Family Involvement in Collaborative Adult Community Mental Health Treatment

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WINSTON CHURCHILL MEMORIAL TRUST

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Abbreviations

AAMFT	American Association of Marriage & Family Therapy
AFT	Association of Family Therapy
BHP	Behavioural Health Practitioner
CFHA	Collaborative Family Healthcare Association
CMHT	Community Mental Health Team
CBT	Cognitive Behavioural Therapy
DBT	Dialectical Behaviour Therapy
ECU	East Carolina University
FT	Family Therapy
GP	General Practitioner
MFT	Medical Family Therapy
NICE	National Institute of Clinical Excellence
OD	Open Dialogue
PCP	Primary Care Practitioner
PN	Practice Nurse
SCC	Shared Care Canada
UCSD	University of Carolina San Diego
UKCP	United Kingdom Council for Psychotherapy
UoR	University of Rochester

About the Author

I am an accredited Systemic Family Therapist. I trained in the 1990's at the Institute of Family Therapy in London. I spent 11 years up until 2007 working part time as a therapist in a GP practice. I saw all patients referred including children, adolescents, families, couples, adults and older people. From 1999 until 2017 I worked for an NHS mental health trust as a Family Therapist in a community adult mental health service. I saw adults individually and in couples, and families. I have also spent time working in substance misuse services as a Family Therapist. I currently work as an independent practitioner and researcher based in a GP practice.

Executive Summary

Family involvement in adult community mental health care was the focus of my Fellowship. I travelled to Canada and the USA to look at whether the structure and delivery of adult mental health care facilitated family involvement. My aim was to contrast my findings with care in England.

I joined clinicians in primary care settings and observed their practice. In addition I met with academics and senior managers who deliver and drive the development of collaborative primary care services. My itinerary included attendance at a family health care conference where discussion focussed on best practice in collaborative care.

The questions explored included the following:

- What is the benefit of collaborative family involvement in the treatment of patients?
- If there are benefits what are they and how are they achieved?
- What are the obstacles and how may they have been addressed in other countries?
- Is there an organisational structure which is most useful for service delivery?
- What are the training needs of mental health clinicians working collaboratively?
- What are the training needs of other clinicians working collaboratively?

Major Findings

- Family involvement is possible and beneficial to patients and family members.
- GP practices are a focus for health care and treatment in the community. As such they are in a unique position and offer the most useful context to develop collaborative family involvement.
- Family therapists need to have access to post qualifying training which will build on their systemic skills and equip them to work effectively in primary care settings.
- Collaborative working is not a competition. Family therapists are not the only mental health practitioners who can be trained to work in this way.

Recommendations

- Development of a family involvement screening device to be used by GPs and Practice Nurses.
- Further training of Practice Nurses to be able advocate and facilitate family member involvement, including patient permission/consent.

- Development of a family therapy post qualifying training. Learning from the family therapy models developed in the USA thus enabling clinicians to be trained to work in collaborative primary care.

- Identify ways to enable all clinicians involved in collaborative care to appreciate the differences between the individual and relational locus of pathology.

- At assessment, systematically agree with patient the potential for, and possible nature of family involvement

1. Introduction

The basis of this Fellowship was to look at family involvement in the care and treatment of adult mental health in Canada and the USA and to contrast with care in England. Primary care was chosen because it is often the first point of contact for patients, and that contact is frequently not for mental health issues. Furthermore, General Practitioners, Practice Nurses and other team members often have a relationship with a patient and their family across the lifespan and generations. I have worked as a Family Psychotherapist for more than twenty years, with a base in a GP practice. I have treated patients and their families referred by their GP at all ages and stages of their lives.

My interest in this topic goes back into the 1990's when I was working as a Family Therapist in a GP practice. They had contracted with me to provide psychotherapy, under the prevailing budgetary system called Fundholding. This allowed them to use funds to buy in services they thought appropriate to the needs of patients.

I accepted referrals across the life span, the youngest person I saw was a four-year-old child and the oldest was a 93-year-old man. I saw people in a variety of combinations, individually, couples, and families. I worked with the whole range of mental health issues presenting in primary care. I worked in a time limited, brief therapy approach. Referring back to the GP those who I considered needed longer therapy, or whom I thought needed to be referred on to secondary mental health services.

