

**INTEGRATING FAMILY-FOCUSED PRACTICE INTO
ROUTINE ADDICTION SERVICES**

by

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ABSTRACT

This thesis reports the evaluation of a training program aimed to promote a whole Organisation shift towards greater involvement of affected family members (FMs) within addiction treatment and services. A two-phase quasi-experimental design integrating action research is described.

Phase one (Pilot phase) involved two teams within the Organisation receiving a family-focused training and on-going supervision package. During this Pilot phase the evaluation outcome measures were developed and pilot tested. Phase two then involved selecting two further teams at random to receive the training package ('Immediate' training) whilst the two remaining teams served as a control and received the package following a delay ('Delayed' training). The package was delivered to all managers and front-line staff within each team.

This thesis reports the evaluation of the impact of the training and support upon a range of outcomes using pre and post quantitative and qualitative measures over a three-year period. Staff who had received immediate training reported significant increases in positive attitudes towards family-focused practice; as well as increases in the proportion of family-focused practice in their daily routine work. Significant improvements in attitudes were, however, also evident in the absence of the training package during the delayed comparison group's waiting period. Possible reasons for the findings are presented along with qualitative analyses that illustrated the complex and sometimes hidden experiences and views of staff, which helped to aid the interpretation of the statistical findings.

The study supports the use of an Organisational platform to implement change towards more family-focused addiction treatment. Overall, the results indicate that addiction services are

capable of implementing family-focused practice; however, success depends on many factors at the level of the individual service provider, Organisation and outside environment in which the Organisation is situated.

To Mum, Dad and Dave

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DISSEMINATION

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LIST OF ABBREVIATIONS

Throughout this thesis, the term family member or FM is used to refer to those affected by the addiction problem of someone within the family, and the term relative, substance user, user, or focal client (FC) is used to indicate those with the substance related problem.

DCSF: Department for Children, Schools and Families

DOH: Department of Health

FC: Focal client

FM(s): Family member(s)

IFM: Involving Family Members

NICE: National Institute for Health and Clinical Excellence

NIDA: National Institute on Drug Abuse

NTA: National Treatment Agency for Substance Misuse

RCT: Randomised-controlled trial

SAMHSA: Substance Abuse and Mental Health Services Administration

SBNT: Social Behaviour and Network Therapy

WHO: World Health Organisation

THESIS OVERVIEW

This section provides a brief overview of the eight chapters within this thesis.

The literature review in Chapter one is concerned with two broad areas. Firstly, what is known about the efficacy of family intervention for substance misuse problems; and secondly, to what extent do professionals implement family intervention following training.

Chapter two presents the research aims and methods employed in order to evaluate whether providing a package of family-focused training and on-going supervision to all teams working within a non-statutory addiction treatment Organisation would be successful in promoting a whole-organization shift from an individualistic treatment philosophy, towards a more family-focused way of working. The Pilot study and main quasi-experiment are described.

Chapter three reports the quantitative analysis and results from the Pilot phase of the research. Two teams were chosen to receive the nine-month family-focused training and supervision package as part of the initial pilot study. During this Pilot phase the research protocol and measures used to evaluate the impact of the family-focused training package were developed and pilot tested.

Chapter four describes the development and validation of the ‘Attitudes to Involving Family Members in Treatment Questionnaire’ (AIFMTQ), a measure developed by the author. The conceptual development, factor structure, internal reliability, content and construct validity of the new measure are reported.

Chapters five and six report the quantitative results from the main quasi-experiment (phase two) whereby two further teams received immediate training, whilst the two remaining teams served as a control and received the package following a delay. Chapter five examines staff attitudes towards family work and Chapter six examines the proportion of family-focused work being delivered within the teams at key time-points before, during and after training.

Chapter seven reports the qualitative analysis and results from the research. The chapter first discusses the experiences of the trained frontline staff and managers regarding the common factors that appeared to be facilitating or impeding family work. Secondly, a summary of the key challenges and lessons learned during the research are discussed.

Finally, Chapter eight discusses the main findings, implications and conclusions from the research. Some recommendations for clinical practice and future investigation are presented, followed by a discussion of the strengths and limitations of the research undertaken.

CHAPTER ONE

EFFICACY AND IMPLEMENTATION OF FAMILY INTERVENTION: A LITERATURE REVIEW

INTRODUCTION

Substance misuse continues to pose public health challenges worldwide (DOH, 2012; NIDA, 2012; SAMHSA, 2010; WHO, 2011). The problems associated with substance misuse pervade the lives of the family and social network, as well as the individual drinker or drug user (Barnard, 2007; Billings, Moos & Collins, 1990; Copello, Templeton, Krishnan, Orford & Velleman, 2000a; Copello, Orford, Hodgson, Tober & Barrett, 2002b; Copello, Velleman & Templeton, 2005; Holmila, 1994; Orford *et al.*, 1983, 1998, 2005, 2010a; Velleman, 1993).

As a result of being concerned about a person with an alcohol or drug problem, it has been estimated that approximately one hundred million people worldwide experience considerable daily dilemmas and stress (physical, psychological and social) (Orford *et al.*, 2009). The quandaries associated with substance misuse (e.g. violence, conflict, debt, shame, relationship difficulties and general family disruption) can cause more upset for family members (FMs) than the drinking or drug-taking itself (Velleman & Orford, 2000). The on-going nature of the stress related to having a relative with a substance misuse problem means it is one of the most common forms of stress that adults are likely to experience (Copello, Templeton, Chohan & McCarthy, 2012; Orford, Natera, Copello, Atkinson & Tiburcio, 2005).

Despite the reciprocity between substance misuse problems and family problems, treatments for substance misuse problems have, historically, tended to focus on the individual substance misuser only (Copello *et al.*, 2000a, 2002a, 2008; Orford *et al.*, 2009; Stanton, Todd *et al.*, 1982; Templeton & Velleman, 2006). However, researchers over the previous three decades have increasingly established the vital role of FMs within the treatment process, and a range of interventions that integrate a family element have been developed and empirically tested. Furthermore, studies have also shown that professionals can be trained effectively in family intervention skills (e.g. Bailey, Burbach & Lea, 2003, Orford *et al.*, 2009; Redhead, Bradshaw, Braynion & Doyle, 2011; Schweitzer *et al.*, 2007). Yet, there is little evidence of dissemination of family-focused approaches into routine service provision (Fals-Stewart & Logsdon, 2004; Lee, Christie, Copello & Kellett, 2012; Sawyer & Campbell, 2009), and currently little is known about how to achieve successful implementation and sustainability of family-focused practice within substance misuse treatment services.

