	**37**	**111**	

A total of 111 Let's Talk sessions were delivered across the two sites, with the 69 practitioners trained in the approach each conducting an average of 1.6 sessions during the two years.   As with SSFC, uptake varied across the sites with the 48 trained practitioners from the Northern partnership running slightly more sessions on average than their counterpart in Eastern ADMH ($\underline{n}$=21; *Northern* $\underline{M}$=1.7 per practitioner; *Eastern* $\underline{M}$=1.4 per practitioner). These figures are misleading though as uptake was mainly limited to project champions – i.e., project champions delivered the majority of Let's Talk consults. While the implementation of Let's Talk at Neami (a partner at the Northern site) was sluggish at the beginning of the roll-out, use of the intervention became more widespread within the teams at later stages of the project.

7.2   Client Feedback - Let's Talk

 As with families participating in SSFC, parent-clients who received the Let's Talk intervention completed a feedback form at the end of each session. The form is based on a measure of therapeutic change by Duncan et al. (2003) and asks respondents to rate various aspects of the session using a visual analogue scale with a numeric range of 1 to 7 (where 1 = strongly disagree and 7 = strongly

agree). Twenty three feedback forms were received from parent-clients. The data is summarised below.
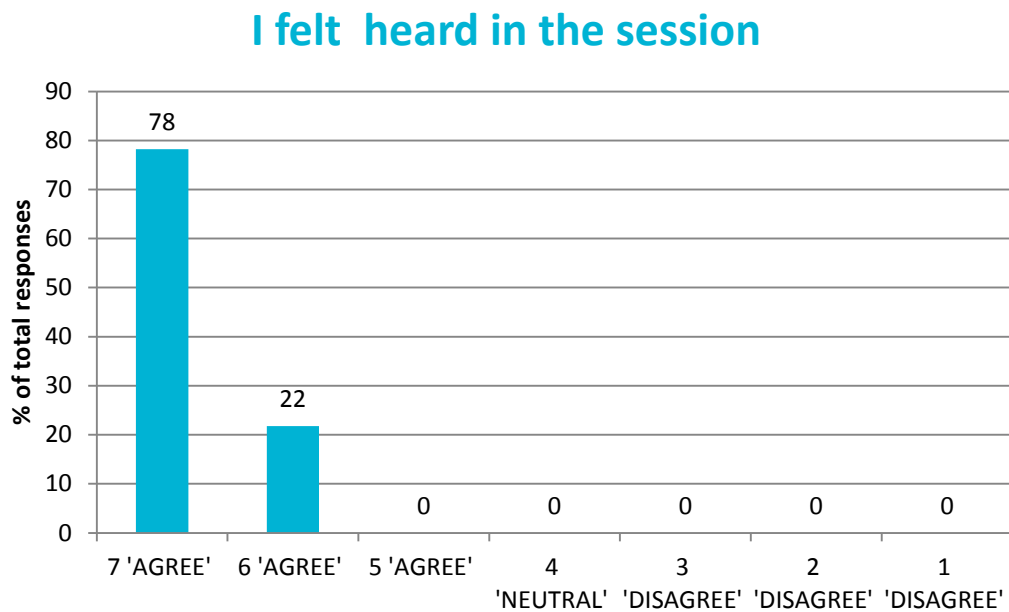
I felt heard in the session

Figure 9. Client ratings for feeling heard in the session

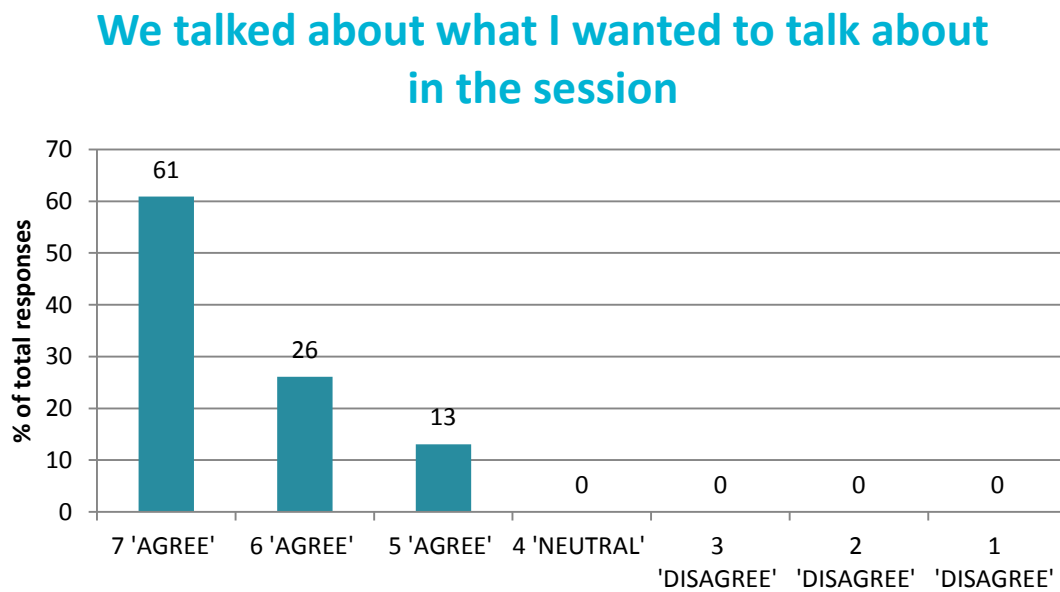## We talked about what I wanted to talk about in the session

Figure 10. Client ratings for feeling they talked about what was wanted in the session
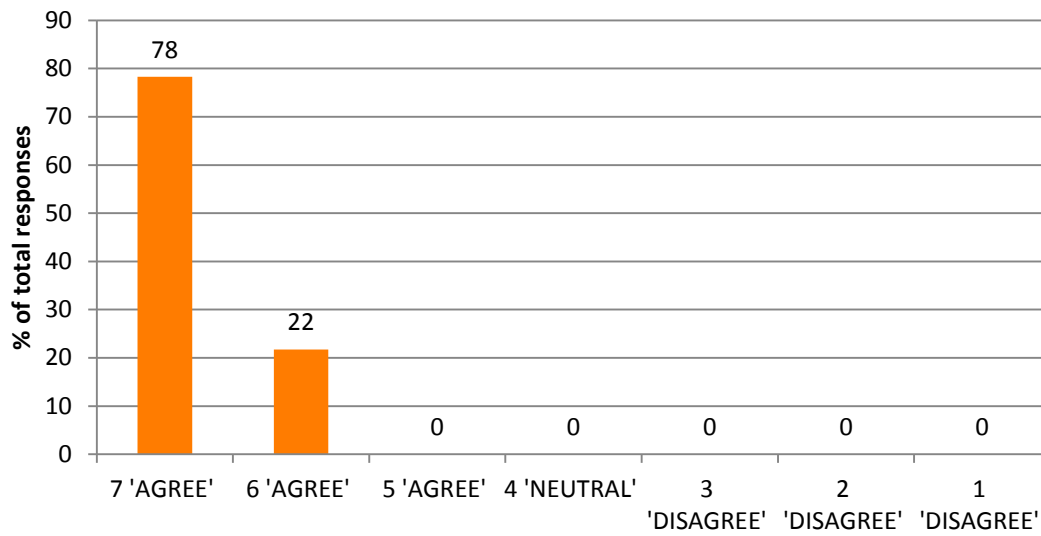
The approach was a good fit for me

Figure 11. Client ratings for feeling that they approach was a good fit in the session
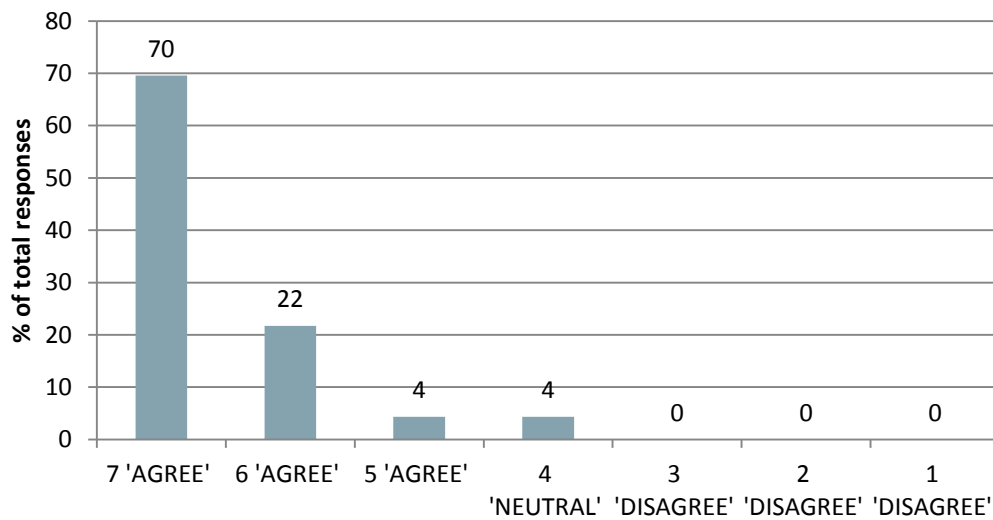
The session was helpful

Figure 12. Client ratings for feeling that the session was helpful
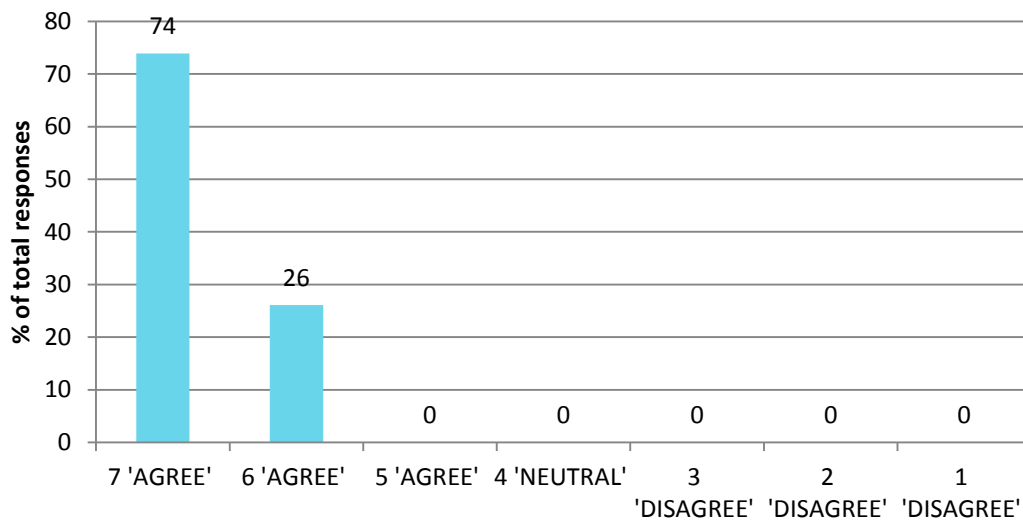
41

The session was right for me

Figure 13. Client ratings for feeling that the session was right for them

Figures 9 through 13 suggest that the parent-clients surveyed were highly satisfied with Let's Talk. Several aspects of the sessions were assigned high ratings by all respondents including feeling heard in the sessions, the approach being a good fit, and the session being right for them. Talking about what they wanted to talk about and the helpfulness of the sessions were rated slightly lower, but overall the feedback was still very positive. It may be that certain components of the Let's Talk program do not offer much flexibility for clients to focus on their primary concerns which may account for these lower scores. For example Discussion One comprises completion of the developmental log, which is a highly structured list of questions.