One of the challenges I had was to find a framework to think about the context in which I was working. Many of my referrals were patients who the GP had known and seen over many years, and also knew and saw other family members. For the GP a referral to me was another treatment, in the same way that they may have been referred for treatment for a physical ailment.

This seemed to locate the GP in a position in which they were the patients' focus, constancy and access point. The language between them seemed often to be of physical ailments, even if the issue was mental health. It also became obvious that patients were not passive participants in this relationship. Those who wanted to access mental health treatment would go to those GPs most likely to refer to me. However, over time it was not unusual for me to receive referrals for different members of the same family.

Family members can often have an important role and function in the lives of someone with mental health issues. This might be as a carer, offering day to day care and support, and/or providing context, stability and a sense of belonging. If we think of families as potential resources in care and treatment, then we need to consider the nature of collaboration between the patient, their family and mental and physical health care professionals.

In England the NHS defines collaborative care as collaboration between adult mental health and social care services, with the aim to provide more 'joined up' provision of care for patients.

In other countries collaborative care is defined in different ways. In order to identify the sites to visit as part of the Fellowship I used two criteria. First, I considered countries with similar health care systems to England. Then I looked at those health care systems which had a history of developing, and trying to implement, collaborative care. Canada and the United States of America were chosen because both, and especially the United States of America, have a history of looking to implement collaborative mental health care.

1.1 Aims, Objectives and Purpose of the Project

The purpose of the Fellowship is to identify best practice in countries with established health care systems who are involving family members in collaborative adult mental health care.

The aim being to enable increased awareness of the potential for active family member involvement in the psychological treatment of adult patients in primary care in England.

1.1.1. Objectives

- Review examples of collaborative family involvement in adult mental health care in Canada and the USA.
- Identify strategies that could be used in primary care health systems which might improve collaborative family involvement.
- Describe how strategies of collaborative family involvement might benefit hard to reach client populations.
- Develop information for GPs and other primary care staff about family involvement in psychological treatment

I spent two weeks in Canada and four weeks in the USA. In the USA I joined clinicians in primary care settings observing their practice. In addition, I met senior managers, clinicians and academics involved in the development of services. In Canada I focused on meeting with those clinicians, academics and managers who both deliver and drive the development of collaborative primary care services.

1.2. Report Overview

This report is looking at the ways that family members may be involved in adult community based mental health treatment. It does not start from the assumption that this will always be desirable or possible; neither does it assume that families are always responsible for the pathology of its members. Rather it starts from the position that family members may be a resource which can be mobilised for the benefit of both patients and family members. It also assumes that some mental health issues are relational and that treating the relationships may be the most effective intervention. It accepts that for many communities the primary care settings, such as GP practices, are the focus for people wanting treatment. Furthermore, that GPs and Practice Nurses are uniquely placed to influence patients' thoughts and ideas about the benefit of particular treatments and ways of working. Another assumption is that a family therapist has skills in relational working which places them in a useful position to work in this way. Although that would require additional

training. It does not assert that they are the only psychological therapists able to do this work. Rather it assumes that there are a number of different psychological and social care professionals who with additional training can work effectively in this approach/s.

Finally, it is looking to Canada, and particularly the United States of America, for examples of structuring primary care services to facilitate collaborative family involvement. The reasons for this are that since the mid 1990's in the USA there has been a commitment, by many health care professionals, to developing collaborative, integrated ways of working, with structures which support it. There is an increasing body of research which confirms the benefits to patients and families of these approaches.

2. Findings in the USA

2.1 Health Care Context

The USA health care system is a mix of private, federal, state and not-for-profit providers of both primary and secondary care. This has shaped the nature and development of physical and mental health care provision, allowing more local autonomy for service providers to innovate and develop approaches. In contrast the National Health Service in England is a universal provision.

2.2 Detail of the Visits

My USA itinerary included visits to clinical providers, universities and support agencies, plus attendance at a national conference. Two of the visits were to work alongside teams of clinicians, and to attend associated training events. The first was to a public primary care setting operated by East Carolina University. This was in a high needs area in Greenville, North Carolina offering open access to the community. The second visit was to La Jolla California, a clinic operated by the University of California at San Diego, accessible to patients with health care insurance including Medicaid.

Whilst in Greenville the East Carolina University staff facilitated a meeting with the Clinical Director of the Vet Center, a local not-for-profit organisation supporting military veterans.