AIMS OF THIS LITERATURE REVIEW

This chapter is concerned with two broad areas. Firstly, what is known about the efficacy of family intervention for substance misuse problems and secondly, to what extent is family intervention being implemented. While a number of reviews examining family interventions for substance misuse problems have been published, the focus has been diverse, with some examining alcohol and drug misuse separately, some examining prevention and/or treatment for substance misuse, and some focusing on specific settings and populations, e.g. family interventions for adolescents or indigenous communities, etc. Therefore, the first section of this chapter reports the results of a review of reviews, or ‘tertiary review’ (a term coined by Torgersen, 2007) whereby the articles included are themselves reviews. By conducting a

tertiary review, it was possible to identify and synthesise the evidence of the efficacy of family intervention for substance use problems, as well as highlighting any conflicting evidence or gaps in the evidence.

The second section then systematically examines the extent to which family intervention is implemented following training. As there are currently no existing reviews examining implementation of family intervention within substance misuse services, initially, this was the intention. However, given the limited number of studies identified, the focus of the review needed to be broadened to include studies evaluating implementation of family work in the wider health care system, i.e. including mental health.

To sum up, this chapter contains two separate literature reviews:

1. A tertiary review to examine the efficacy of family intervention for substance misuse problems.
2. A systematic review to investigate evidence of whether training and supervision in family intervention led to professionals implementing family work. Furthermore, the review aims to specifically identify any barriers to implementation where family work is not successfully implemented.

EFFICACY OF FAMILY INTERVENTIONS FOR SUBSTANCE MISUSE: A ‘TERTIARY’ REVIEW

Search strategy and inclusion criteria

This tertiary review (Torgersen, 2007) intended to assess the current status of the efficacy of family intervention for substance misuse problems by bringing together the evidence from a range of previous reviews across various settings and populations. Reviews of family intervention that were published between 1995 and 2012 were examined. Using OVID, Web of Knowledge (WOK) and the Cochrane Library, a keyword, title, abstract and topic search for relevant reviews was conducted by searching EMBASE, Medline, PsycARTICLES PsycINFO and the Social Sciences Citation Index (SSCI). Using Boolean search terms, keywords included in the search were: Addiction, alcohol, alcohol misuse, drug, drug misuse, family, intervention, substance. The search strategy was limited to review articles only. Reviews were included if they reviewed evidence from family interventions focusing on prevention, treatment and aftercare outcomes for substance misuse (drug and/or alcohol use/misuse). Additionally, interventions targeting affected family members (FMs) in their own right, with a focus on family outcomes were also reviewed.

RESULTS

Fifteen published reviews were identified and were eligible for inclusion. Additionally, a systematic review carried out on behalf of the Department of Public Health and Epidemiology West Midlands Group was identified and included. Table 1 summarises the included reviews.

Reviews are summarised in chronological order (starting with the oldest publications identified) to get a feeling for how the field has progressed over time.

The majority of reviews (ten) examined family-based interventions for substance misuse (alcohol and drug misuse), five reviews examined alcohol misuse only and one review examined drug misuse only. Nine reviews focused on adults, one focused specifically on indigenous communities and another focused on the outcomes of affected FMs. Four reviews focused on adolescents (between the ages of 12 and 18), and three reviews focused on both adolescents and adults. Eight of the sixteen reviews were systematic reviews, of which one was a Cochrane review, and six reviews included a meta-analysis.

Table 1. Summary of Reviews of Family Intervention for Substance Misuse Problems

No.	Author(s), year	Drugs and/or alcohol	Focus of review	Population	Number of studies reviewed	Years reviewed	Family interventions reviewed	Conclusions
1	Edwards & Steinglass (1995).	Alcohol	Treatment initiation, during treatment and aftercare	Adults	Systematic review (+ meta-analysis) of 21 studies	1972 - 1993	Community Relationship Therapy (CRT), Johnson Institute Intervention (JI), Unilateral Family Therapy	Family therapy effective in encouraging problem drinkers to enter treatment. Once in treatment family-involvement is slightly more effective than individual treatment. Humble benefits obtained in family-involved relapse prevention programs.
2	Stanton & Shadish (1997).	Drugs	During treatment	Adults and adolescents	Systematic review (+ meta-analysis) of 15 studies	1977 - 1997	Individual counselling, peer group therapy, family-couples therapy, family psycho-education groups and family-attention placebo.	Family therapy is effective for both adults and adolescents and appears to be a cost-effective supplement to methadone maintenance.
3	Epstein, McCrady (1998).	Drugs and alcohol	Treatment initiation, during treatment and aftercare	Adults	Narrative review of 6 randomised controlled trials (RCTs)	1970 - 1998	Behavioural Couples Therapy (BCT) and Alcohol Behavioural Couples Therapy (ABCT).	RCTs suggest that different types of family-involved therapy appear to be more effective than treatments that do not include the family.
4	Liddle (2004).	Drugs and alcohol	During treatment	Adolescents	Narrative review of 30 studies	Up to 2004	Multi-systemic Therapy, Functional Family Therapy (FFT), Cognitive Behavioural Therapy (CBT), Brief Strategic Family Therapy (BSFT).	Family-based treatments for adolescents produced better outcomes compared to standard treatment methods and produced considerable decreases in alcohol and drugs use, delinquency, school and family problems.