7.3 Impact on practitioners

7.3.1 Family focused mental health practice questionnaire

Similar to family consultation, Let's Talk trained practitioners and project champions completed questionnaires on family focused practices (family focused mental health practice questionnaire-FFMHPQ) to explore the impact of participation in the strategy on workforce capacity. The survey, which measures perceived skills, knowledge, attitudes and willingness to undertake family focused practice, was administered immediately prior to the training (pre) and 12 months afterwards (post). Thirty-five Let's Talk trained practitioners from NAMHS, Neami and Eastern Health Mental Health Service completed both pre and post questionnaires. Two mixed design ANOVAs were performed to explore the overall effects of the supported implementation strategy and whether these were moderated by: practitioner parental status and whether respondents had conducted at least one LT

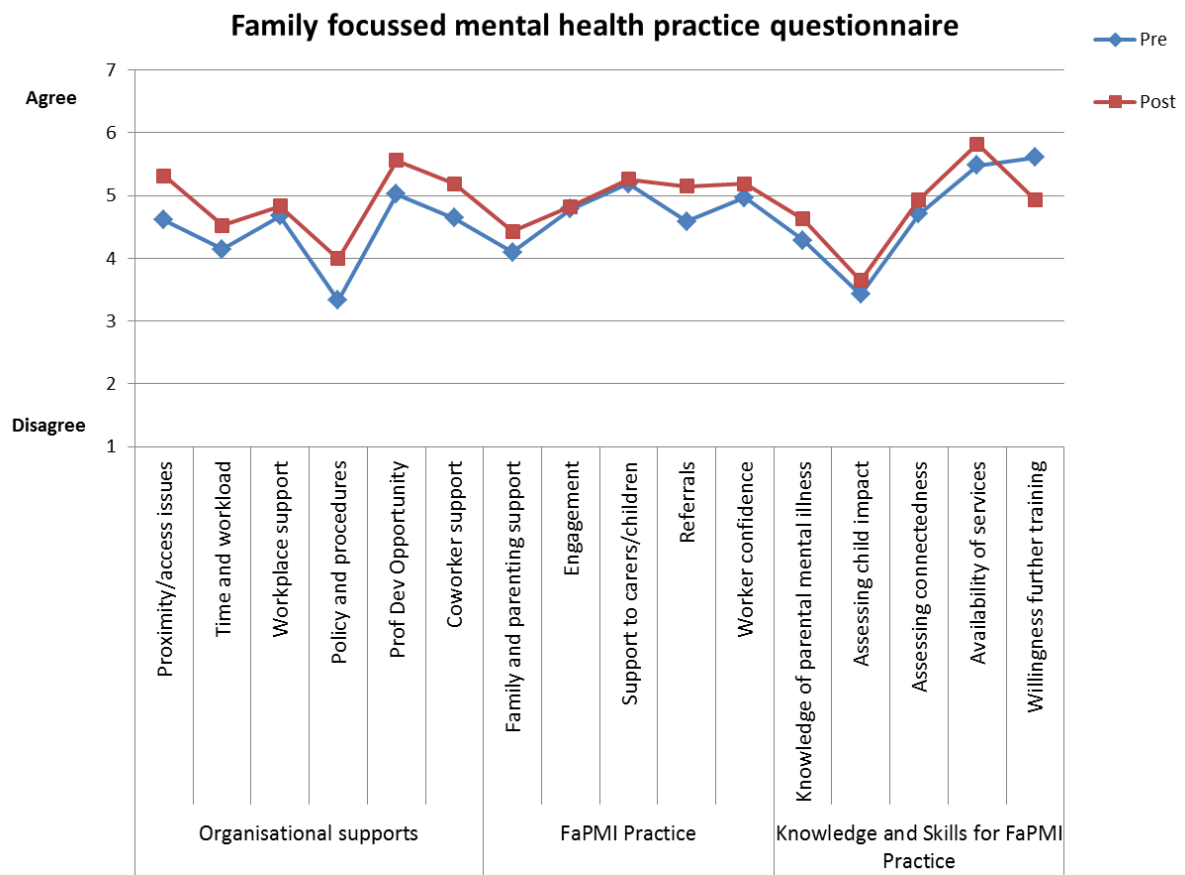session within the two year period. The results are presented in Figure 14below and Table 11 on the following page.

Figure 14. Mean pre-training and 12-month post scores on components of family focused mental health practice from Let's Talk trained practitioners

Table 11. Mean, standard deviation, and p values of ANOVA comparisons of subscale scores

MH Practice Questionnaire	Subscales	Pre mean (standard deviation, n=35)	Post mean (standard deviation, n=35)	Statistical significant difference (2x2x2 Mixed design ANOVA)
Organisational supports	Proximity/access issues	4.61 (0.99)	5.31 (1.06)	p=.000 pre to post diff
	Time and workload	4.14 (1.08)	4.52 (1.21)	
	Workplace support	4.67 (1.36)	4.83 (1.84)	
	Policy and procedures	3.33 (0.91)	3.99 (1.15)	p=.008 pre to post diff
	Prof Dev Opportunity	5.02 (1.25)	5.56 (1.23)	
	Co-worker support	4.64 (0.93)	5.19 (1.33)	p=.008 pre to post diff
Family Focussed Practice	Family and parenting support	4.10 (0.82)	4.43 (0.84)	p=.011 pre to post diff
	Engagement	4.79 (0.48)	4.82 (1.17)	
	Support to carers/children	5.19 (1.07)	5.26 (1.21)	
	Referrals	4.59 (0.93)	5.15 (0.87)	p=.005) pre to post diff
	Worker confidence	4.96 (0.92)	5.18 (1.30)	
Knowledge and Skills for FaPMI Practice	Knowledge of parental mental illness	4.29 (0.81)	4.63 (0.84)	p=.021 pre to post diff
	Assessing child impact	3.43 (1.17)	3.65 (0.96)	
	Assessing connectedness	4.71 (0.74)	4.94 (0.90)	
	Availability of services	5.48 (0.82)	5.82 (0.97)	
	Willingness further training	5.61 (0.69)	4.93 (0.99)	p=.064 pre to post diff

- Bold indicates a statistical significant difference pre to post the Let's Talk training.

Figure 14 and Table 11 indicate that Let's Talk trained practitioners' perceptions of the amount of organisational support available for family work were more favourable post training, with the exception of 'workplace support' which remained constant over time. In particular, the results suggest that access issues formed less of a barrier to family focused practice 12 months in to the project and that at the time of follow up, amendments had been made to policy and procedures and collegiate support had increased encouraging more family friendly practice.

Comparison of Let's Talk respondents' pre-post ratings also point to practitioner-level changes that occurred. According to the results, Let's Talk trained participants made significant gains in their knowledge of parental mental illness 12 months after training. Perhaps not surprisingly, the perceived need for further training in family focused practice had also reduced significantly at this point, suggesting that the training and support received as part of *MH Beacon* had sufficiently addressed respondents' professional development needs in relation to family focused practice.

The results also indicated a significant shift in FaPMI Practices in the area of the 'provision of family and parenting support' and in 'referring family members to support services' from Time 1 to Time 2, suggesting that training in Let's Talk increased family work and increased the provision of avenues of support for family members through referrals to support services.