I also made a non-clinical visit to the University of Rochester Medical Centre, to meet a senior academic and family therapy clinician to discuss the training of Medical Family Therapists.

During my time in the USA I attended the Collaborative Family HealthCare Association national conference in Charlotte, North Carolina. This is a large conference of predominately USA based clinicians, managers, policy makers and academics, who meet to discuss and debate best practice in collaborative care.

All the teams I met employed systemically trained doctoral or masters level behavioural health clinicians. The core training is in family therapy, with the nationally recognised qualification of Marriage and Family Therapist. However, there were local variations. For example, at East Carolina University in a high needs area, there was additional training in physical health care. This variation was reflected in the title of the qualification Medical Family Therapist. It's worth noting that the concept of Medical Family Therapy does not exist in the UK.

2.3 Emerging Themes

The following themes emerged from working alongside and observing teams.

2.3.1 Peripatetic Teams

Clinicians worked in peripatetic teams, covering a number of clinics during opening hours. There were facilities in the primary care clinics to see patients, but clinicians were not expected to be office based. The clinics were geographically spread and required the senior clinician to agree with their staff which clinics were to be covered the following day. This sometimes meant that

staff would travel long distances, up to 150 miles on occasion, to be available at a clinic.

2.3.2 Visibility

The approach to treatment was to respond to requests from primary care physicians to see patients attending the clinic. Therefore, part of the role was to regularly ‘walk around’ the primary care facility, to be visible and signal their availability for referrals.

2.3.3 Availability

The idea of immediate availability was often described as ‘warm handoffs’ whereby clinicians were constantly available to see patients referred by primary care physicians. This could be after or during a consultation, and with the aim to see them whilst they were still on the premises. This seemed to offer a particular opportunity for family involvement because the patient may have been accompanied by a relative, carer or other member of their network.

2.3.4 Flexibility

The notion of flexibility is illustrated by being open to and seeking collaboration with other medical professionals. An example of this was one primary care site that shared premises with dental practitioners, which offered a potential route to family involvement.

2.3.5 Collaboration

Collaboration was demonstrated by the sense of openness and availability of team members to work together, without hierarchy or competition. There was a willingness to accept and respect the skill and expertise of others.

3. Findings in Canada

3.1 Health Care Context

Canada has a system of universal access to health care similar to the UK. However, it covers a very much larger geographical area (9.09 million square metres), which is approximately 41 times larger than the UK. In terms of population Canada has approximately 35 million people (2017). In contrast the UK had 65.64 million in 2016, which is almost twice as many.

3.2 Detail of the Visits

I visited a number of settings in Hamilton, a city close to Toronto, including a Family Health Service which was a secondary care provision providing psychological treatment across the lifespan. I also visited a Family Health Centre in a high needs area of Hamilton. This is the equivalent to a GP practice in the United Kingdom. They employed a dedicated mental health therapist as part of their team.

In Toronto I spent a day with Family Therapy colleagues employed in a variety of settings in the city and across Ontario. We focussed on different ways of working, and how family therapy practice and training may need to adapt in response to new demands. In Ottawa I visited and spent time in another Family Health Centre, this was located near the city centre and served a mixed population of people. They used a peripatetic mental health therapist, employed by a mental health team based in Ottawa hospital. The Family Health Centres in Hamilton and Ottawa were employing structures designed to support collaborative working.

In addition, I chose to visit the Vanier Institute of the Family in Ottawa because I wanted to look at their research and dissemination of findings aimed at enhancing the understanding of family life in Canada.

I also travelled to Kelowna to attend 17th Collaborative Mental Health Care Conference, which was titled 'Growing Ideas'. This brings together a range of mental and physical health professionals interested in and applying collaborative approaches. It was described by the organisers as a place for participants to, 'share ideas, build new paradigms for practice, and add to their own practice'.

3.3 Emerging Themes

The following themes emerged from my visits.

3.3.1 Use of groups

This approach draws on a variety of therapeutic modalities, including CBT and DBT. Working with groups seemed to offer maximum accessibility on the basis of lower cost when compared to individual work. This combined with some of the geographic distances involved seemed a very effective use of a clinician's time.

3.3.2 Creative use of therapeutic techniques

The clinicians' use of techniques was both creative and pragmatic. Motivational interviewing was used to both enhance the efficacy of other therapeutic approaches and as a treatment in itself, delivered individually and in groups.