5	Austin, Macgowan & Wagner (2005).	Drugs and alcohol	During treatment	Adolescents (12 – 18)	Systematic review of 11 studies	1994 - 2004	Brief Strategic Family Therapy (BSFT), Family Behaviour Therapy (FBT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), Multi-systemic Treatment (MST).	MDFT was the only intervention to reveal clinically significant changes in substance use at 12 month follow-up and sizable effect sizes at post-treatment. FFT, MST and FBT represent encouraging interventions.
6	Copello, Velleman & Templeton (2005).	Drugs and alcohol	Treatment entry for user + outcomes for family members	Adults and adolescents	Narrative review of 31 studies	1986 - 2005	Pressures to Change, Community Reinforcement and Family Training (CRAFT), Johnson Institute Intervention (JI), Network Therapy, Co-operative Counselling.	Working with family members can trigger treatment entry for user. Some evidence that family interventions are helpful in alleviating problems caused for affected family members.
7	Velleman, Templeton & Copello (2005).	Drugs and alcohol	Prevention	Young people	Narrative review of 4 reviews and 15 studies	Up to 2005	Strengthening Families Program, family-based prevention programmes.	Highlights a scarcity of methodologically highly sound research. Findings do, however, suggest that the family can have a vital role in thwarting substance use and misuse among young people.
8	Copello, Templeton & Velleman (2006a).	Drugs and alcohol	Treatment initiation and during treatment	Adults	Narrative review of 6 reviews and 6 studies	2004 - 2005	Behavioural Couples Therapy (BCT), Community Reinforcement Approach (CRA), Motivational Enhancement Therapy (MET), Social Behaviour and Network Therapy (SBNT).	Findings continue to reinforce the evidence-base for family and social network interventions in substance use treatment.

9	Fernandez, Begley & Marlatt (2006)	Drugs and alcohol	To engage treatment resistant users	Adults	Narrative review of 47 studies (broadly discusses empirical data for seven family interventions).	1982 - 2004	Al-Anon, Johnson Institute, A Relational Sequence for Engagement (ARISE), CRT, CRAFT, Unilateral Family Therapy, Pressures to Change.	The acceptance and history of the Al-Anon and JI has permitted more therapists to be trained in this approach, however, such strategies tend to be inflexible and may deter involvement. A wider range of interventions needs to be made available to friends, families, and colleagues of alcohol or drug-misusing individuals.
10	Mead, Ting, Dretzke & Bayliss (2007).	Alcohol	Treatment for users + outcomes for family members	Adults	Systematic review (+ meta-analysis) of 34 RCTs	1974 – 2006	Compared family-based therapy with other individual counselling and treatment.	Compared to individual or group counselling, family therapy demonstrated greater outcomes. Compared to other care family therapy demonstrated greater increases in abstinence, relationship functioning and substance user treatment entry rates.
11	Powers, Vedel & Emmelkamp (2008).	Drugs and alcohol	During treatment	Adults	Systematic review (+ meta-analysis) of 12 RCTs	1985 - 2006	Compared BCT to IBT, ASFI, TAU	BCT showed enhanced outcomes compared to individual-based treatment for married and co-habiting couples.
12	Donohue <i>et al</i> (2009).	Drugs and alcohol	During treatment	Adolescents and adults	Narrative review of 15 studies	1967 - 2005	Family Behaviour Therapy (FBT) (discusses historical context and how FBT can be useful for other problems as well as substance misuse).	Growing body of evidence that FBT is effective in addressing problem behaviours.

13	Roozen, de Waart, van der Kroft (2010).	Drugs and alcohol	To engage treatment resistant users	Adults	Systematic review (+ meta-analysis) of 4 RCTs	1986 - 2002	Community Reinforcement and Family Training (CRAFT), Alcoholics Anonymous (Al-Anon)/Narcotics Anonymous, Johnson Institute intervention.	CRAFT found to be better at engaging substance users who are resistant to treatment compared with traditional interventions.
14	Templeton, Velleman & Russell (2010).	Alcohol	During treatment	Outcomes for adult family members	Narrative review of 34 studies (broad range of qualitative and quantitative studies).	1979 - 2009	Two interventions dominated the literature: Pressures to Change and the 5-Step intervention	Increasing evidence that involving the family in treatment brings benefits and cost-savings to services.
15	Foxcroft & Tsertsvadze (2011).	Alcohol	Prevention	Adolescents	Cochrane review of 12 RCTs	2002 - 2010	Universal Family-based prevention programs (Iowa Strengthening Families Program (ISFP), Preparing for the Drug-Free Years Program (PDFY), social-development model-based).	9/ 12 studies demonstrated significant effects for prevention of alcohol use. Evidence supports the effectiveness of family-based programs for alcohol misuse prevention among young people.
16	Calabria, Clifford, Shakeshaft & Doran (2012).	Alcohol	During treatment / to reduce alcohol use	Indigenous communities	Systematic review (+ meta-analysis) of 19 studies (63% RCTs)	2003 - 2010	Family and cognitive-behavioural therapy, Multidimensional Family Therapy (MDFT)	Family intervention offers the potential for reducing alcohol related harms among native peoples. Tailored family-based approaches should be developed that include consultation with indigenous communities.

Largely based on the format of the reviews conducted by Copello *et al.*, (2005; 2006a), Templeton *et al.*, (2010) and Velleman *et al.*, (2005), the family interventions to be discussed in this review were categorised into five main areas that have been used to structure this section:

1. Working with family members to help prevent substance misuse;
2. Working with family members to encourage treatment-resistant substance misusers to enter treatment;
3. Working jointly with family members and substance misusers during the treatment process;
4. Working jointly with family members to prevent relapse;
5. Helping affected family members in their own right.

1. Working with family members to help prevent substance misuse

Two reviews examined family interventions with an aim of preventing the initiation of substance misuse in young people. Foxcroft & Tsertsvadze (2011) conducted a systematic review to evaluate universal family-based prevention programs for alcohol misuse in school-aged children up to eighteen years old. Twelve randomised parallel-group trials were reviewed. Results from nine out of the twelve trials indicated statistically significantly greater reductions in alcohol use for the family-based intervention, compared to the control groups. The duration of post-intervention impact ranged from two months to eight years. The overall conclusion was that the effects of family-based prevention interventions for young people are small, but generally persistent into the longer-term.

