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Working with Teams and Organisations to Help them Involve Family Members

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Akan Ibanga**

ABSTRACT

In this chapter we describe our work in trying to influence whole service teams to move their practice towards greater involvement of affected family members. Work with five teams is described. The process varied but in all cases it included recruitment of the team, training, continued support, and evaluation of results. Use of a standard questionnaire for assessing attitudes towards working with affected family members showed significant changes in team members' knowledge, confidence, and team support for working with family members. Records of all project events and meetings suggested that change takes time but that a 'cultural change' can take place whereby earlier misgivings are dispelled and positive attitudes towards involving family members become embedded in a team's approach. Diary audit indicated that the frequency of involvement of family members in sessions can be increased three to five fold, with teams beginning to carry out work with a diversity of family members, in diverse ways and with diverse positive outcomes. In a number of cases teams were encouraged to institute new family-friendly procedures, for example changes to appointment letters, assessments, and design of waiting and counselling rooms. Lessons have been learnt, including the need to accommodate different levels of initial experience of working with family members, and the need to be clear about project aims and objectives. Sustainability of change remains an issue. A general conclusion is that the capacity of services to take on work with family members affected by substance misuse of close relatives varies greatly. Where organisations

already have a mission to involve family members, capacity is good. Where alcohol and drug services have previously been focused on individuals who are misusing substances, change is difficult but can be achieved. For most non substance-specialist organisations, such as primary care health centres and most non-statutory organisations, capacity is very limited. In addition to training and continued support for practitioners, explicit commissioning of work with family members combined with management support is necessary.

Eight years ago, in an editorial in *Addiction*, we expressed the opinion that, ‘Despite the accumulating evidence for the important role of families, on the whole service delivery remains focused on the individual drinker or drug user, with families and other members of the user’s social network playing a very peripheral role, if any’ (Copello and Orford, 2002, p.1361). It was clear to us, therefore, that we needed to raise our sights and to try to influence services and service delivery. That has been the focus of a number of our more recent projects. Unlike our previous work, in which individual alcohol and drug practitioners or primary healthcare staff had volunteered to use the 5-step Method as part of their routine work, we would now aim to bring on board whole teams or practices. This move might be seen as one step in a lengthy process of moving our target upwards, from individual volunteer service providers, to service providing units or teams, to whole services or agencies, and finally to dissemination on national and international levels.

Aims and objectives

The aim of our work with teams and organisations has always been to move their practice towards greater involvement of family members. The specific objectives have been: to obtain the agreement of a whole team or practice to work with us to that end, making sure that there exists sufficient support at all levels of the organisation; to provide all members of the team with training about the stress-strain-coping-support (SSCS) model (see Orford et al, 2010, this volume) and the 5-step family intervention method (see Copello et al, 2010, this volume); to provide the team with continuing support; to work with the team on modifying procedures to support the greater involvement of family members; and to evaluate the results by assessing changes in

staff attitudes towards working with families, change in the frequency of engagement with family members, and the putting in place of family-positive procedures. We were therefore engaged in organisational change and the work had many of the features of action research (Reason and Bradbury, 2001).

Table 1 about here

Table 1 lists the five service teams we have worked with. Work with three of them was carried out as part of our Involving Family Members (IFM) project, funded by the Alcohol Education and Research Council, designed to include both specialist alcohol and drug teams and primary health care teams (Orford, Templeton, Copello, Velleman, Ibanga and Binnie, 2009). They will be referred to as the IFM teams. Work with the Muslim team was part of a project funded by the Department of Health, designed to disseminate our model and methods in BME communities (Orford, Copello, Simon, Waheed et al, 2009). Work with the non-statutory drug service was carried out as part of a commissioned study to evaluate the introduction of the 5-step Method within the service (Templeton, 2009).