3.3.3 Team collaboration

Clinicians were working very closely to organise care and treatment within their speciality. There was a strong sense of team cooperation, showing an awareness of the demands of a high needs situation. Also, they demonstrated a commitment to maintaining clear effective communication.

3.3.4 Co-location

This appeared to be built on the idea that it encouraged accessibility and improved communication between clinicians. In one setting the mental health clinician was based in a primary care practice, he had an office there where he saw patients. He was a full member of the team and had access to, and recorded on, the same electronic patient record. However, it was also acknowledged that the distributed nature of populations and limited resources often militated against this.

3.3.5 Care across the lifespan

Care and treatment was needs driven with the clinician determining the most appropriate intervention regardless of age or stage of life. The aim in mental health care delivery was a seamless transition between children's and adult services.

3.3.6 Family systems ideas and thinking

The intention in most treatment plans was to involve family members in the care, particularly where children and young people were concerned. However there seemed to be a number of obstacles, these included distance, economics, and data protection.

4. Reflecting on the Themes

Following the completion of the visits I considered the emergent themes from the USA and Canada against the current situation in England to inform the recommendations at the end of this report.

Since the Depression Report (Layard) in 2007, and the creation of the Improving Access to Psychological Therapies programme, there has been an attempt to create consistent primary mental health care provision across the country. This service is aimed at patients presenting to GPs with mild to moderate disorders. The need for this was in response to the pre-2007 provision which was considered to be inconsistent.

At that time there was no statutory requirement to provide a service. Patients presenting with mild to moderate disorders would be referred by GPs into secondary mental health services if they were considered to meet the threshold for referral. The alternative provision would be for the practice to buy in a service. There were no guidelines or recommendations for what type of service, qualifications of provider, nature of provision, or what treatment was evidence-based. As a consequence, it was very difficult to assess the nature of provision and its efficacy.

The statutory provision which has been put in place removes a GP's ability to buy in a service. It is provided for the most part by secondary mental health trusts and a system of contracting enables a GP to gain access to the service. It is based on the current evidence-base for the treatment of mild to moderate disorders. The models of therapy which are currently considered to meet these requirements are Cognitive Behavioural Therapy and Interpersonal Therapy. There is no provision or requirement within the service to involve family members or carers. However, it may be argued that there is nothing to prevent a therapist involving them.

However, the mostly widely used model Cognitive Behavioural Therapy is a prescriptive model, which does not prescribe family member involvement. There is one exception to this, which is the Exeter model; this is a Cognitive Behavioural Therapy based approach which uses systemic skills and thinking to enhance its delivery. It meets the NICE guidelines for the treatment of Depression and is a couple therapy model developed by Professor of Family Therapy Dr Janet Reibstein and Hannah Sherbensky at the University of Exeter. My understanding is that whilst some mental health trusts have sent staff on the training, it has not yet been widely adopted in the UK.

I will now consider the themes from the USA and Canada against the current provision in England.

4.1 Comparing USA Themes to the Context in England

4.1.1 Peripatetic teams

In the USA the idea of team is very much about professionals occupying the same locality and with face to face contact. They share access to electronic client note recording and attend regular meetings between physical and behavioural health practitioners. It does not mean that always the same behavioural health

professionals will be working in the locality. The principal reason for this is the use of trainees supervised by a senior clinician, who may be a regular team member, and familiar with the practice and its personnel. The consistency is in the form, nature and location as opposed to the personnel.

In England the idea of team is also central, however primary mental health professionals have to work with a number of structural factors which may make this difficult. In the original recommendations from Lord Layard the idea was that they would deliver the service from the GP practice. This has proved difficult for a number of reasons. These include space because many practices do not have room/s available consistently to be used. Also, economics plays a part with some practices wanting to charge rent for a room. Furthermore, should primary mental health professionals have a number of referrals from different practices, they could find themselves moving from practice to practice. This is because they are not able to see a patient in one practice who is from another.

A further issue is client note recording as they are not part of the GP practice and do not have access to their note system. They will be recording on a system provided by their employer which is the mental health trust. Despite investment and various attempts at integrating the systems, the only way they can communicate client recording is face to face, by email (securely), letter or telephone. In addition, their employer is the secondary care service and, as such, is where they are principally accountable.