Velleman *et al.*, (2005) conducted a comprehensive review of family interventions aimed at preventing adolescent substance use and misuse. Four previous reviews and fifteen studies were reviewed. Seven areas in which the family environment could influence substance use were discussed: family relations versus structure, family cohesion, family communication, family management and attitudes, modelling of parental behaviour, supervision from parents and parent/peer influences. The review focused largely on the Strengthening Families Program (SFP) which uses a combination of family and child-focused approaches, and has been widely tested with varied audiences in both rural and urban locations in the U.S. and some on-going studies in the U.K. Results presented from randomised controlled designs concluded that adolescents attending the program had significantly lower rates of drug and alcohol use compared to control groups, and that multi-faceted approaches involving families, schools and communities are expected to be more effective by developing positive family-functioning, enriched family interactions and increased resilience.

Taken together, the family interventions reviewed within this section suggest that the family can have a principal role in preventing substance misuse in young people, however, it is important to note that this evidence is based only on two reviews. Nevertheless, the findings here do corroborate with other recent family-based prevention programs in preventing many different health and psychological problems, including delinquency, obesity, child maltreatment, depression and other mental health disorders (Kumpfer, Pinyuchon, Teixeira de Melo & Whiteside, 2008; Small & Huser, 2010). Such findings provide increasing support for the value of prevention programs for adolescents and their families.

2. Working with family members to encourage treatment-resistant users to enter treatment

Seven reviews examined family interventions to encourage treatment-resistant users to enter treatment. Community Reinforcement and Family Training (CRAFT), and its predecessor Community Reinforcement Training (CRT) were examined within five reviews. CRAFT and CRT are rigorous treatment packages designed to engage resistant substance users into treatment. The users' concerned significant others (CSOs) are trained to encourage sobriety and treatment, but wait until the user states a desire to stop using substances. CRAFT and CRT also aim to reduce the physical and psychological distress of the CSO. Similarly, Copello *et al.*, (2005; 2006a) and Fernandez, Begley and Marlatt (2006) concluded that CRAFT and CRT have been identified in several meta-analyses as having among the highest levels of treatment efficacy and positive outcomes.

Edwards and Steinglass (1995) also reviewed CRT in which a pilot study of twelve non-drinking female partners concerned about their relative's drinking was reported. Five concerned FMs received a traditional program and seven received the CRT program. Findings revealed that none of the drinkers related to the partners in the traditional program entered treatment; whereas six out of seven (86%) of the drinkers related to the partners in the CRT entered treatment. Furthermore, before entering treatment, the drinkers increased their abstinent days from 20% to 63% during the time their female partners were receiving CRT.

Roozen *et al.*, (2010) conducted a systematic review and meta-analysis to compare CRAFT with two more traditional interventions: i) Alcoholics Anonymous (Al-Anon)/Narcotics Anonymous (Nar-Anon), whereby FMs are instructed to accept being powerless and are

encouraged to disengage from the user and resist any effort to influence the substance use; and, ii) the Johnson Intervention (JI) in which members of the user's social network challenge him or her about the harm drinking or drug use has produced and the action they will take if treatment is refused. The three interventions were compared in terms of their ability to involve patients in treatment and improve outcomes for FMs. Four high quality randomised controlled trials (RCTs) were identified and reviewed. Findings confirmed that CRAFT produced larger rates of user engagement (67%) compared to Al-Anon/Nar-Anon. Although based on limited evidence, CRAFT was also more effective than the JI (64% vs. 30%). It was concluded that, overall, CRAFT was more successful in engaging substance misusing individuals compared with the traditional interventions.

The Johnson Intervention (JI) was also reviewed by Edwards and Steinglass. Results indicated that of the families trained to confront their drinking relative, only 29% chose to. However, of the drinkers who were confronted, 86% entered into treatment compared to 17% who were not confronted. Furthermore, confronted drinkers were found to be continuously abstinent for eleven months compared to 2.8 months for non-confronted drinkers. Two more recent reviews by Copello *et al.*, (2005) and Fernandez *et al.*, (2006) also suggested that a limited number of evaluations of JI have shown that only a small number of trained FMs go on to carry out the confrontation. Furthermore, when drinkers do engage in treatment as a result of JI, retention in treatment is limited and relapse rates are high.

Unilateral Family Therapy (UFT) was examined in three reviews. UFT suggests that it is possible to modify family functioning without all members of the family being present. Working unilaterally with the non-drinking spouse, UFT aims to neutralise old behaviours

and prepare the FM for confrontation with the drinker to encourage treatment entry. Edwards and Steinglass' review showed that 61% of the drinkers whose spouses participated in UFT 'improved'. Participation in UFT was also related to a reduction in spouse psychopathology and life distress and an increase in marriage satisfaction. Similarly, Copello *et al.*, (2005) and Fernandez *et al.*, (2006) reviewed results from a small study revealing a 53% reduction in alcohol consumption in the UFT group compared to a non-treatment condition, where slight increases in alcohol consumption were found.

A review conducted by Epstein and McCrady (1998) examined the efficacy of Alcohol Behavioural Couples Therapy (ABCT) for encouraging drinkers to enter treatment. Rooted in social learning theory and family systems models, ABCT incorporates a collection of approaches that includes a FM in the treatment of an alcohol problem. ABCT assumes a reciprocal relationship between substance use and relationship functioning. The review provided an overview of the 20-year history of ABCT and concluded that unilateral formats of ABCT with the spouse were consistently associated with increased likelihood that the drinker would enter into treatment.

Copello *et al.*, (2005) and Fernandez *et al.*, (2006) also examined the 'Pressures to Change' (1995) intervention, designed to work with FMs of an individual with a drink problem in the absence of the user. The method focuses on educating FMs and preparing them to challenge the person with the drink problem. Overall, results concluded that compared to traditional individual therapy or group therapy (e.g. Al-Anon), more drinkers entered treatment after their FMs were included in the pressures to change intervention.

A number of other interventions aimed at assisting treatment entry through the influence of FMs were examined within the review conducted by Copello *et al.*, (2005). The ‘co-operative counselling service’, a strategy for change which is developed by working with concerned others, led several treatment-resistant drinkers to enter into treatment. Another approach developed from the Johnson Institute Intervention is the ARISE intervention (A Relational Intervention Sequence for Engagement). By placing less of a focus on confrontation and more on support for the substance user and FM, results from ARISE indicated that 65% of substance users entered treatment or self-help. The review conducted by Fernandez *et al.*, (2006) came to the same conclusions.