Exactly how we worked varied from team to team as it was bound to do. Given the diversity of the teams involved and the nature of the project being undertaken. However, there was a common core to the approach which is summarised in Table 2. For example, our work with the NHS drug and alcohol unit and with the non-statutory alcohol team involved regular visits of one or more members of the research team (at least every two months and often monthly, for a period of two years) in order to encourage team members to engage family members more often; to increase their confidence in carrying out family-oriented work; and to help the teams find new ways

of promoting and facilitating family-oriented work. Two-day training or progress workshops were held at the beginning, half-way through and at the end of that two year period. In the other cases, time available for this type of work was necessarily more limited. For example, work with the NHS primary care health centre lasted for a total of 30 months. Contact was maintained by regular visits of the research team to the practice, supplemented in the final nine months by basing a member of the research team in the practice for two days a week. The first two orientation and training meetings at the practice lasted for one to two hours and were well attended by nearly all practice staff. Thereafter, progress meetings, which lasted for an hour, took the form of joint project steering group meetings chaired by a senior medical member of the practice and attended by between one and four other practice members and by the research team.

Table 2 about here

Was change achieved?

Changes in attitudes towards working with family members

In our work with three teams (the IFM teams) we administered a standard attitude measure to as many team members who were available at the beginning and again at the end of the project. The Attitudes to Addiction Related Family Problems Questionnaire (AAFPQ) is an adaptation of one designed by Cartwright (1980) to measure aspects of the attitudes of different groups of practitioners towards working with people with alcohol problems. The AAFPQ is an adaptation which refers to

working with *family members* of people with alcohol or drug problems. It consists of 28 questions with 7-point Likert response scales (strongly agree to strongly disagree). Previous analysis of the AAFPQ results from an earlier study confirmed the existence of seven interpretable factors: knowledge; confidence; support from the service; legitimacy; motivation; self-belief; and impact on the substance user (Copello, Templeton, Krishnan, Orford and Velleman 2000).

Confining the analysis to those team members who were present at both times (there had been some staff changes during the course of the project) total AAFPQ scores increased significantly. As might be expected, attitudes were more positive at the outset amongst staff of the specialist services than amongst medical and nursing staff in primary care, but change occurred in a positive direction for both groups so that by the end of the project the average for primary care staff had risen to a level comparable to that of the specialists at the beginning of the project (see Figure 1). Changes in scores on the sub-scales of the AAFPQ provide more detail about the nature of the attitude change. Whereas there was a negligible change in terms of motivation to work with family members of substance misusers, or in terms of self-belief that one would be able to do such work, there were changes in all other sub-scales, particularly in terms of knowledge (e.g. *I know enough about the relationship between alcohol or drug misuse and family problems to work with relatives of misusers*), confidence (e.g. *I feel confident when working with relatives of alcohol or drug misusers*) and support (e.g. *I feel adequately supported within my team/practice to work with relatives of alcohol or drug misusers*).

Figure 1 about here

In addition to the standard AAFPQ measure, we have used a number of other methods to enable us to learn more about the process of trying to help move established teams towards greater family work. We kept detailed notes from all project meetings and events; focus groups were held towards the end of the project with members of the two specialist IFM teams; and half-way through the project individual interviews were held with each member of the larger non-statutory team. From this collection of material we believe we learnt in greater depth why attitudes might need to change and what underlies change when it occurs. In each of the three IFM teams, working with family members was not the norm at the outset and progress in the early months of the project was slow and frustrating. There was difficulty in each team about identifying family members to engage with, and it was up to a year into the project before sufficient experience had accumulated for teams to be recognising the benefits of involving family members. However, from a slow start, by the end of the project the two specialist teams believed there had been a ‘cultural shift’, that the approach the project had aimed to foster had now ‘permeated’ the whole team, and had become firmly ‘embedded’. From having been services with an individualistic orientation, based on one-to-one counselling or therapy for individual alcohol or drug misusers, and probably discouraging of family members, it had ‘become the norm’ to welcome family members and teams had become more ‘network minded’ and ‘family friendly’.