4.1.2 Visibility and availability

In the USA these go hand-in-hand. The service is structured to be responsive to the demands on primary care physicians in busy practices. It acknowledges the following ideas. Patients will often present in primary care with a physical ailment, which whilst it exists, may also be indicative of a psychological issue. Compliance with treatment for a physical condition, such as diabetes, can be affected by psychological issues such as depression. If the behavioural health clinician can be available when the patient sees the physician, this may offer the opportunity for the patient to come to understand the way their psychological issues may manifest. It may also offer the opportunity, through collaborative working, for the patient and their family members to understand the holistic nature of health, and how they as a family can collaborate to improve each other's wellbeing. It may also facilitate the treatment of the presenting pathology which may have its locus in relational issues in the family system. In doing this the patient can be seen to be collaboratively in the centre of what is described in the USA as the 'Tri Optic'. This is because they have structured their system to ensure that the patient is placed at the centre of the health care resources, including the family.

Family member involvement can provide a view of the patient's condition, particularly where a condition, such as depression, is difficult for them to acknowledge. They are also a potential resource who can be used to support and enhance the efficacy of an intervention. Patients, accompanied by someone to support them, may have travelled some distance to see their physician. They may be concerned about losing money because they have missed work, or worst still they may feel they have

jeopardised their employment. If they can be seen by the behavioural health clinician at that visit it may reduce the risk of non-attendance at a follow-up appointment.

In England, as in the USA, it is acknowledged that the GP or primary care physician carries the overall responsibility for the patients' care. However, service delivery in mental and physical health, and primary and secondary care, seems to be organised by silo working. Each individual professional working in their own expertise, communicating with others within defined pathways, at referral, after assessment, at review and at the end of treatment. Whilst these are important, it does not foster a sense of collaborative treatment or the holistic nature of health.

Looking specifically at primary mental health care and availability. The patient sees the GP who agrees a referral to the service, but there may be a 6-18 week waiting list. The GP may not know the specific therapist and the appointment may take place in a venue the patient is not familiar with. Or, in the case of being seen in a secondary care setting, the patient may know of it and have negative ideas about what being seen there means. There is no provision for family involvement, and no suggestion that it might be useful or desirable. Even if the GP supported the notion of family involvement, they are referring to a service which, with the exception of being seen as a couple for the treatment of depression, is unable to accommodate family member involvement. To put this in perspective, in the year 2015-16 of 152,452 seen in primary mental health services to recovery, 894 were couple therapy for depression.

4.1.3 Collaboration and flexibility

The features of the services I observed in the USA were flexibility and creativity, characterised by behavioural health clinicians not needing to work to conventions. The services in England are based on 50-minute therapy sessions, dedicated therapy rooms, unitary models, and structured preparation time.

The following example of the flexibility in the USA service is based on a number of observations. A primary care physician asked a behavioural health practitioner to see an adult person who had presented with a physical problem. The physician had thought they might be depressed and had used a depression screening tool, which suggested this might be the case. The patient had been accompanied to the practice by another adult family member. At the end of the physician consultation, with consent, the accompanying family member and behavioural health practitioner joined the physician and the patient. There then followed a collaborative conversation about the patient's low mood and potential treatment.

The patient was seen by the behavioural health clinician separate from the physician. The session lasted approximately 20 minutes and was conducted in a spare physician consulting room. The behavioural health practitioner used Family Systems ideas, to think about the pathology and a Solution Focussed framework to deliver the application of Cognitive Behavioural Therapy techniques.

If we contrast this to England, it is more difficult to work flexibly. There are those who question the usefulness of this approach because it fails to adhere to the conventions of psychological treatment. Even if this were not the case, one of the difficulties is in the statutory nature of the primary care mental health service. It was

created in response to the pre-2007 service shortcomings. In its place the current systems aim to address those concerns with contracts specifying the nature of service delivery. This includes the conditions to be treated, the duration and frequency of sessions, the use of evidence-based treatments, outcome measures and model fidelity. The qualifications and accountability of practitioners are specified with targets for individual practitioners and services to achieve within an agreed and contracted cost framework.

Whilst it can be argued that this is preferable to the previous arrangements it may limit flexibility and creativity. This is because evidence-based treatments only can become so if innovative ways of working are applied and researched on a day to day basis.