Network Therapy (Galanter, 1993a; 1993b) was also found to successfully introduce the user to engage in treatment. The advantage of this intervention is that the user’s wider social network (e.g. work colleagues) can be involved in attempts to encourage the user to seek treatment.

Finally, Mead *et al.*, (2007) conducted a systematic review of the clinical and cost-effectiveness of therapy involving family and friends for alcohol misuse. Thirty-four RCTs were reviewed that compared programmes including the individual with the drink problem and family, with other psychotherapy or counselling (individual or group CBT), or other care (desensitisation, electric shock, general education, advice). Results indicated that family therapy was found to be more effective for drinker treatment entry compared to no intervention or no counselling.

The seven reviews described in this section demonstrate the power that FMs can have on motivating substance misusers to enter treatment, and to alter their drinking or drug taking behaviour. Although predominantly based on alcohol misuse, these six reviews all concluded that there is reliable evidence of family involvement in motivating previously unwilling substance users to enter treatment. This is particularly important when considering that the majority of users do not seek treatment (Meyers, Apodaca, Flicker & Slesnick, 2002; Price *et al.*, 1991; Regier *et al.*, 1993).

The findings here point to several effective family interventions, however, most noteworthy are CRAFT and Unilateral Family Therapy, consistently being the most empirically effective, using robust evaluations. Such findings highlight the importance of working with FMs to develop skills and strategies to motivate change through support, without the need for confrontation. Findings were also corroborated with previous findings indicating that FMs are not ‘powerless’, and that pursuing disconnection may even be counterproductive (Landau *et al.*, 2004; Meyers & Wolfe, 2004; Miller, Forcehimes, Zweben & McLellan, 2011). Finally, the reviews point to increasing evidence of the benefits of involvement of the user’s wider social network in the treatment process. Such findings have also been more recently supported with research demonstrating that restricted social environments have been found to be a ‘negative interference’ in the addiction treatment process (Daddo & Broome, 2010; Souza, Kantorski, Vasters, & Luis, 2011).

3. Working jointly with family members and substance misusers during the treatment process

This section examines family interventions in which the substance user and family member (FM) work together during the treatment process. This section is the largest, with ten reviews being examined, of which the first two reviews focused specifically on adolescent substance misuse.

Austin *et al.*, (2005) conducted a systematic review of family-based interventions for adolescent substance misuse problems. The review first discussed previous research showing that substance misusing adolescents are a unique population with discrete treatment needs. Strict inclusion criteria were employed whereby only randomised clinical trials published in the last ten years (1994 – 2004) were reviewed. Interventions focusing on treatment only, not prevention, were reviewed. Five family-based interventions were reviewed: Brief Strategic Family Therapy (BSFT), Family Behaviour Therapy (FBT), Functional Family Therapy (FFT), Multidimensional Family Therapy (MDFT), and Multisystemic Treatment (MST). Although the five interventions are separate from each other, they share characteristics including contingency management, communication skills, and conflict resolution. The review concluded that all of the five interventions had revealed positive changes in substance use at post-treatment. However, within-group differences in substance use were no longer significant at follow-up for MST and FFT. Furthermore, only BST, MDFT and FBT demonstrated statistically significant between-group differences compared to control groups. When judged against the American Psychological Association's (APA) guidelines for psychological interventions, two of the five interventions (MDFT and BSFT) were regarded as probably efficacious treatments and had the best evidence to date.

Liddle (2004) also reviewed MST, FFT, BSFT as well as Cognitive Behavioural Treatment (CBT) in an attempt to characterise the status of family-based treatment for adolescent alcohol and drug problems. The review discussed the significance of integrative treatments (selecting elements of family therapy, family preservation, parent training and cognitive therapy methods depending on assessment). Following an integration of FFT, FBT and substance related CBT, outcomes outperformed the component approaches in reducing drug use among teenagers. The review also discussed the importance of flexibility in format and delivery of treatment. Multidimensional Family Therapy (MDFT) was designed for considerable flexibility and has been found to be successful in a range of cultural backgrounds in both day treatment and intensive residential programs. The review concluded that treatment retention rates for family intervention in controlled trials have been dramatically higher (between 70% - 90%) than treatment as usual (TAU), and that these effects can be sustained for at least 6 – 12 months beyond the conclusion of treatment.

Edwards and Steinglass (2007) reported a meta-analysis of fifteen studies in which family-involved treatment was compared to traditional individual treatment for adults with alcohol problems (electric shock therapy, covert sensitisation, systematic desensitisation). Results indicated that family-involved treatment led to significantly higher rates of abstinence than did individual treatment. However, average effect sizes at follow-up at 18 months or four years were non-significant. The review concluded that family-involved treatment showed a mixed-picture of effectiveness, and it may be first necessary to identify what improvements the substance user would value most in order to provide the most effective treatment.

Stanton and Shadish (1997) conducted a systematic review and meta-analysis of fifteen studies in which the primary interest was misuse or addiction to illicit drugs. The review employed strict robust criteria, studies were only included if two or more comparison control conditions were used (at least one of which was family or couples therapy). Furthermore, only studies in which individuals were randomly assigned to treatment conditions were included. General treatment effectiveness was evaluated by comparing family-couples therapy with non-family-couples therapy (individual counselling, group therapy) and other family-oriented interventions (family psycho-education, relatives' groups, family-attention placebo). Results indicated that family therapy was superior compared to non-family modalities, giving "an edge to family therapy over family psycho-education" (pg. 187).