In the primary care health centre all practice members who were interviewed during the project or who completed post-project questionnaires, expressed positive views about the project. All recognised the consequences for ill-health of having a close relative with an alcohol or drug problem and nearly all, asked whether they thought

that the primary care general practice setting was the right one for this kind of work, answered in the positive. At the non-statutory drug service, and in the Muslim service, it was the case that much of the initiative for the work had come from the teams themselves and they were already committed to some form of family work. Hence it took less time for the 5-step Method to be incorporated positively. Team members said, for example, that it was ‘really powerful’, and that ‘it gives people the tools that they need’.

Table 3 about here

In the first year of our work with the specialist IFM teams it started to become clearer why many of those working in drug and alcohol misuse treatment services might be reluctant to engage family members. Table 3 illustrates some of the concerns about involving family members which surfaced during the first year of the project. Some of these were concerns about resources. In the primary care team it was lack of time that was most commonly mentioned and the need for additional help in order to take on what was often seen as a new line of psychological treatment. Although such concerns were also expressed in the specialist teams, it was more often uncertainties of other kinds that were mentioned. A second set of concerns was about the potentially disruptive effects of including family members; for example, that they might bring unhelpful attitudes, might dominate sessions, or have needs and goals which were incompatible with those of the substance misusing clients. A third set of anxieties were more to do with lack of confidence on the part of the practitioner; for example about handling confidentiality questions or managing conflicts which might arise.

Table 4 about here

As the project progressed, and teams had more experience of working with family members, some of these worries diminished. Equally, if not more important, was a growing realisation of the rewards of involving family members. Table 4 illustrates the kinds of statements that team members increasingly made about the benefits of family work. Although it was recognised that the teams now had a powerful method for helping family members in their own right, there was also increased acknowledgement that involving family members aided rather than hindered substance misuse treatment goals; for example, by enabling fuller information to be obtained, being able to helpfully work through conflict, giving family members greater understanding of what the service was trying to do, and even experiencing some relief that dealing with the problem was being shared with family members.

Auditing the involvement of family members

In the cases of the two specialist IFM teams, a researcher who had not been involved in project work with the teams carried out, at the end of the project, with each member of the team individually, a retrospective two-week audit of the involvement of family members. With the help of their work diaries, participating team members went back through each working day of the previous two weeks, noting for each treatment session held, whether a family member had attended (alone or with a substance misusing client or with another family member). Telephone and other extra-session family member contacts were also noted. In order to constitute a quasi-experimental design the same exercise was carried out with members of two comparison teams in

the same organisations who had not taken part in the project. The results showed that family members were being seen three to five times as often in the project teams compared to the control teams (15-17% of sessions versus 3-5%). It was now the case that the majority of team members were seeing family members at least sometimes whereas that was true of only a minority of team members in the comparison teams. In the primary care practice, over a period of 18 months, 32 adult patients were identified as suitable for the project and 13 were recruited for the project. In the Muslim service, 29 affected family members were recruited over a period of 18 months. In the non-statutory drug service, 12 family members attended a themed carer group programme and were assessed before and after.

More detailed analysis of the audit findings suggested that a simple count of numbers of sessions attended by family members does not do full justice to the degree to which a team has become family oriented in its work. For example, project teams were carrying out considerable amounts of family work informally, for example on the telephone, during home visits, or in the waiting room. Even more informal family contacts might have been recorded if reception staff had also been included in the audit. There was also a suggestion that project teams were now carrying out a greater spread of family work in terms of the relationships of family members to substance misusing clients. In comparison teams family members were almost always partners or sons or daughters, whereas in project teams, parents and siblings, and sometimes friends, were also being seen. In fact the diversity of family work that was being carried out was impressive. There was diversity in terms of: (1) the relationships of involved family members and others to the focal clients they were concerned about (ranging from partners and parents to aunts, uncles, friends and neighbours; and from

one person to three or four or more); (2) the form and sequencing of ways in which family members were involved (varying from phone calls and other minimal contact to multiple joint sessions; and including family involvement from the outset to involvement following sessions with substance misusing clients; and including joint sessions and meetings with family members alone); and (3) the main reasons for involving family members and the principal gains achieved (varying from emotional support for the substance misusing client to advice on coping for family members). This is reassuring because it illustrates well one of the key principles of the 5-step Method, which is its flexibility.