4.2 Comparing Canadian Themes to the Context in England

I chose Canada to visit because it had a health care system based on universal access to care. It also has a network of family health centres, which are primary care settings and function in a similar way to GP practices in England. However, clinicians often cover much larger geographical areas. When visiting Hamilton, I spoke to a mental health practitioner who travelled 300 miles to a clinic. This, combined with an overall population of approximately 50% of the United Kingdom and a land area 41 times larger, poses challenges for how mental health care and treatment is shaped and delivered.

I will now consider the themes from Canada against the current provision in England.

4.2.1 Use of groups

This way of delivering treatment seemed to be in response to the previously mentioned geographical distance, combined with economics, and a commitment to delivering evidence-based therapies. When practitioners travel long distances, they need to maximise the time spent in a clinic. This is because their travel time has reduced their availability and the frequency with which they can visit. If they see six people in a group for three hours, this is twice as many as if they were seen individually. It also means that the alternative would be to employ more therapists in different localities. Apart from the cost there is an issue of how these practitioners are managed and the extent to which they can build a sense of being part of a team. In effect they are lone practitioners with limited direct contact with their colleagues. There is also the challenge of delivering evidence-based treatments effectively, with greater time intervals between treatment sessions. The models of treatment most frequently adopted were Cognitive Behavioural Therapy and Dialectical Behaviour Therapy, both of which are evidence-based, including evidence for group treatment. The use of groups in Canada also employed the idea that participants may offer support to each other, combined with telephone or email contact from the therapist in between group sessions.

In England there is use of groups in primary care mental health. As with Canada they employ evidence-based treatments such as Cognitive Behavioural Therapy, and may address specific issues such as low self-esteem, or behavioural activation for depression. It is not clear if delivery in this way is considered to offer an enhanced therapeutic or economic benefit or maybe both.

4.2.2 Family systems, ideas and thinking

One of the challenges for the therapist, given the geography, is family involvement. The notion of family involvement was acknowledged as being useful with therapists employing family systems ideas and techniques. However, the infrequency of visits could be an advantage as well as an obstacle to involvement. An advantage because all concerned would know exactly when the therapist would be available, an obstacle because this availability was probably not going to have much flexibility.

It did not mean that individual therapy was not available in some contexts. Those Family Health Centres in more urban settings offer individual evidence-based treatments. The in-house therapists in those practices worked from a dedicated therapy room and saw themselves as working collaboratively as full members of the primary care team. In other settings the therapist may cover a number of practices with regular clinics in each practice. In all settings therapists talked about seeing family involvement as desirable, whilst acknowledging the difficulties that might obstruct it.

Economics was the most frequently cited obstacle to family involvement, especially in those practices serving high needs populations. Family members may be working in several jobs and taking time out to attend a meeting may prejudice the employment and/or lead to a loss of income.

In England there is no provision for family involvement in adult primary mental health care, with the exception of couples' therapy. The reason for this is fairly straightforward. It is the adoption of Cognitive Behavioural Therapy as the dominant modality in therapist training. This approach does not include provision for, or benefit from, family involvement, and therefore means it cannot be offered.

As previously mentioned the only exception is in couple therapy. However, the most recommended couple therapy training for primary mental health therapists is the Tavistock Institute of Marital Studies approach, which is psychodynamic in orientation. The only approach which employs systemic ideas and techniques is the aforementioned Exeter model.

4.2.3 Creative use of therapeutic techniques

This was an interesting aspect of my visit and seems to be based on the need to adapt to the challenges that geography and a smaller, more dispersed population posed. It also seemed to represent a desire by therapists to develop ways of working which were responsive to patient circumstances. An example is the use of motivational interviewing. This is a technique which has its origins in addictions work and can be delivered in a short space of time, often a single session. This approach seemed to be used with patients with a variety of presenting conditions. Either to enhance the efficacy of an approach such as Dialectical Behaviour Therapy, or as a treatment in itself.

A further example of creativity was described to me by family therapy colleagues at a training day I attended in Toronto. This was the establishment of approximately 60 single session walk-in clinics based in Family Health Teams across Ontario, which I was told employed a Solution Focussed Therapy approach.

4.2.4 Team collaboration and co-location

In all my visits in Canada the staff talked about team collaboration and the idea that co-location was desirable to support it. Whilst they acknowledged that this was often a challenge given the geography and the widespread nature of service provision. In those settings with an in-house mental health therapist it was easier to see how team collaboration worked. The physical and mental health clinicians talked about the sharing of information, the joint creation of formulations and frequent feedback on treatment.