A review conducted by Epstein and McCrady (1998) examined the efficacy of Behavioural Couples Therapy (BCT) for alcohol and drug misuse. BCT posits that substance misuse problems and relationship functioning are combined and actively involves a partner in treatment. The purpose is to build support for abstinence and to improve the functioning of the relationship. Six studies were presented as evidence that BCT produces significant reductions in alcohol consumption and improvement in relationship functioning. The review discussed how the consistent effectiveness of BCT had led to the approach being adapted to treat drug abuse. More recently, Powers *et al.*, (2008) conducted a systematic review and meta-analysis of Behavioural Couples Therapy (BCT) for drug and alcohol problems. A robust inclusion criteria identified twelve RCTs, with results indicating that BCT outperformed control conditions at post-treatment in relationship satisfaction. Furthermore, compared to control conditions, BCT produced more positive outcomes at follow-up in overall frequency of substance use, consequences of use and relationship satisfaction. It was

concluded that, overall, BCT produces superior outcomes than individual-based treatment for married and cohabiting couples who seek treatment for drug or alcohol problems.

Calabria *et al.*, (2012) conducted a systematic review of family-based interventions and their potential to reduce alcohol-related harm in Indigenous communities in Australia. It has been found that in countries where alcohol is generally accepted, a greater proportion of indigenous people abstain from alcohol, however, those indigenous people who do drink, consume alcohol at riskier levels. Studies published between 2003 – 2010 were searched. Nineteen studies were reviewed of which eleven included FMs in the treatment of problem drinkers. The results suggested that there is merit in exploring family-based approaches to reduce alcohol-related harms. The two interventions identified as both effective and robust were family and cognitive-behavioural therapy and MDFT. It was concluded that, given the predominant role that family relationships play in reinforcing behaviour and maintaining family cohesion, family-interventions offer significant potential for reducing alcohol-related problems among indigenous people.

The review conducted by Copello *et al.*, (2005) reported over 50 studies whereby a social or family component has led to improved outcomes for both alcohol and drug treatment. In addition to interventions mentioned previously, marital therapies for alcohol problems were reviewed. Marital therapy for substance misuse problems typically aims to alleviate distress and encourage positive adjustment in the marital relationship, as well as aiming to reduce substance misuse. Behavioural Marital Therapy (BMT) and the aforementioned BCT have been shown to result in substance users being more likely to complete treatment; as well as greater marital happiness after treatment.

Copello *et al.*, (2006a) reported the results from the United Kingdom Alcohol Treatment Trial (UKATT) which compared Motivational Enhancement Therapy (MET) (an individual treatment for alcohol problems) with Social Behaviour and Network Therapy (SBNT), a family and network-based intervention. The core principle of SBNT is the development of social support from a network of FMs or friends for a positive change in substance use. Both interventions led to improved outcomes and although no differences were found between the two treatments, SBNT was found to be as effective and cost-effective as the individually focused intervention.

Donohue *et al.*, (2009) reviewed Family Behaviour Therapy (FBT) for adult and adolescent substance misuse and associated problems (e.g. conduct disorder, child maltreatment, depression etc.). Evidence from 15 studies demonstrated that FBT has consistently demonstrated efficacy in trials involving both adults and adolescents misusing alcohol and drugs, with results also being maintained for up to nine months. The review pointed to evidence from studies whereby adults and adolescents were randomly assigned to either FBT or a control group, with results indicating that the participants assigned to FBT showed significantly larger improvements in: drug and alcohol use; conduct problems; family functioning and satisfaction; and depression.

Within the review carried out by Mead *et al.*, (2007), twenty-seven out of the thirty-four RCTs reviewed focused on the problem drinker and involved one or more FMs in the treatment process. Results indicated that therapy including the problem drinker and family versus other psychotherapy or counselling (individual or group CBT) was not statistically

significant for abstinence outcomes. However, family involvement in treatment was more effective than other care (desensitisation, electric shock, general education, advice). Furthermore, family therapy was more effective than the two comparators for outcomes of hospitalisation rates and positive relationship. It was concluded that therapy involving family or friends appears to positively improve family functioning for the individual with the drink problem and their FMs.

The ten reviews within this section demonstrated that there is an increasing amount of evidence that working jointly with the user and their family during the treatment process can be effective. It is worth pointing out that six of the nine reviews within this category were systematic reviews, of which three included a meta-analysis. Such reviews are likely to limit any bias in the research findings and help to ensure the conclusions drawn are reliable and accurate.

While some evidence for several family interventions reviewed in this section could be strengthened, the overall results from this section are promising. The consistent benefits of Multidimensional Family Therapy (MDFT) and Brief Strategic Family Therapy (BSFT) emphasise the importance of integrated family-based approaches for adolescent substance misuse, whereby multiple factors (e.g. personal issues, relationships, overall family functioning, and social forces) are examined. Furthermore, the results suggest the need for family interventions to be flexible and individualised rather than a ‘one-size-fits-all’ approach.

The reviews highlighted that Behavioural Couples Therapy (BCT) appears to have the strongest research support for its effectiveness, with consistent results from multiple studies across diverse populations reporting greater reductions in substance use following BCT compared to individual counselling. Such findings emphasise the importance of improving relationships and communication skills for married or cohabitating substance abusers and their partners. Based on the strength of the evidence-based, BCT is recommended by NICE (2007) to prevent relapse to opioid dependence, as well for harmful drinking and mild alcohol dependence (NICE, 2011).

Another important finding within this section is the potential of family-based interventions to reduce substance-related harm in indigenous communities. Consumption of alcohol is an important part of indigenous habit/culture in order to share feelings or reduce stress and depression (Chen, Chang, Hsieh, Chen, Huang & Kuo, 2012). The findings from the review here are important since attempts made by mainstream health service providers to assist indigenous peoples in recovering from substance abuse has led to only minimal success (McCormick, 2000). The extended family is important in determining positive and negative behaviours within indigenous communities (Trotter, Rolf & Baldwin, 1997), meaning that involvement of the substance user's family is likely to play a crucial role in effective treatment and prevention.

Finally, the current review pointed out that SBNT was found to be as effective as an individually-focused approach. At the time of publication it was concluded that further research was needed to examine the potential of SBNT for longer-term outcomes, and whether it is feasible to deliver SBNT in routine service provision. Such research is currently

being undertaken within two statutory community drug treatment teams in the UK, whereby a randomised controlled trial aims to establish whether SBNT is more effective in reducing illicit heroin use compared to a case management intervention or treatment as usual. The findings will explore the longer-term efficacy of the approach by evaluating outcomes at 12 months.