The introduction of new family-oriented team procedures

We had some success in encouraging teams to introduce new family-oriented procedures. Particularly effective in some teams were thought to have been changes to initial appointment letters and substantial changes sometimes made to assessment forms – including in one team the incorporation of the drawing of a network diagram which played an important part in helping one team to routinely ‘think network’. In another team noticeable improvements had been made to the ‘family-friendliness’ of the team building: the waiting room had been improved, now including family-welcoming notices and a game for children to play; and one of the counselling rooms had been designated a family room, with space to accommodate children.

One of the issues that forced its attention on us was the difficulty of incorporating family-oriented work into the record keeping systems of services. The latter had been based on the assumption that all their work was with individual alcohol and/or drug misusing clients. The standard data collection systems in operation in some services

simply do not allow for recording work with family members except as a minor adjunct to the main work.

Successes and lessons learned

Table 5 summarises what we believe to have been the main successes of our programme of work with teams. However, the work is not easy or straightforward and a number of difficulties were encountered and lessons learned.

Table 5 about here

One lesson we learnt was the need to recognise the differing levels of experience and confidence for doing family work possessed by different team members. The project model was based on training and supporting the teams as whole teams, and insufficient recognition was given to variation in training needs. Some team members were more comfortable working with family members because of their professional training and/or previous practice: social workers and community psychiatric nurses for example. Some team members were more oriented towards family practice for cultural reasons: for example South Asian workers were more likely to already have experience of seeing substance misusing clients and their family members together. We were surprised to find that some team members had had no experience of working jointly with two or more clients in the same room. We also probably under-estimated how different from their normal practice it would be for some primary care health workers to work in a counselling or psychological way.

One of the biggest lessons we learnt in the IFM project was about clarity of objectives. The research team failed for a long time to make it clear that it was a *flexible* approach to involving family members that was being proposed and not a routine application of the 5-step (and/or network) Methods. It emerged as time went on that there existed two versions of the objectives. One, mostly held by the researchers, was that the main objective was to routinely seek to involve family members, in whatever way suited the needs of the case, using existing skills supplemented by techniques drawn from our methods. Work with families would range from brief to intensive, often involving simple strategies or telephone conversations and use of the 5-step self-help manual. Occasionally the work might correspond to the full course of the 5-step Method, in some cases involving the substance misusing relative using the social network methods, but that was likely to be exceptional and there was no requirement that ‘one size would fit all’. The belief was that team members ‘had the skills’ to do family work, and that the project was ‘providing a framework’ or ‘giving permission’ for family work to be done. The alternative version, which it turned out was held in the early months of the project by many members of the specialist IFM teams, was that team members were being asked to carry out the 5-step and network methods in more or less pure form, not routinely, but only as appropriate. This meant acquiring the advanced skills appropriate to those methods. Misunderstanding about project objectives can take a variety of forms. For example, in one general health practice, which we visited on a number of occasions with a view to working with the whole team – although in the event that did not happen – we only realised slowly that there existed a quite fundamental misunderstanding about whether our focus was family members affected by substance

problems (which it was) or primarily substance misusing patients and only secondarily their affected family members (which it was not).

We are much more conscious now of how strong and pervasive is the focus of most services on individual patients or clients and how difficult it is to change that focus, however motivated individual practitioners may be to move their practice in that direction. Nor do we under-estimate the sheer logistics of maintaining contact with a busy service team once the initial period of training is over. Time for meetings may be very limited and without special effort it is very easy to lose regular contact with sub-sections of a service team who may not think they are central to the project or who are less enthusiastic than others: for example, receptionists and secretaries, attached students, part-time staff, or attached workers who may be part of the team but are managed separately.