Subsequent analysis suggests differences between pre and post survey responses may have been influenced by respondents' parenting status and whether or not the intervention had been put into practice within the specified time period. Twenty of the 35 Let's Talk trained survey respondents were parents prior to completing the survey. Sixteen conducted at least one Let's Talk session during the 12 months after training; 19 did not. Figures 15 and 16 below present the average subscale scores by parenting and implementation status.
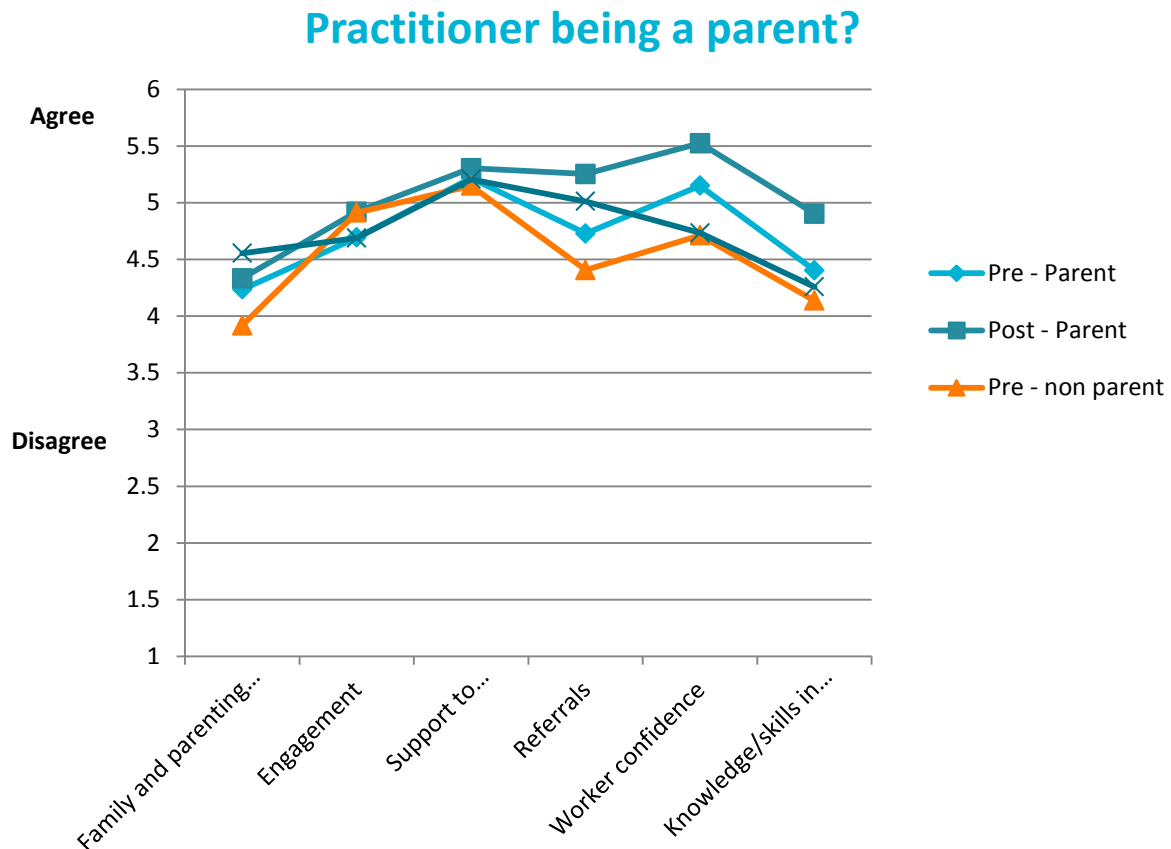
Practitioner being a parent?

Figure 15. Mean pre-training and 12-month post scores on components of family focused mental health practice from LT trained practitioners according to parental status

Unsurprisingly, from the outset practitioners who were parents prior to the training tended to rate themselves as more confident, knowledgeable and skilled in working with parent-clients affected by mental illness in comparison to non-parents**.**   Parent-workers also reported experiencing greater improvements on average in these domains than non-parent workers 12 months following participation in Let's Talk training. Ratings of the amount of family and parenting support offered by *non-parents* rose significantly from Time 1 to Time 2, suggesting respondents who were not parents at Time 1 made bigger shifts in their practice than parent workers. These results, although preliminary given the small sample size, indicate that parenting status may influence the response of the worker post training. We are keen to follow this up in future research.

Interestingly none of the perceived organisational support subscales were influenced by the parental status of the worker.
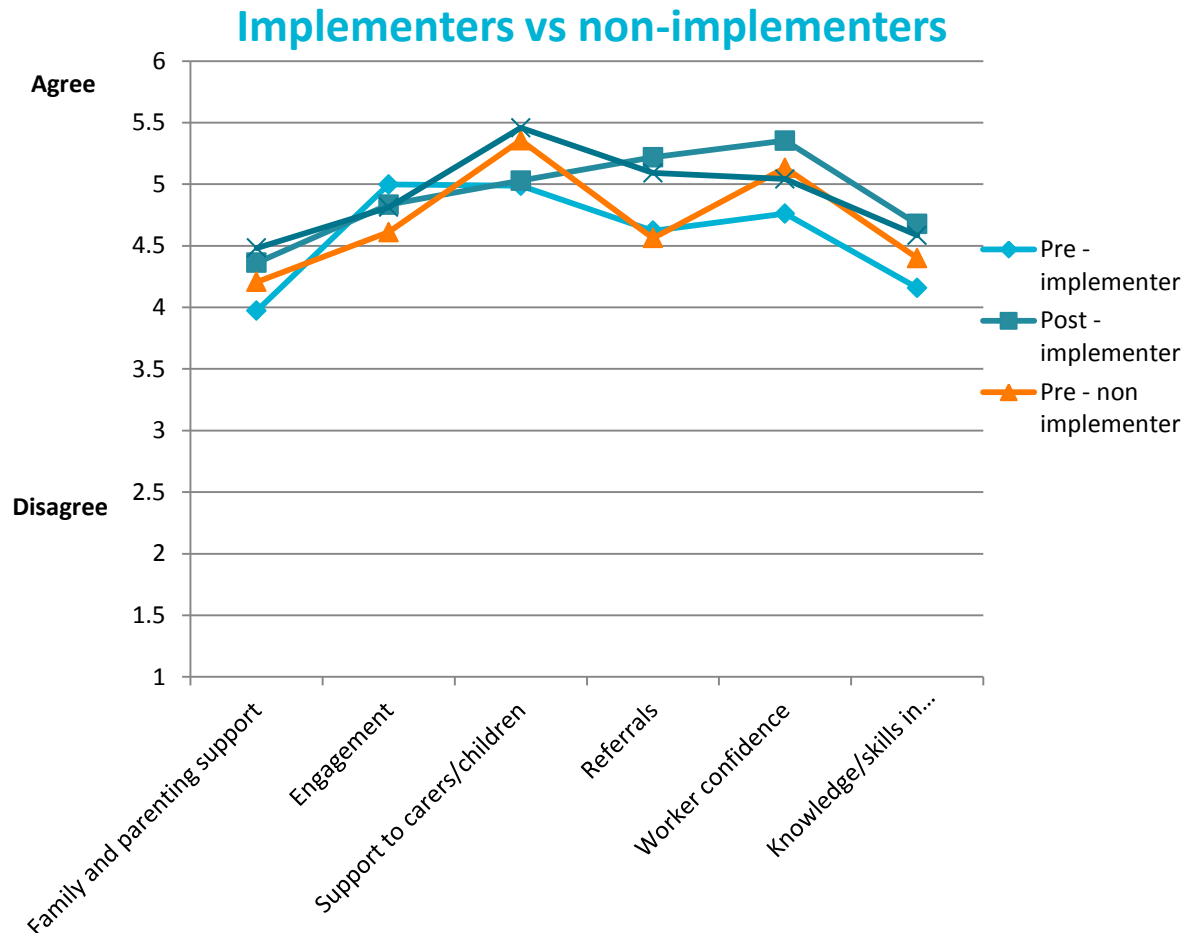
Figure 16. Mean pre-training and 12-month post scores on components of family focused mental health practice from LT trained practitioners according to implementation of LT into practice.

Not all of those trained in Let's Talk implemented the intervention by the 12 month mark. Interestingly those that went on to conduct at least one Let's Talk session in the 12 months following training had higher baseline ratings re: families perceived willingness to engage, and lower baseline ratings of their confidence, knowledge and skills about working with parent clients affected by mental illness in comparison to practitioners who were yet to conduct at session at the 12 month follow up. Thus *implementers* were more open to family engagement but did not rate themselves as having as much confidence or knowledge/skills.

Interestingly, implementers showed the biggest shift in confidence from pre to post. It may be that putting an intervention like Let's Talk into practice is the key ingredient to boosting confidence in working directly with parent clients and their families. This fits with informal reports from practitioners that once a practitioner has completed a Let's Talk one they wanted to do another.

Alternatively, supporting practitioners to implement Let's Talk might be particularly beneficial for workers lacking in confidence and skills in working with families.

Overall there was also a significant increase in referrals, family and parenting support and knowledge and skills for both groups. This indicates that a change in practice occurred post training regardless of whether practitioners had conducted a LT session or not at the time of follow up. This suggests that training itself created 'awareness and spurred increased family-focused practice'. This would fit with reports of an increase in local Parents and Playgroup referrals.

7.3.2 Family Intervention Schedule

Along with their SSFC trained colleagues, Let's Talk trained practitioners were also asked to complete an adapted version of the Family Intervention Schedule (FIS) on two occasions - prior to training (pre) and 12 months afterwards (post). The FIS asks mental health workers to rate the extent to which a number of different known barriers present difficulty for them in their work with families. Barriers are rated from 1-5 with 1 representing not at all difficult and 5 representing extremely difficult. Hence a higher represents greater perceived difficulty. Completed pre to post data was obtained from 43 practitioners. This data was analysed using a series of paired t-tests. The means and standard deviations are presented in Table 12 on the following page.

Table 12. Mean, standard deviation, and p values of paired samples t-test comparisons of perceived barriers to family work

Family Intervention Schedule - Perceived barriers	Pre mean (standard deviation, n=43)	Post mean (standard deviation, n=43)	Statistical significant difference (Paired samples t-test)
Burden of work	3.38 (1.03)	3.60 (1.04)	
Clash of client needs	2.94 (0.89)	3.08 (1.06)	
Keeping discussions on track	2.34 (0.63)	2.34 (0.68)	
Caseload/other responsibilities	3.37 (0.95)	3.53 (1.09)	
Allowance of time	3.29 (0.92)	2.98 (1.28)	
Working outside hours	3.40 (0.82)	2.69 (1.28)	$p < .01$
Available families to work with	2.34 (0.91)	2.69 (0.98)	$p < .05$
Lack of familiarity with approach	2.22 (0.80)	2.39 (1.04)	
Concerns about conflict	2.19 (0.76)	2.03 (0.83)	
Anticipating hostility from family members towards worker/service	1.88 (0.68)	1.69 (0.73)	
Non-applicability of approach to client/family need	2.17 (0.64)	2.22 (1.00)	
Lack of confidence	2.20 (0.82)	2.08 (1.01)	
Lack of collaboration work with colleagues	1.70 (0.71)	1.74 (0.87)	
The travel	1.94 (0.83)	1.75 (0.94)	
Lack of manager/colleague support	1.87 (0.97)	1.72 (1.05)	
Total	**37.23 (6.97)**	**36.51 (8.74)**	

In contrast to SSFC, the mean ratings assigned to the 15 barriers by Let's Talk trained practitioners at Time 1 ($\underline{M}$=37.23) versus those assigned at Time 2 ($\underline{M}$=36.51) did not differ at statistically significant level. The only statistically significant *improvement* observed was with respect to the difficulty associated with working outside of hours. On average, this was perceived by LT trained practitioners as posing less difficulty 12 months after training; which is to be expected given Let's Talk is designed to be conducted with existing clients during scheduled sessions.