4. Working jointly with family members during aftercare to prevent relapse

Two reviews examined family intervention during the important aftercare phase (often called relapse prevention), where additional intervention, support, and education are often needed to help the substance user maintain the gains they have made during the treatment process. Within traditional treatment programs there is a heavy reliance on group therapy and Al-Anon to provide these aftercare services. However, Edwards and Steinglass (2007) evaluated three studies in which a simple family-involved intervention aimed to increase attendance at aftercare sessions. Although the collective results came from just three studies, effect sizes for outcomes with family-involvement during aftercare were significant and differences between family and non-family involvement was clinically significant. Taken together, the results demonstrated support for the importance of family in relapse prevention.

Within their review of Alcohol Behavioural Couples Therapy (ABCT), Epstein and McCrady also examined more contemporary research on ABCT which included the addition of relapse prevention sessions and techniques. Results from two studies indicated that problem drinkers randomly assigned to receive ABCT plus relapse prevention sessions over 12 months had more abstinent days and better maintained improvements in the relationship, compared to couples who did not receive relapse prevention booster sessions.

Although based on a small number of studies, the findings reported here demonstrate modest benefits of family-involvement during aftercare programs and support findings elsewhere in terms of the benefits of family involvement during the recovery stage, by first helping the treatment provider to identify any high-risk relapse situations and secondly, to reinforce contingency planning (Anderson, Ramo & Schulte, 2007; Carlson & Ellis, 2004). Some of the most challenging aspects of substance misuse occur after treatment is over, meaning family involvement during the aftercare process is likely to ensure the continued mobilisation of support long after professional treatment has concluded. Interestingly, recent research examining the role of the family during aftercare has started to move away from the idea of abstinence and instead focuses on the ‘recovery agenda’ and outcomes for both the user and their families (e.g. improved health, leisure activities, positive relationships etc.) (White, 2007; White & Kurtz, 2005; Yates & Malloch, 2010).

5. Helping affected family members in their own right

Finally, three reviews examined evidence from family interventions whereby affected FMs were targeted in their own right. Templeton *et al.*, (2010) conducted a systematic review to examine interventions for families affected by alcohol misuse. Due to the diversity of the field, a broad methodology was adopted and a narrative approach was employed to evaluate the studies. Twenty-one studies involved FMs, with an aim of assisting FMs in their own right. Two interventions dominated the studies: the aforementioned ‘pressures to change’ approach and the 5-Step Intervention (Copello *et al.*, 2000b). The 5-Step approach, based on the stress-strain-coping-support model (Orford *et al.*, 1992), was designed for FMs concerned about and affected by the excessive drinking (and/or other drug use) of a relative. Professionals are

trained to counsel FMs by: i) listening to, reassuring and exploring their concerns; ii) providing relevant information; iii) exploring their coping; iv) exploring their social support; and v) discussing any needs for other sources of specialist help. Taken together, results from Copello *et al.*'s review indicated that interventions targeting FMs' own needs are capable of positively influencing FMs' health, coping, stress, life and relationship satisfaction. The review also highlighted how the field has progressed from primarily focusing on how FMs can engage and support the user, to adopting a wider focus which also considers the needs of affected FMs in their own right. It was concluded that interventions working with FMs in their own right are still in their infancy, however, demonstrate strong benefits.

Copello *et al.*, (2005) also reviewed the 5-Step intervention and concluded that the approach was effective in reducing FMs' strain and positively altering their coping mechanisms. The same review also examined Behavioural Exchange Systems Training (BEST), an eight week programme for parents of drug using adolescents whereby the first four weeks are spent focusing on improving parents' wellbeing. Findings revealed that when compared with control groups, BEST was associated with decreases in mental health symptoms, increased satisfaction for parents and use of more firm parenting behaviours.

Within their review, Calabria *et al.* (2012) examined eight studies that targeted FMs of problem drinkers. Primary outcomes recurrently measured for FMs were coping, self-esteem, family/marital functioning and satisfaction, with the most commonly reported effect for FMs being improved coping. Furthermore, four out of the eight studies measuring family functioning reported improvements.

In conclusion, although based on only three reviews, evidence is mounting that working with FMs in their own right can help to relieve substance-related problems for affected FMs. Within the reviews it was noted that until recently, most studies of family interventions aimed to treat the substance user only, and paid little or no attention to impacts on the family. That this section is included within the current tertiary review is an indication of how the impact of substance misuse problems on FMs is being seen as increasingly important within family interventions.

The 5-Step Method was the prevailing approach reviewed in terms of supporting affected FMs in their own right. A number of more recent studies have provided further support for the efficacy of 5-Step, including the development of a web-based format (Ibanga, 2010), a focus on ethnic minority community services (Orford *et al.*, 2009) and community care settings in Mexico (Natera *et al.*, 2010). Further support for 5-Step has also been published by Copello, Templeton, Orford and Velleman (2010), whereby the evidence from a number of studies in the UK and Italy are presented, concluding that 5-Step is a promising approach to reduce addiction-related harm. Such findings strengthen the conclusions from the three reviews.

WHAT CAN BE CONCLUDED FROM THIS TERTIARY REVIEW?

The results from the current tertiary review allow some conclusions to be drawn. The review has demonstrated that there are numerous robust studies and reviews consistently revealing the benefits of family involvement for substance misuse problems. The review has brought together much evidence to show that family involvement can prevent and/or influence the course of the substance misuse problem, trigger treatment-resistant substance users to seek treatment, improve outcomes for the substance user both during and after treatment and can

help to prevent relapse, and finally, help to diminish the negative effects of substance misuse on the family. Collectively, the results and evidence from the past reviews have shown that family intervention is, by and large, considered to be superior compared to control conditions in terms of substance use and family functioning.

Together, the fourteen reviews examined over 250 studies involving family-based interventions for substance misuse, with over 60% being systematic reviews. The strict and robust inclusion criteria within these systematic reviews means that the evidence for the efficacy of the family interventions reviewed was based on robust and methodologically sound methods.