The big issue that we are left with is the one we started with. Is it possible, in routine care, to disseminate a way of understanding the needs of affected family members and a method of responding which follows from it? We have to be sanguine and certainly not complacent. For one thing it has not always been easy to recruit teams who are interested in working with us. In the case of most of the specialist teams that we worked with we had what amounted to privileged access because of the roles that several members of the research team played in the organisations of which they were part or in other services in their areas. In the case of primary care health centres, however, the situation was very different. We began by contacting by letter all general practices of at least medium size in the Birmingham area. That produced only six expressions of interest and after further negotiation only the one health centre

which took part remained interested. We had also hoped to recruit a general practice in the Bristol, Avon and West Wiltshire area of the country. From a small shortlist of contenders, one was chosen, but after considerable effort on our part, sufficient collaboration was not achieved. In the case of the BME project, the Muslim project which we worked with very successfully was the sole survivor of a process which began by contacting 162 statutory services (many of them general practices) and 24 non-statutory organisations, of which 18 statutory and 17 non-statutory expressed interest and three statutory and seven non-statutory sent staff for training. A conclusion of that project – and it is one which may more generally be true – was that the capacity for service organisations to take on this kind work is mostly very limited. If services are to be provided to family members affected by close relatives' addiction problems, as recommended, for example, in the recent document, *Supporting and Involving Carers*, produced by the National Treatment Agency for Substance Misuse (2008), then the capacity to provide that service, currently very limited, needs to be built. That will require the following:

- Explicit commissioning and funding of work with affected family members.
- Management support for work with family members.
- Organisational procedures and practices which are family-relevant.
- Training and continued support and supervision for practitioners in their work with family members.

Even in the case of those projects which did work successfully with us, the question of the sustainability of change was one about which both the service teams and the

researchers were uncertain at the end of the work. We were naturally concerned that there would be pressure on teams members to revert to more individualistic practice. In addition there were threats, such as organisational mergers, changes in managers, and changes to the commissioning and contracting of services. We were therefore heartened whenever there was indication that the changes we had helped bring about might be spreading within the organisations of which the teams we had worked with were part. In the larger of the non-statutory teams the research team has in fact been asked to roll out the project across the remainder of the organisation's teams: this is now underway using a quasi-experimental design in which two further teams at a time are incorporated into the project. Throughout the work with the NHS specialist team, interest has been expressed by other teams in the same service and by service managers and commissioners. A presentation about the work had been made to service commissioners during the course of the project, and at the end of the project there were encouraging signs that the work would spread. In Bristol, where the work with the non-statutory specialist drug service had taken place, it had been decided that the 5-step Method would play a central part in a city-wide service for family members. We view that as an important decision in a national climate that is finally beginning to give family members and carers the recognition that they deserve (Department of Health, 2007; Home Office, 2008; National Treatment Agency for Substance Misuse, 2008; and see Velleman, 2010, this volume).

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Table 1: Service units we have worked with include:

- A National Health Service (NHS) drug and alcohol treatment unit
- One team of a non-statutory organisation serving clients with alcohol problems
- An NHS primary care health centre
- One branch of a Muslim family-oriented foundation
- A non-statutory drug service

Table 2: Our approach to working with teams includes:

- Training days
- Materials provided
- Continued support
- Advising on organisational practices
- Regular progress meetings

Table 3: Some concerns in the first year

- I don't feel confident about handling open conflicts between users and family
- It is often inappropriate to ask users about involving their family members
- Family members just want to have the drink or drug problem fixed
- I have concerns about confidentiality if family members are included
- Involving family members will require more time which we don't have
- Won't it open a Pandora's box of marital and family problems?

Table 4: Seeing the benefits of working with family members

- I get a clearer picture of the problem when I involve family members
- Making sure the family is well informed is an essential part of good treatment
- Encouraging open communication between user and family is important
- I believe that involving family members should be the norm
- I am now responding to the needs of family members in their own right
- Clients can be discharged more easily knowing that they have support

Table 5: A summary of successes of working with teams

- Positive changes in attitudes towards including family members
- Family members seen more often
- Changes to record-keeping systems
- Changes to the service environment
- Family involvement becomes embedded

Figure 12.1: AAFPQ scores before and after working with primary care and specialist teams