Working outside hours, caseload responsibilities and the burden of the work were the most frequently endorsed barriers to working with families prior to the training, with average ratings of the difficulty associated with the former two barriers actually increasing slightly in the 12 months following training (although these pre to post differences in average scores were not statistically significant). A lack of available families to work with tended to be perceived on average as more of a barrier 12 months on. Taken together, these results may suggest that much of the difficulty in putting Let's Talk into practice was perceived by practitioners as the result of factors largely out of their control.

7.3.3 Common characteristics of practitioners that implemented Let's Talk

Analysis of the interview data, in particular project champions' and managers' observations of practitioners' responses to the implementation of Let's Talk, pointed to a number of key characteristics shared by practitioners who managed to conduct a Let's Talk session in the 12 months following training. These included:

- Experience in other therapeutic modalities in addition to case management experience/skills

- Some exposure to other FaPMI/COPMI programs within the service

- Some experience as a parent

- Eagerness to offer Let's Talk to clients

- A familiarity with sharing/reflecting on their practice with peers

- A willingness to sit with and hold risk and vulnerability without trying to 'fix or refer'

7.4 *Impact of Let's Talk on the service*

A number of organisational systems and processes were modified to accommodate the implementation of Let's Talk. These included the establishment of targeted practice supervision structures accommodated within organisational teams of trained Let's Talk practitioners and also inter-agency supervision sessions with clinical and non-clinical PDRSS services. This was in addition to

monthly group supervision for champions. There was also an expansion of champions at the sites, with one organisation ensuring there was a local champion embedded within each location site of the service. Training and orientation to Let's Talk was also conducted with other key nursing educators, with the view to incorporating Let's Talk training within existing training programs within the organisation.

The promotion of consumer involvement and advocacy also developed through the involvement of consumers in Let's Talk training at each of the participating sites. In light of the success of consumer involvement, one site has gained organisational support to further develop existing Peer Support initiatives/programs in the future.

The NAMHS/Neami inter-agency collaboration also resulted in a number of outcomes. As part of their joint involvement in *MH Beacon*, a sense of mutual accountability and shared responsibility at multiple levels of the organisation (senior, team, practitioner) developed. As a result, there was a secondary outcome related to an increased understanding of shared and differing perspectives and approaches to working with parents with mental illness between the two services.

Another key outcome at one of the sites was the establishment of formal documentation and practice guidelines and protocols to embed Let's Talk as a required procedure. As part of this development, Let's Talk at Eastern Health Mental Health Service is now an opt-out intervention that will be offered to all parent-clients with dependent children attending the service.

7.4.1 Barriers and enablers

Interviews with Let's Talk project champions and managers highlighted a number of barriers and enablers for the implementation of the Let's Talk intervention. The main themes are highlighted below.

7.4.1.1 Intervention not seen to fit with core practice

A key barrier to implementing the model was a 'perceived' lack of fit of Let's Talk with the role of the mental health practitioner. A key learning for sites was realising that it was important to listen and validate these concerns, while at the same time, change agents would do well to provide convincing reasons for why the work is important - in highlighting the need, value, importance and versatility of Let's Talk within the constraints of the mental health system. For example, a project champion at one site talked about how it was possible to be also monitoring a client's mental state whilst you were completing the developmental log that constitutes discussion 1 of the intervention. Another project

champion explained how it was a positive experience for her client that the outcome of Let's Talk was an admission to a mother-baby unit.

> *"Let's Talk was important for one of my clients, as it led to the involvement of the maternal child health nurse and admission to a mother baby unit, after becoming aware of particular assistance needed by the Mum in her interactions with her baby."*

7.4.1.2   Perceived tensions of the applicability of the model

Practitioners often struggled with the applicability of the model. Common issues included waiting for the client to be *ready* to do the intervention, seeing the program more suited to clients who were in later stages of their care with the service, in more of a stage of recovery rather than early on in their engagement with the service or in an acute stage of the illness. It was often the case that crisis management would interfere with the implementation of the intervention.

> *"The client can still be in crisis but they need to have stability in their living situation with housing etc. It is important that the client is not combating other pressing priorities. It is important that parenting issues are at the forefront, that the client is engaged in addressing their parenting concerns and see it as a priority."*

There were also tensions arising from the compatibility of the style of working that the practitioner preferred with that required by Let's Talk. Common issues were either with the more structured component of the intervention (the development log in discussion 1) for more narrative *therapeutic styles* or with the less structured and conversational component (discussion two) for practitioners who wanted more guidance in how to have conversations about the impact of mental illness on parenting and child well-being with their client.

Finally there was also a perceived issue around the appropriateness of mental health practitioners delivering what might be considered an intervention more appropriately delivered by a *specialist* within the team. Whilst there was an identified need for the work, some practitioners feel it is better suited to a specialist team of practitioners who are specifically allocated and supported by the organisation in this type of work.

7.4.1.3   A research agenda

While the research agenda attached to the Let's Talk Controlled Trial created a drive for the intervention to be implemented by practitioners, it was asserted by some management sponsors and project champions that once the research-driven uptake targets were reached, the practice, in some cases, ceased to be offered. So while the research agenda creates an environment for practicing new

approaches, it may not in itself embed sustained systemic practice change. In response to this, one site (Eastern Health) went on to develop a practice guideline for Let's Talk, endorsed by the organisation, to promote the work across the rest of the service and to support sustained and on-going practice change across the organisation.

7.4.1.4 Enabling a therapeutic approach to clients

Project champions talked of the importance of Let's Talk in providing an opportunity for practitioners in mental health services to do some therapeutic work, as opposed to limited opportunities to that type of work within a case management model.

> *It was doing things differently – it was not driven by the medical model, and allows the mental health system to be validating of a broader view of the client, and of health and wellbeing….It was a move away from just a focus on the absence of symptoms, to be mindful of the client as a parent, and to be more holistic. But it is different because LT is allowing the system to support a parenting role in clients, and that it is a part of my clinical role, not something extra I have to do.*

8   Uptake and Impact – MFG and BFT

No formal outcome measures were used to assess the impact of the MFG and BFT. However uptake of the two interventions was tracked by each site and project champions and managers were asked to comment on the implementation of MFG and BFT in semi-structured interviews.

8.1   Multiple Family Groups

There were mixed results across the two sites trained and supported to implement the Multiple Family Group intervention. Whilst both sites succeeded in forming an MFG in their respective services 12 months following the initial training, the Bendigo group disbanded soon after the delivery of the educational workshop component of the intervention due to low numbers. The group was already quite small at the time of commencement and its composition diverse. (Participants in a MFG typically tend to share similar diagnoses. However, this was not the case for the Bendigo MFG. Different diagnoses created divergent needs and less than full engagement in the group process.) Furthermore, there were a number of other groups programs running at the agency when MFG was introduced which interfered with recruitment.

The Barwon MFG attracted a small group of families in a short period of time, which contrasts with the experience of sites in the Inner West and Northern AMHS where recruitment has been a protracted process. This is especially significant given concerns expressed by practitioners within the service that families of young people with emerging psychotic illnesses might not want to participate in a six month long group because of their hope that their relative would recover and not require ongoing treatment. This is a significant achievement given the challenges of recruiting families to these groups.

8.2   Behavioural Family Therapy

Behavioural Family Therapy showed a similarly slow uptake to MFG. Despite providing these sites with additional input, the rate of uptake remained so low at the point of the project closing, that the attempt to establish BFT at these sites could only be viewed as unsuccessful. In each of the two sites where practitioners were trained in BFT, champions reported feeling the additional model was competing with the implementation and practice change initiatives for SSFC. There was some success in implementing BFT later in the last stages of the project at Peninsula Health. In addition practitioners saw the BFT model as beneficial for families and incorporated elements of BFT such as information sharing and communications skills within SSFC.

9   Evaluating the Mental Health Beacon Implementation Strategy

9.1   Manager and Project Champion Perspectives

Views on the implementation strategy were sought from management sponsors and project champions from each of the sites in the semi-structured interviews conducted following the cessation of the two year project.

9.1.1   What worked well?

9.1.1.1   The role of champions

The champion's role was viewed as very important in the practice change process. Their encouragement of the work with their peers was considered to be vital to supporting change and in maintaining momentum of the practice change.

> "I really like the use of the champions. They are at the coal face in terms of change management."

> "On-going reminders from champions were important too to continue that momentum in the service. The champions created ways to do the work and facilitated reminders."

9.1.1.2   Working with The Bouverie Centre

The Bouverie Centre with its specialised knowledge of family interventions and implementation were perceived as bringing credibility to the project. Sponsors and champions believed that The Bouverie Centre provided the rationale and the evidence of the need for change that otherwise would have to be generated by the service internally.

> Because it was done with Bouverie, there was a bit of credibility to it, there was a good research background, and the preparation that an organisation needs to do for this kind of change was done already by Bouverie. It was quite clear what the research suggested, what the benefit might be, the reason why you do it, how it is aligned with the national mental health standards, and a whole range of things. When it is a specialist service like Bouverie, who hold the specialist knowledge, you tend to get a bit more buy in. It helps things come across as worthwhile.

Working with The Bouverie Centre was also viewed as important because it was an external organisation to the service attempting to implement change. This was regarded as significant because

of the opportunities for reflective practice that flowed from this through booster sessions and external supervision.

The flexibility to roll-out the training locally to suit the needs of the particular team and service was highlighted as an important part of the strategy. In addition there was the opportunity to conduct booster sessions to hone family work skills when needed.

> *The initial training was pretty basic but additional training and boosters provided more information about how to redirect difficult families – how to engage families when difficult and when you may be dealing with conflict – and how to include circular questioning.*

9.1.1.3 Long-term support and realistic timelines

The on-going support over a longer timeframe that was feature of the *MH Beacon* implementation strategy was really appreciated by the sites.

> *It was superior to other projects as there were more resources and longer term support so Bouverie would hang in there for the long haul. It created an understanding that it is not going to happen immediately but the support was there to enable it to happen in the long term.*

> *That kind of support is crucial and hanging in there – because the change happens over time especially to support the work becoming part of the work they do.*

The project included a staged roll-out of the interventions and the timelines assigned to both Let's Talk and SSFC was seen as a realistic for supporting the implementation of the new practice.