4.2.5 Care across the lifespan

I was very interested in this aspect of the work in Canada. I had experience of secondary mental health settings in which the transitions, from children services to adult services, were often challenging. The difficulties in England seemed to relate to the fixed point of transition, and the idea that what was expected of the patient in adult services was different to that in children's services. In Canada the approach seemed to be different. If a young person at eighteen was appearing to continue to benefit from a service they had accessed when younger, they would continue to use it. On the other hand, if a sixteen-year-old could benefit from a service provided for adults then they could access it. This approach employed the idea that people do not develop at the same pace, so may not all have the same needs at a given age such as eighteen. However, it was accepted that achieving their majority may mean that family involvement needed to be approached differently. It would require permission from the young adult rather than agreement with a child or younger person.

5. Conclusion

The title of my project is family involvement in collaborative adult mental health treatment. I chose this because there were a number of questions I wanted to explore. These included; was there benefit in involving family members in community-based adult mental health treatment and if so what was it? If it was desirable how would it be achieved? What might be the obstacles and is there an applied framework in which they could be considered and understood?

I was seeking a framework in order to consider the nature of the relationships between professionals, patients, the family and the physical and mental health issues. The work of developing a biopsychosocial model by Professor Susan McDaniel, and her team at University of Rochester in the United States of America, offered the basis to think about the relationships. This was then incorporated in the Tri Optic framework in which the patient is seen through the lenses of team collaboration, biopsychosocial understanding and family involvement.

This framework has been the basis for the formation of my family involvement questions. The choice to focus on primary care was because this is the context which patients and family members look to initially if they require physical health treatment. It is also the place which is most likely to hold the patient's stories of physical and mental health and often of family. It may well be the place in which the patient has most confidence and trust and is most accessible to them. My visits in both the USA and Canada restated this for me.

As far as the question of the benefit of family involvement is concerned this remains difficult to answer. In my visits to the USA all the services I saw employed Medical Family Therapists, or Marriage and Family Therapists, these are practitioners trained to work systemically and involving family members. They had created services and ways of working which seemed to maximise the opportunity to involve family members and were often successful in achieving it. At the same time, they all acknowledged how challenging this was. In Canada they were at a different point of development, however they consistently described a commitment to developing collaborative mental health services in which family involvement was desirable. Whilst they also acknowledged how difficult this often seemed to be.

The challenges seem to be accessibility and availability. If family members are to be involved then they need to make themselves available and services need to be accessible. Availability also involves patients giving permission or consent for involvement, and an agreement from the family member that they will be involved. In many ways this would appear to be simple to achieve, however there would appear to be a number of obstacles. These include how we think about and construct an understanding of pathology. If we believe that family functioning may be partially, or wholly, responsible for the patient's pathology then family member involvement might seem at best unhelpful, at worst dangerous, and likely to worsen the patient's condition.

An example of this occurred when I was making a presentation to a conference in Ottawa. A member of the audience, who represented a carers organisation, challenged me when I made reference to an approach called Open Dialogue, which

is family therapy based and used in the treatment of patients in a mental health crisis. She argued that this pathologized families, particularly parents whom she felt were held responsible for creating their adult child's difficulties.

These ideas can maintain an explanation that the pathology is located within the patient, and not in the family relationships. If we think about it as existing in the relationships then family involvement offers the opportunity to address and treat the issues. It can also help patients to think differently, and more usefully, about their mental health issues and involvement with treatment.

The final question concerns an applied framework. The answer to this is that there are in the USA a number of applied frameworks or models of working. They carry different titles and there are some structural differences. However, the majority would I think describe themselves as providing collaborative, integrated mental and physical health care, which aims to locate the patient at the centre of treatment. The majority are located in primary care services, although there are some exceptions to this in secondary care. As far as family involvement is concerned, the services I deliberately visited aimed to achieve it. However, I am aware there are those services which do not give as much priority to this achievement.

In England there has been for some time interest in developing different approaches in primary care. In 2015 the NHS Five Year Forward View made the case for 'triple integration' integrating social care, primary and secondary care, plus mental and physical health care. The Mental Health Taskforce report argued for the implementation of integrated care which addressed the mental, physical and social needs of the community. This led to the establishment of a number of Vanguard sites across England which were designed to develop and evaluate different approaches.

However, there is little mention of collaboration, and the terminology is very much about integration, which could simply mean physical and mental health services located on the same site or in very close proximity. It may mean different structures which provide opportunities for different and more collaborative ways of working. However, as far as primary mental health services are concerned, any structural changes which involve funding are likely to require changes to the statutory requirements.

In the previously mentioned NHS Five Year Forward Plan carer needs are acknowledged, including the possibility of involvement. This is not elaborated and the term carer has been employed to include family members involved in care. There is no specific reference to family member involvement, and how that might be employed. It could be seen that this is a time of opportunity, in which it might be possible to trial different ways of working.

6. Recommendations.

- Development of family involvement screening device to be used by GPs and Practice Nurses

This is based on the idea that family involvement may need to be introduced to relatives quickly and easily, whilst gaining some indication as to their willingness to be involved. It needs to be straightforward and brief because it would need GPs and Practice Nurses to be able to see its value and feel able to employ it in a consultation, if they felt it was appropriate.

- Further training of Practice Nurses to be able to advocate and facilitate family member involvement, including patient permission and/or consent

Practice Nurses are at the frontline of working with patients, and their relationship with patients may feel more accessible. Patients may feel more able to ask nurses questions about prescribed treatment. This would seem to offer an opportunity to discuss family member involvement and address any questions the patient or family member may have. However, to achieve this, Practice Nurses would need to understand the value of the approach.

- Development of a family therapy post qualifying training. Learning from the family therapy models developed in the USA thus enabling clinicians to be trained to work in collaborative primary care.

There is no history in the United Kingdom of family therapists working in primary care settings. In the past it was argued that family therapists working in secondary physical health settings, such as general hospitals, were employing a Medical Family Therapy approach. If family therapists are to work in collaborative primary mental health care, they will require additional training, particularly in physical health issues, to enable them to work holistically.

- Identify ways to enable all clinicians involved in collaborative care to appreciate the differences between the individual and relational locus of pathology.

In physical health care the locus of pathology is within the person, and clinicians such as GPs may also employ this concept when thinking about a patient's mental health issues. Enabling them to understand that pathology can be relationally located, does not necessarily require them to abandon their individual ideas, rather to understand that there is another way that it can be thought about and worked with.

- Incorporating systems thinking in all clinicians' initial training as a framework for developing collaboration.

This employs the idea that initial training offers an opportunity to incorporate the value of thinking relationally, whether about a patient or about the team you are working with. That this may improve potential collaborative working and recognise the potential value of family involvement.

- At assessment, systematically agree with patient the potential for, and possible nature of, family involvement

This is aimed at mental health practitioners, wherever an assessment might be occurring. It employs the idea that the benefit and value of family member involvement may need to be explored with the patient.

Appendix 1

Visits made during the Fellowship

Canada	
Hamilton Family Health Team	123 James St. N, Suite 300 Hamilton, ON L8R 2K8
Crown Point Family Health Centre	67 Kenilworth Avenue, North Lower Level, Hamilton, ON,L8H 4R6
The Vanier Institute of the Family	94 Centrepointe Drive, Ottawa, Ontario K2G 6B1
Growing Ideas. **17th Canadian Collaborative Mental Health Care Conference**	The Coast Capri Hotel, Kelowna British Columbia
Primrose Family Medicine Centre	35 Primrose Avenue, East Ottawa, ON K1R 0A1
United States of America	
East Carolina University Family Therapy Clinic	612 East Tenth Street, Greenville, North Carolina
Human Development and Family Science Department,	College of Health and Human Performance East Carolina University, 238 Rivers West, Greenville, NC 27858-4353
Vidant Family Medicine – Greenville	2450 Emerald Place, Greenville North Carolina
Vet Center, **US Department of Veterans Affairs**	Readjustment Counselling Services 1021 WH Smith Blvd Greenville, North Carolina
Institute for the Family Department of Psychiatry and Family Medicine	University of Rochester Medical Center, 300 Crittenden Blvd, Rochester New York State
Division of Family Medicine Department of Family & Preventative Medicine	University of California San Diego, 9500 Gilman Drive, La Jolla, California
UC San Diego Health – La Jolla	9333 Genesee Avenue, San Diego, CA 92121
Celebrating The Many Faces of Integration,	Collaborative Family Health Care Conference Association 18th Annual Conference, Westin Charlotte Hotel, Charlotte, North Carolina

Appendix 2

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