> *What was helpful about the project was the realistic timelines and the length of the project – it took into account how long training can take, how long it takes to pull everything together for an organisation and then for individuals to start implementing change. There weren't these huge expectations in short periods of time which I think sometimes can be a bit of a trap that organisations can fall into, of needing something done pretty quickly.*

9.1.1.4 The EOI process

The EOI process was considered to be an important component of the project as it ensured some pre-planning within the organisation, committed upper management to the project, and created a sense of importance that the service had been selected to work in partnership with The Bouverie Centre.

The project was set up well beginning with an EOI submission that required the organisation to commit and prepare for it early on which was important and when you were accepted it was all 'that's fantastic'. In doing that it kind of set the scene and organisations had to prove that they could do this – so you already created a space where you were thinking about this, and teams were already engaged in thinking about family inclusive practice and how that worked currently.

9.1.1.5 Reminding and nudging the work

All sites talked of the need for persistence in getting the work happening on the ground. This was done through continual reminders from management and particularly project champions who continued to ask about the work on the ground.

I think getting used to altering small things can seem so large, you need to be constantly saying to them that we engage with families, even at the point of intake, and we recognise that it's an important intervention, and have that conversation from the start – it like you need some bright flashing lights saying 'don't forget about family consultation'.

9.1.1.6 The family intervention models

For SSFC and Let's Talk, the models' appeal to the practitioner and their useability were some key element of the success of the strategy. These models were viewed as relatively simple, well-structured and contained.

And I think starting with FC (SSFC) is brilliant because I think people are still a bit confused about what family work actually means. And that if it's Bouverie it's all about some kind of complex systems theory, family work, that's going to take sessions and sessions and sessions to do and whose going to buy into that and what is it going to cost and what therapists are we going to train to do that. When in actuality it's extremely feasible. And I am hoping that if there are good outcomes from this project that in itself might create enough evidence and propel other organisations. And it falls in line so very clearly with the broader recovery model for which there's already been lots of policy documents out from the Department of Health – about empowering individuals and the people around them to have the information to make decisions about their care. And I think it's utilising all the other directions in contemporary mental health care that support that family work which I think Bouverie already do, but I think that is a way to grab people in as well. And, like I said, start with something that's easy, achievable and makes a difference and single session family consultation does that. And, wherever possible, get your families and clients in to do the talking for you. Clients in particular. That's the other thing you

don't want to get lost in all of this. This is actually an intervention for the client. It's not just other work that a family or peer support worker can do. I mean they might be able to do it if they have been trained. But this is actually client intervention.

9.1.1.7 Responding to unexpected barriers

A key component of the project reported by project champions and managers was to develop strategies to counteract potential barriers as they arose. Sites talked about this being an important part of the partnership with The Bouverie Centre, whereby sites worked with the centre and their family practice consultant to plan for issues prior to the introduction of the new models. The ongoing relationship provided the opportunity to discuss potential strategies for unanticipated issues that emerged. Different strategies put into place also highlighted unexpected implementation successes.

> *We responded to these potential barriers by talking about the need to do the work (with all clients), a discussion about why clients should be denied this service, and to advertise the success stories to ensure good uptake. There were some learnings too form these conversations – some clients and families were offered FC in a crisis time, and it worked quite well – so we learnt that we could offer at any time and the times that you previously thought it might have been less relevant , it actually worked best. So we also changed the way the intervention was offered in the service.*

9.1.2 What didn't work so well?

9.1.2.1 Staff turnover of champions and/or management

A common difficulty for all sites participating in MH Beacon was losing momentum for the project due to staff turnover. This was described in terms of losing influence within the organisation and the effect of new people becoming involved in the project who might bring new and different agendas from those established at the beginning of the project.

> *There were some issues with the champion going part-time, which affected a lack of promotion on the ground. Two managers also went on leave – and the level of management support dropped. So it was left with us just talking about it without much back-up. This all resulted in a lack of influence and power to effect change.*

> *And then three levels of management departed within three months. As a longer term project it can be difficult when personnel and management change as it can be different people coming to the project with different ideas and passions, and your project can lose momentum and lack clarity as to where the project was heading.*

9.1.2.2 The Project Implementation Groups (PIGs)

The PIG had a mixed impact across the sites. They were structured to ensure representation of different levels of management, including representation by project champions and management sponsors, and were designed to; plan for the roll-out of the strategy; problem solve implementation issues and facilitate organisational changes needed to support the adoption of the new practices. However feedback from management sponsors and champions highlighted that groups did not run as intended. Some PIGs had poor representation and/or poor attendance which reduced their ability to problem-solve and think creatively, and to exert influence over the participating team where uptake may have been slow.

> *We started off with a reasonable momentum, and we included the consultant psychiatrist and the manager of the adult team. But we didn't have great buy in from the manager of the adult team for the project. On reflection the PIG ended up at times just being about me, the champion and the Bouverie consultant – people that were already invested.*

> *The PIG group sometimes worked, sometimes though there were not enough in attendance, and therefore hard to have meaningful conversations when not many people there. Sometimes there were no outcomes from the meeting – at times it felt like we were having meetings about meetings about meetings.*

Like other aspects of the project, the PIG was another component that needed to be maintained to ensure its effectiveness.

> *That said the PIG wasn't really prominently on my radar over the course of the project and had there been a more rigid structure around that I could've imposed, it might have worked better. The importance of the PIG wasn't maintained over the course of the project and probably we could've had some more shared responsibilities of tasks and things, rather than it being left to the champion and me perhaps. I guess we found ways to work around the PIG – but it could have enriched the process, had more creative problem solving, and I think it could've assisted in the adult team. But I don't think it was a major stumbling block in terms of the progression of the project.*

9.1.2.3 Clashing with an individualised model of care

A core organisational hurdle experienced by many sites is how to prioritise family work within a system that prioritises an individual model of care.

> *The service was quite client focused but we weren't proactive or big on incorporating families.*

Other factors as well were involved – the organisation is typically singularly focused on the client, although there is now some care coordination with families, but overall family inclusive practice is low.

But there was some reluctance to involve the wider family of our clients, as it was a challenge to their way of practice (working in silos).

9.1.2.4 Changing practice is just hard

Project champions and managers came to a realistic appreciation of the difficulty involved in trying to change practice within their service. One of the important learnings was not to become dis-heartened when practice change does not occur.

What was challenging was not realising how hard it was to create a change in practice, and it was such a change in practice - it was a fine line between talking to people about what to do, but not making it mandatory.

Crucial to maintaining enthusiasm was the longer term support from The Bouverie Centre. The importance of realistic time frames for change and having realistic expectations about the extent of practice change that could be achieved was also seen as critical.

9.2   Reflections on key learnings from the project-The Family Practice Consultants

The four members of the *MH Beacon* project team who undertook the roles of Family Practice Consultants (FPC) across the six project sites met at the end of the project to reflect on what they had learned from the experience. They identified a number of areas where they believed there had been important learning.

9.2.1   The timing and number of new practices being introduced

MH Beacon involved first introducing SSFC as a way of increasing the likelihood that families could be recruited to the more intensive and evidence based interventions of MFG and BFT. The assumption was that SSFC would increase practitioner-family contact and improve the relationship between these groups which in turn would make it more likely that families would be willing to participate in interventions that would be more demanding of time and energy. The impression of the Family Practice Consultants was the introduction of BFT or MFG required the champions and practitioners to spread their implementation efforts across the two interventions. This dual focus appeared to result in insufficient time to continue to establish SSFC or to introduce BFT or MFG. However it was noted that

one of the four sites did establish an MFG which raised the question of what factors were associated with this site that accounted for its success.

The Family Practice Consultants found it difficult to assess the level of uptake achieved in *MH Beacon* interventions because there were few benchmark levels of uptake reported in the literature. That is, it was difficult to know what would constitute an acceptable or successful level of uptake of SSFC. This has implications for setting realistic and achievable targets during implementation and for ongoing delivery of SSFC within a service.

9.2.2   Levels of uptake are not simply a function of practitioner behaviour

The feedback to the Family Practice Consultants in line with information from the practitioner logs was that many families decline participation in SSFC. This is despite practitioner's best efforts to invite them to sessions. This went against the consultants expectations that given longstanding concerns about families not being included in care, nearly all families approached would want to take part in a SSFC. Consumers and families clearly have their own reasons for not participating in SSFC including practical constraints and competing priorities. The critical issue here is the extent to which practitioner behaviour (generally, and in terms of inviting family participation) can influence participation in SSFC.

9.2.3   The champion role

The use of a champion role in *MH Beacon* was a distinctive and previously untried feature of the implementation strategy. The Family Practice Consultants reflected that the champions were important in the implementation process and were critical in terms of the outcomes achieved at each site. Champions facilitated communication between the various players and particularly between the Family Practice Consultants and the service, initiated important changes in service operation, motivated colleagues, and role modelled the family practices being implemented and in many instances supported the use of the models through co-working.

The champions and management sponsors appeared to relish the opportunities to come together with their colleagues from other *MH Beacon* sites in Booster events. The benefits reported to Family Practice Consultants related to practitioners feeling that they were part of a larger endeavour; a degree of healthy competitiveness between sites in terms of uptake and a very practical sharing of ideas and resources developed across the sites.

9.2.4   The management sponsor

The Family Practice Consultants noticed that although management sponsors exercised their roles in different ways they were important to the implementation process. For example, some management sponsors played a 'hands on' role, even to the extent of modelling the new family practices while other played more of an authorising role. In a practical way management sponsors had the authority to make important decisions in relation to implementation at their sites such as freeing up staff to participate in training or facilitating changes in organisational processes to enable the new practices to be incorporated within the operation of the service.

The Family Practice Consultants believed that their role was helpful in facilitating implementation. The dedication of a Family Practice Consultant to each site over a two year period enabled the development of trust with the champions and management sponsors and the building of knowledge about each service. In turn this helped the Family Practice Consultants tailor their implementation efforts to the needs of each site. The long period of time working with each site and the extent of the Family Practice Consultant involvement contributed to a sense of partnership with the sites. This contrast with their previous experience of delivering training where the period of contact was brief and the extent of involvement was limited to training.

9.2.5   Structures to support implementation

The Family Practice Consultants observed that influencing the operation of team meetings, handovers and clinical review meetings was important in the implementation process. Often the operation of these meetings needed to change to incorporate and support the new practices. For example, an intake meeting could include a standard question about whether SSFC or Let's Talk had been considered or offered to the family. Changes of this kind seemed likely to be also important to sustaining family practices over time.

The Family Practice Consultants envisaged implementation groups would play a vital role in coordinating activities at each site and that this would be important for implementation success. However, contrary to expectations, one of the sites with a poorly attended implementation group had one of the highest uptake rates. Equally a well-attended implementation group at another site seemed to experience more difficulties with implementation. This led the Family Practice Consultants to speculate that poor functioning in one component may be compensated by over-functioning in another. For example, active champions may have served some of the functions that were not performed through the implementation groups.

9.2.6   The inclusion of consumers and families

One of the key learnings from the Let's Talk component of the project was the value of a consumer's involvement in the development of training materials, participation in staff training (i.e., sharing lived experience) and in the wider advocacy of the Let's Talk model. Although consumers and family members did play a role at the SSFC sites, the extent of their involvement was much less than at the Let's Talk sites. There appears to be scope for early engagement of consumers and family members in the implementation process. This could involve providing input about the family practices and how they might be best promoted to consumers and families.

9.2.7   The use of data in the implementation process

The Family Practice Consultants reflected how important data collection and analysis was to the implementation process. Registration data can help identify the likely demand for family related services and make sense of uptake rates. For example, if an area has younger clients who live predominantly with their families, then it could be expected that demand for SSFC might be higher than in an area where clients are older and living alone. Contact data can measure the extent of family contact at baseline and at different points during implementation. This allows the recognition of progress or the initiation of corrective action if uptake is not occurring as anticipated. In *MH Beacon* the Family Practice Consultants observed that while services did collect data about client and family demographics and contact through systems such as CMI-RAPID, this data could not be easily accessed to support implementation. At two sites services were able to modify their local client management systems to capture the use of SSFC and Let's Talk and this enabled better monitoring of uptake.

10 Summary and Conclusions

10.1 Major project achievements

A significant group of consumers and their families received support and therapeutic intervention as a direct result of *MH Beacon*. In total, 242 SSFC and 111 Let's Talk sessions were conducted and a Multiple Family Group program commenced over the course of the project.

Clients and families who accepted the invitation to participate in SSFC or Let's Talk found it a largely satisfying experience. Both clients and their family members rated various aspects of the sessions very favourably and this is indicative of a strong therapeutic alliance between practitioners and families. The high ratings given by consumers in relation to SSFC should allay fears expressed by some practitioners that working with families would threaten the therapeutic relationship between clients and practitioners. There was also evidence that families found the MFG meetings helpful, particularly in reducing feelings of isolation. The very limited use of BFT makes it difficult to draw any conclusions about the acceptability of BFT for families. The demonstrated association of therapeutic alliance with positive outcomes suggests that research examining whether SSFC leads to changes in individual and family functioning using a randomised control trial is warranted. This is important given that SSFC is the only one of the four interventions without an established evidence base.

Several practitioners took part in an array of professional development activities designed to enhance their capacity to involve families constructively in care. A total of 151 practitioners from the six sites were trained in SSFC or Let's Talk during the project while 16 practitioners participated in either MFG or BFT training. Those practitioners in champion roles received additional training and participated in a total of 66 supervision sessions. Practitioner questionnaire data points to positive changes in family related practitioner behaviour that was likely to be a result of the training and support provided. Pre and post training differences in relation to the FFMHPQ suggest SSFC practitioners were more likely to perceive families as willing to engage with services and to offer the necessary support to families and parents at the 12 month follow up. Similarly, FFMHPQ scores suggested Let's Talk trained practitioners' knowledge of mental illness expanded and they too were more likely to provide family and parenting support and to refer families 12 months in to the project. In addition pre to post differences on the FIS suggest that SSFC trained practitioners' became less constrained from working with families by concerns about hostility expressed by families, conflict or the difficulty of keeping the discussion on track. These results suggest that the implementation strategy used in *MH Beacon* had a significant and positive impact on the practitioners who participated in the project.

A total of 50 site based implementation meetings occurred over the course of the project. Sites made a range of changes to operational processes beyond those they committed to during the EOI process to help embed the new interventions. These included development of promotional materials for family inclusion, changes to clinical processes and pathways, data collection changes and incorporation of the new practices into training and orientation programs. Practitioners reported improvements overtime in FIS and FFMHPQ ratings regarding policies and procedures and co-worker support which further indicate that important organisational changes occurred. Together these results suggest that the implementation process adopted in *MH Beacon* led to identifiable changes in the operation of the teams that were involved in the project.

10.2 Putting the achievements into context

Despite these significant achievements, the proportion of sessions conducted relative to the number of practitioners trained in each approach suggests that even with a comprehensive implementation strategy, uptake of the new interventions could be viewed as modest. The 82 practitioners trained in SSFC conducted an average of 2.95 sessions while the average for the 69 practitioners who undertook Let's Talk training was 1.6. This needs to be weighed against the fact that evaluation of training rarely encompasses tracking of whether practitioners actually apply skills acquired in training so comparison between *MH Beacon* and 'standard' training is difficult. Consideration of outcomes in terms of uptake is an important element in determining the ultimate cost effectiveness of comprehensive implementation strategies over existing training practices.

The higher uptake of SSFC compared to Let's Talk is interesting given that Let's Talk could be seen as the less complex of the two interventions. Let's Talk needed only to involve the practitioner and client and could be conducted within the context of ongoing practitioner-client appointments. SSFC on the other hand typically involved scheduling a separate meeting and including other family members in the session. One possible explanation for this unexpected finding is that Let's Talk involves exploring the potentially sensitive domain of parenting and children that may lessen the likelihood of both the parent consumer and practitioner engaging in the intervention. This is supported to some degree by a finding at the only site where rates at which clients declined the intervention were tracked that 44% of those approached declined participation.

It is difficult to compare BFT and MFG in the same way as SSFC and Let's Talk given the relatively low levels of activity in relation to these interventions that occurred in the project. However the successful facilitation of an MFG might suggest an advantage of a model that requires two practitioners who can provide mutual support to each other in conducting the group. The model also does not require large

scale system change but can be provided as an 'add on' by a service. Although BFT can be conducted by individual practitioners with single families, experience suggests that significant organisational support and change is needed to establish this intervention as an ongoing part of service delivery.

10.3 What might account for variability across sites?

A range of consumer and family, practitioner and organisational factors are likely to account for variability in the uptake of family interventions. At the consumer/family level, tracking of invitations to participate in SSFC revealed that across two sites between 26-68% of those invited declined participation in a SSFC. Whilst practitioner approach and skill might have been a factor in whether the offer was taken up, the findings suggest client demographics also play a role. In the case of Let's Talk, a relatively small proportion of clients are parents with estimates usually falling in the range of 20-30%. This places an obvious limit on the number of clients who can participate in the intervention. One implication of this observation is that it may be better to train a select group of practitioners with an interest in working with clients who are parents rather than all staff to avoid training practitioners whom will have limited opportunity to use the intervention. In the case of SSFC the youth oriented services appeared to have higher rates of uptake and a lower proportion of refusals. This finding is consistent with family-practitioner contact research that indicates that younger clients are more likely to have their families involved in their care (Riebschleger, 2005). Higher levels of informal family practitioner contact may also make it more likely that families will accept an invitation to participate in a formal process such as SSFC.

The practitioner log sheets and champion and management sponsor interviews generated a number of possible client and family level explanations for why offers of SSFC were declined. These included; the client's belief that family members would not be interested; the client's mental state; the nature of the relationship between client and family (conflicted, estranged or geographically distant) and families' caution about new approach or not perceiving a need for support. Clearly consumers and family members have different and probably changing preferences regarding participating in interventions such as SSFC. At the level of implementation and ongoing service delivery it is important to acknowledge that not all consumers or their families will want to participate in a family intervention. Having informed and realistic expectations of uptake is important so that practitioners are not held exclusively responsible for what might appear to be low levels of engagement. On the other hand family involvement is no doubt influenced by a number of practitioner factors including the nature of the existing practitioner-client and family relationships and the manner in which the invitation to participate is delivered. Further investigation into why family interventions are declined directly with consumers and families is an obvious domain for further investigation and could help

improve the way in which interventions are presented to families or promoted more generally within services.

Practitioner level variables are likely to account for variability in uptake of interventions. For example, although it was not possible to track formally in SSFC, it was evident from Let's Talk that clear that some practitioners used the new interventions repeatedly while others did not use them at all following training. The qualitative data suggests differences in practitioner's personal attributes (workers' openness and flexibility; tolerance for uncertainty), beliefs about the intervention trialled (perceptions of a model's applicability, the advantages it confers and how well it fits with established ways of working) and practitioners' belief in their capacity to put the intervention into practice that all contributed to variability in uptake. This was most obvious in Let's Talk where champions observed that practitioners who implemented Let's Talk were familiar with FaPMI and the concept of reflective practice and had experience with therapeutic modalities. Some practitioners were uncomfortable with the structure imposed by some aspects of Let's Talk, while others were off put by the lack of structure associated with other parts of the model. In addition FFMHPQ scores revealed Let's Talk trained workers who were parents made greater gains in confidence and skills 12 months after the training than non-parents. It seems likely that many of the same practitioner variables described in relation to Let's Talk would also operate in relation to SSFC.

Factors operating at the organisational level were also identified as important in influencing the extent of uptake. Interviews with champions and sponsors revealed that the individually oriented nature of service delivery made it hard for practices in relation to families to be prioritised. Staff turnover was also seen to adversely affect project momentum. FIS data also revealed that practitioners saw organisational level factors as barriers to using family interventions. The burden of work, integration of family work with caseload and other responsibilities and allowance of time by the service were perceived barriers to working with families by practitioners. The barriers applying to Let's Talk and SSFC were likely to be even more significant for the time intensive interventions of BFT and MFG.

10.4 What was learned about the implementation strategy employed in MH Beacon?

The participating services and the Family Practice Consultants valued the following aspects of the implementation strategy and as such these should be considered for incorporation in future implementation endeavours:

- The Expression of Interest process: This was seen to promote awareness of the project requirements and encourage preparatory work prior to selection as a participating site.

- Management sponsors and champions: Champions were seen to provide on the ground support to individual practitioners and teams and provide an important linkage function with the Family Practice Consultants.

- External facilitation: The involvement of an external specialist service was seen to add credibility to the project as well as conducting activities that would have otherwise fallen on the service. For example, presenting the rationale and evidence for the use of the interventions.

- Sustained support: Measurable practice change takes time and progress is often hard won. This can lead to discouragement. Longer-term support can help keep the initiative on the agenda and improve the chance of implementation success.

- A flexible approach to training: Scheduling of training and other implementation support activities was challenging. Flexibility regarding the number of hours of face to face training delivered, the topics chosen and when these are presented was important. It would be wise to look into making online resources available to counterbalance the reduction in the hours of face-to-face training and increase the ease with which practitioners can complete training.

Elements that did not always produce the intended effect that require further consideration:

- Implementing two different interventions at the same site within a two-year period might lead to neither being fully implemented. In theory, SSFC provides a pathway for BFT and MFG, however, it proved difficult to establish fully in one year. As such, it might not have been effective in recruiting families for the other two interventions. Also, it was difficult for sites to muster the necessary enthusiasm for the implementation of another new practice. It would have been interesting to see if the uptake of MFG and BFT would have been different had they been the sole intervention implemented.

- Project Implementation Groups: These governance and co-ordinating groups did not all meet regularly and did not appear critical to outcomes at particular sites. In *MH Beacon* the functions performed by this group sometimes accomplished by champions, Family Practice Consultants and managers working informally and this may have obviated the need for the implementation group. It may be that the role played by this group and meeting frequency needed to be negotiated on a site by site basis to determine the most efficient use of implementation resources.

- Most services struggled to make use of existing client data collected via the state-wide CMI Rapid system or to make use of the options to modify it to collect uptake data. One service bypassed this limitation by incorporating measurement of SSFC into their electronic client management system and was able to report on uptake regularly and easily. A lack of local capacity to collect, analyse

and feedback information to practitioners and managers about clients and their families and current levels of family engagement is likely to impede efforts to implement family practices.

10.5 Conclusion

During the two year period of the implementation of the Mental Health Beacon Strategy (2011-2013) significant practice and organisational changes in relation to the use of family interventions were observed at participating sites. These changes have had a positive impact on clients and their families, on mental health practitioners and on the participating services. Central to this success was a strong partnership between The Bouverie Centre and the partner services that involved significant contributions of 'inspiration, perspiration and determination' from both groups.

More broadly, *MH Beacon* contributed significantly to understanding how to best implement family interventions in routine care within public mental health services. *MH Beacon* has generated a great deal of valuable learning about the value of the new practice models of SSFC and Let's Talk and about the obstacles facing families and practitioners in the introduction of new and more established family interventions such as BFT and MFG. It has also provided important clues about how these obstacles can be addressed. Significantly, *MH Beacon* involved moving beyond the 'train and hope' method of practice change to the use of a comprehensive implementation framework. Beyond a renewed appreciation of the challenges of facilitating practice change, *MH Beacon* highlighted the importance of organisational partnership, the value of practice champions and the importance of data collection in the implementation process. The learning about practice models and how they are viewed by families and practitioners and effective strategies for implementing these models provide an impetus for improving efforts to realise the potential of family involvement in mental health care.

11 Appendices

11.1 Appendix 1 – Let's Talk About Children Controlled Trial

Parent-clients involved in Let's Talk were part of a broader controlled trial study investigating the evidence base for Let's Talk in Australia, in conjunction with Monash University. As such, parent-clients of NAMHS, Neami National, and Eastern Health and additionally a family service called SHINE Family Life also participated in the control trial study. The study involved examining the impact of Let's Talk on parent-clients (n=20), as compared to a control group of parent-clients who were receiving standard care from the same service (n=19).

11.1.1 Methodology

This broader study employed a quasi-experimental research design. Let's Talk (LT) practitioners invited parent-clients they deemed appropriate to participate in the study and receive LT along with routine service provision. A second set of parent-clients were invited to participate in the study as part of a comparison (control) group. Participants were told that the study was designed to investigate the needs of parents accessing mental health services and that they would be asked to provide information on any changes that occurred in their parenting and family relationships as a result of receiving support for their mental health issues.

The study involved mixed methods. Parents completed questionnaires that included standardised measures of family functioning and parenting stress at two time periods: two weeks prior to receiving the intervention/standard care and four to six weeks following completion of the final session of the intervention or four to six weeks on during the standard treatment process.

Semi-structured interviews were also conducted with parents in the treatment group who received Let's Talk four to six weeks following the completion of the intervention. As this project was the first study of its kind to measure the impact of the Let's Talk intervention for parents in Australia, this qualitative component was utilised to capture any unanticipated outcomes of the intervention. Post-intervention interviews with parent-clients focused on parents' impressions of LT, including whether they felt it assisted them to have conversations with their children about mental illness and whether parents were aware of any other effects of the intervention on their parenting or their relationships with family members, including children.

Parent-clients who were part of the Let's Talk group were reimbursed for their time with a $50 supermarket voucher for completion of the pre and post questionnaires and participation in an

interview. Parent-clients who were part of the control group received a $30 supermarket voucher for the completion of pre and post questionnaires.

Various standardised questionnaires were utilised to measure pre and post intervention change in all parents who received Let's Talk and those receiving standard care including *The Parental Stress Scale* (PSS; Berry and Jones, 1995) which measures perceived parenting stress. The PSS consists of 18 items and yields an overall score of parenting stress in addition to four factors including parental rewards, parental stressors, lack of control and parental satisfaction. Scores indicate that a participant is experiencing high stress and low satisfaction in his or her role as a caregiver. Participants were also asked to fill in the *General Functioning Index* of the *McMaster Family Assessment Device* (FAD; Miller et al., 1985). This measure of family functioning consists of 12 items and generates an overall score of family functioning that distinguishes between 'effective and problematic' family functioning. Both of these widely used measures have been well validated and exhibit strong internal consistency ratings (0.83 for the Parental Stress Scale, Berry & Jones, 1995; 0.86 for the General Functioning Index of the FAD, Byles, Byrne, Boyle & Offord, 1988).

11.1.2 Results

Data is presented in figures below, outlining the mean score for the Let's Talk Intervention group as compared to the Comparison (control) group.
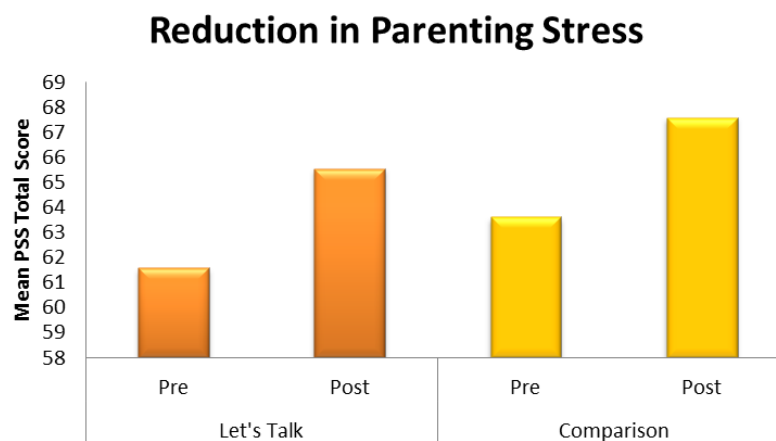

Figure 1 Pre and post scores on parenting stress scores for parent-clients who received the LT intervention and for those in the comparison group receiving standard care.

We saw a reduction in parenting stress following the Let's Talk intervention. Note that the calculation of the questionnaire measuring parenting stress stipulates that a lower score means more parenting stress**.** Thus an increase in score post the intervention indicated that LT parents felt more positive about their parenting role. However this same change was interestingly also observed in the comparison group that did not receive LT.

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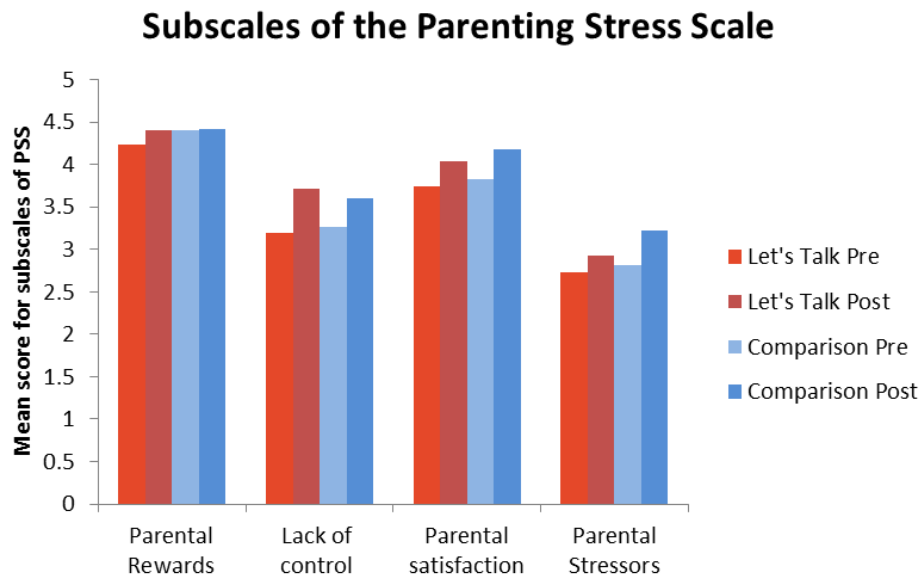## Subscales of the Parenting Stress Scale

Figure 2 Pre and post scores on subscale components of parenting stress for parent-clients who received the LT intervention and for those in the comparison group receiving standard care.

When we analysed the subscales of the parenting stress scale and examined the type of parenting perceptions that improved following the intervention, we found that the biggest change in the LT group was in a sense of control over the parenting role, with parents indicating a significant improvement in their sense of control. Whereas the biggest improvements for the comparison group were observed in parenting stress and satisfaction.

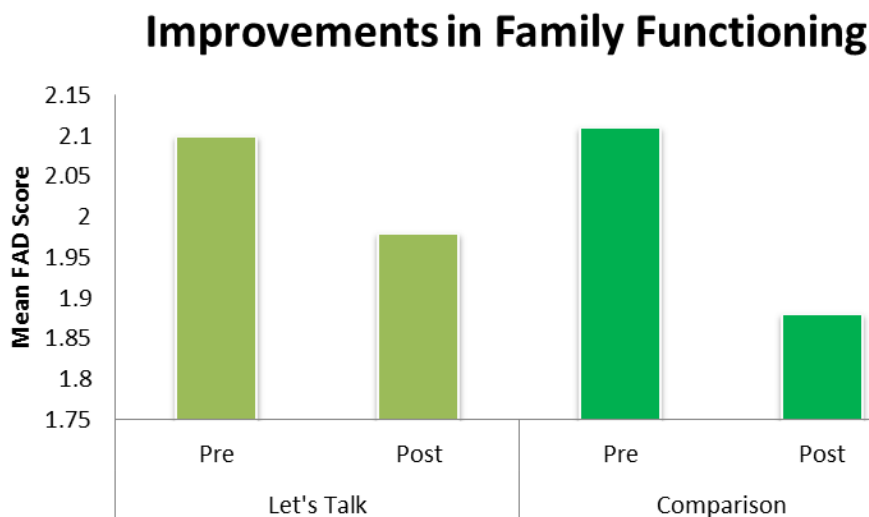## Improvements in Family Functioning

Figure 3 Pre and post scores on subscale components of parenting stress for parent-clients who received the LT intervention and for those in the comparison group receiving standard care.

We also found an improvement following Let's Talk in family functioning. In fact there was a shift from nearing the cut-off distinguishing 'unhealthy' family functioning (2.17) towards more 'healthy' family functioning. Again this same effect was evident in the comparison group.

In summary, the results indicated that there were significant shifts in the pre-post comparisons, and an improvement in parenting stress levels and family functioning were evident in all parent-clients participating in the trial. This could be a function of the small sample size or the chosen methodology where there was extensive engagement with the study participants in the recruitment phase. There is a small indication though that Let's Talk may change slightly different components of parenting perceptions, and perhaps lead to more lasting change over time. However given the small numbers these findings are purely speculative at this stage.

This control trial data was also used as pilot data in a successful grant submission for the Mental Illness Research Fund (Victorian Department of Health) in 2012. The Mental Illness Research Fund is a $10 million Victorian Government initiative supporting multidisciplinary and cross-sector collaborative research that has the potential to be translated into tangible improvements for Victorians with mental illness and their carers. MIRF grants were awarded to five significant research projects, including a randomised control trial of the Let's Talk intervention conducted by Monash University (lead) in conjunction with Bouverie, NAMHS, Neami, Eastern Health, SHINE, and additional new partners. The project titled 'Developing an Australian-first recovery model for parents in Victorian mental health and family services' will be funded for four years from July 2013-June 2017 for in excess of 1.85 million dollars.

11.2 Appendix 2 - The Single Session Family Consultation Model

The core elements of the family consultation model were drawn from interviews with project champions and management sponsors who were asked to reflect on the benefits of the model for mental health services. These are summarised in the Figure below.

Figure 1 Core components of the family consultation model for mental health services

The model is said to be deceptively simple, and brings a structure to family meetings that facilitates effectiveness to the work. The preparation and agenda setting contribute to its effectiveness, along with flexibility built into the model which enables it to be adapted to client's needs. The containment of the model alleviates the hesitation and nervousness of the practitioner to manage potential conflict and contrasting views.

> *It's quite clear and its structured, and that provides containment particularly for anybody who may be a bit nervous, which a few people were I think. They were nervous around engaging other family members, brothers and sisters, and the broader family unit. It was the structure of the model, the simplicity of how it looks, and the ability to hold the agenda and what we are here for, and the modelling around how to deal with conflict which happened through the*

training. Family consultation seemed to work better when a lot of preparation work had been done rather than attempting to do it ad hoc if you had the family there and tried to do a family consultation. Having a quite clear sense of the role of preparation and a clear sense of what's going to happen in the session is quite containing for clinicians and they found that really helpful.

For a lot of practitioners, it provided a structure to the family work they may already do, but it was a way to get the most out of a family meeting.

The initial audit showed that family work was high. But SSFC was a model that was contained and specific – it showed how to be effective in getting more of the work done for families. Having a model to stick helped to get more done. It helped for the families we worked with.

The model had broad appeal; it could be used to hone the skills of practitioners already doing some family work or support those who may have been a little reluctant at first, but predominantly it illustrated good practice.

The model was a good example of best practice, and good practitioner skills. When we saw the model we thought that any good practitioner would work in that way (involving families). The model provided support for those already working in that way, and gave a foot-in and a platform to encourage staff that may have been reluctant to involve families. Gave endorsement for advocating that this is what we do (involving families) and this is how we do it.

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11.3 Appendix 3 - The Let's Talk Model

As part of this project, we were able to explore the core elements of the Let's Talk intervention from the perspectives of parent-clients, project champions and management sponsors from each of the organisations engaged in the trial and in *Mental Health Beacon*. The thematic analysis of interview data indicated that Let's Talk was perceived positively both by parent-clients and practitioners. Underpinning the benefits of the intervention was a dual impact of the intervention with both parent-clients and practitioners experiencing changes as a result of the intervention. The parallel processes of change are summarised in the figure below.
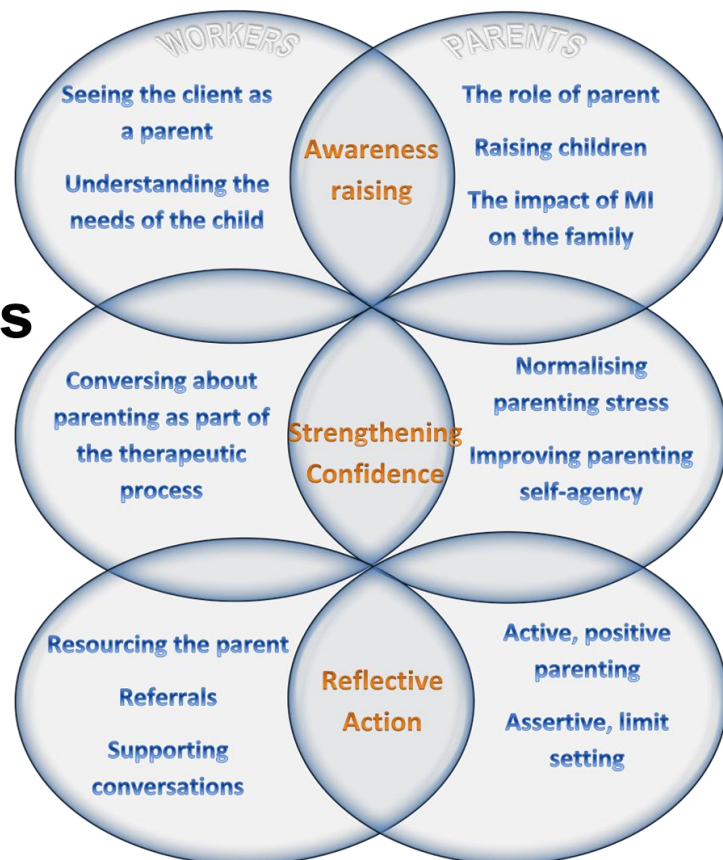

Figure 1 The core elements of change from the Let's Talk Intervention for practitioners (workers) and parent-clients (parents)

As represented in the Figure above, a significant benefit of the intervention was in the parallel processes of changes that occur as a result of Let's Talk for both the parent-consumer (right) and the practitioner (left). Together the diagram is representing the overarching mutuality of impact and effect for both the parent and the worker that underpinned the effectiveness of Let's Talk. As part of this change process, there was a deepening of the therapeutic alliance (represented by the joining of the circles). Each of these steps was progressive and builds on the previous one.

One of the first steps in the process is raising practitioner awareness of the client's broader family role.

> *I have more awareness of clients as parents and more awareness of the added stress and impact that their parenting role has on illness and vice versa. I knew this before but I was made more aware of how clients do an amazing job parenting well despite their mental health challenges. (Practitioner)*

There is also an awareness raising process for the parent-client about their role as a parent and about the needs of their children, and of the potential impact of mental illness for their children.

> *It made me think about the strengths. It made me think about parenting – in your normal daily life you don't sometimes have the time to think about parenting. (Parent)*

The second step in the process is the strengthening of confidence in the parenting role by the parent-client.

> *I can see now that the kids are going well and their behaviour is normal for their age. It is validating – and talking helps because it gets everything off your chest. I was stressed – but now what I was worried about was normal. I was thinking before that I'm paranoid, or parenting the wrong way. (Parent)*

And increasing the confidence of the practitioner to converse about the parenting role.

> *Having LT keeps parenting work on the agenda…you're able to work in a family capacity without having to bring in others like family services to do the work for you. You can work with the client to focus on staged goals, which fits with the recovery focus. (Practitioner)*

The last stage of the processes of change is where reflective action takes place through the provision of appropriate support and resources by the practitioner and a modification of parenting behaviour and strategies by the parent-client.

> *LT was important for one of my clients, as it led to the involvement of the maternal child health nurse and admission to a mother baby unit, after becoming aware of particular assistance needed by the Mum in her interactions with her baby. (Practitioner)*

> *For another client, we had a thorough discussion of the relapse management plan and involved the son in that discussion. The mother talked more to the son about what might happen if she became unwell. (Practitioner)*

I now have a post- it note praise system. I was typically focused on the negative before - on what they didn't do. (Parent)

Now we are making more time to be together as a family. We went on holidays at Christmas and the kids loved it. Now we want to go away every year. (Parent)

You get to know the strengths and weaknesses of your child. It helps for your children in the future. It addresses issues in the child as they grow, and how to talk about things more often. The focus is on resilience, and it can hopefully protect them from getting unwell. (Parent)

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