Based on these strengths it has been argued elsewhere that the only reason not to include FMs is if their involvement is refused by the FMs themselves or by the substance user (O’Farrell, 1993). The current review has, however, shown that even in cases of the latter, offering educational and social support to affected FMs in their own right can help to improve their physical and psychological health.

Above all, the findings from the current review showed how the field has progressed from a not so distant past where FMs were unfortunately seen as part of the problem, not as part of the solution. The findings show how this attitude and misconception has started to change over time through the engagement of FMs, with much research supporting the inclusion of FMs as both advocates of the substance user’s treatment as well as being beneficiaries in their own right. It is also encouraging that certain programs (particularly those targeting adolescents) view family involvement as essential to successful treatment and recovery, and

in some cases will not accept an adolescent client without the involvement and commitment of the family (Hornberger & Smith, 2011).

It is also noteworthy that seven of the selected reviews discussed the importance of implementing family work in routine practice within their concluding statements. It was concluded that implementing family therapy services are likely to result in a reduction in the incidence of alcohol-related disease, reductions in in-patient hospital stays, and a decrease in other disease-related costs (Mead *et al.*, 2007). Similarly, that family involvement should be a routine component of treatment programs (Powers *et al.*, 2008; Templeton *et al.*, 2010), and that research should be conducted on successfully implementing family interventions in practice settings (Austin *et al.*, 2005; Edwards and Steinglass, 1995). It was, however, also concluded within two reviews, that despite the robust evidence of their effectiveness, family interventions are not implemented in routine practice due to widespread barriers related to dissemination and adoption. Furthermore, most substance misuse treatment providers do not have access to training in family-based interventions and therapies (Copello *et al.*, 2005; Liddle, 2004).

Understanding more fully the reasons for the limited provision of family intervention and how best to implement routine family-inclusive practice within substance misuse treatment services is, therefore, essential to reduce the gap between research and practice behaviour. The following section aims to assess the research evidence on the extent to which treatment providers implement family-focused practice following training and supervision.

IMPLEMENTING FAMILY INTERVENTION FOLLOWING TRAINING: A SYSTEMATIC REVIEW

INTRODUCTION

The previous section discussed the evidence that family intervention within addiction treatment services is beneficial for both positive substance use outcomes and family functioning. Acknowledging the benefits of involving family members (FMs) in addiction treatment, key agencies and organisations such as the Home Office, National Institute for Clinical Excellence (NICE), National Treatment Agency for Substance Misuse (NTA) and World Health Organisation (WHO), among others have published a number of governmental and national documents pertaining to family-inclusive addiction treatment. Velleman (2010) reported 31 substance misuse strategy documents where there was mention of the effects on FMs, the needs that FMs have in their own right, or the usefulness of involving FMs in the substance users' treatment. However, despite the wide promulgation of the importance of and benefits of family-focused addiction treatment practice within these guidelines and policy documents, it appears evident that family intervention has not been implemented as widely as could be expected.

It has been argued that specialist drug and alcohol services generally devote very little of their resources to FMs (Velleman, 1999, 2003; Copello *et al.*, 2000a). In the UK, family-focused service provision is patchy with some areas having well-developed family support services while other areas have no family-inclusive services (Copello & Templeton, 2012). Even where family-focused service provision is good, “services are often run by a few dedicated

volunteers and one or two paid family workers” (*Reducing Drug and Alcohol Harms to Communities and Families*, (Home Office, 2010, pg. 27)), and tend to be “reactive, poorly thought out and marginal” (Copello & Orford, 2002b, p. 1361). Largely due to policy frameworks supporting an individualistic focus on the individual drinker or drug user, there is little evidence of the delivery of family-focused approaches within routine service provision (Fals-Stewart *et al.*, 2004; Sawyer, 2009).

This section reports the results of a systematic literature review to examine to extent to which family work is implemented following training in family intervention. Studies were reviewed whereby staff were first trained in family invention and the impact of the training on implementation of family-focused practice was then evaluated. The current review aimed to establish the current status of the literature to demonstrate what the evidence is regarding context, barriers and facilitators of family-focused practice, and the best ways to tackle these barriers. Initially, the focus of the systematic review was to examine implementation of family work within addiction treatment services, however as previously noted, due to the limited number of studies identified, the review was broadened to include the wider healthcare system including mental health services.

METHODS

A systematic literature review spanning 2000 – 2012 was conducted. Systematic reviews are overtly different from traditional literature reviews or expert commentaries in that they methodologically map out, critically evaluate and interpret all available research evidence relevant to a particular question (Greenhalgh, 1997; National Health and Medical Research Council, 1999). The systematic review process involves developing a protocol that includes a

relevant research question, a search strategy to find available studies, a set of inclusion and exclusion criteria to select the studies for review, and a relevant quality appraisal strategy (Brown *et al.*, 2012; Capblance *et al.*, 2012; National Institute for Health Research Systematic Reviews Programme, 2012).

Systematic review protocol and search strategy

Two primary methods were used in conducting the literature search. The first was a keyword, title and abstract search via Ovid and Web of Knowledge (WOK) using the following databases: Embase, Medline, PsycINFO, PsycARTICLES and the Social Sciences Citation Index (SSCI). The second method included hand searching the references of articles identified as being relevant.

Deciding how broad the scope of a review should be is commonly known as either “lumping” or “splitting” (Gotzsche, 2000). The initial search strategy was to use a very narrow approach (“splitting”) by examining studies conducted within addiction treatment only, however, there is support for the rationale for taking a broader approach (“lumping”). Systematic reviews aim to identify the “common generalisable features within similar interventions, meaning differences in study populations and settings may not be crucially important” (Grimshaw *et al.*, 2003, pg 299). Therefore, for reasons previously mentioned, the search strategy was broadened to include studies attempting to implement family work within practice within the wider healthcare system.

Using Boolean search terms, the following terms were included in the search:

Family

AND

Implement* OR technology transfer OR adopt* OR involve*

AND

Train* OR supervise*

AND

Staff OR therapist OR professional OR clinician OR provider

Truncation using an asterix (*) ensured additional flexibility by searching for multiple forms of a word. The articles' title, abstract, topic and keywords were searched for the above terms.

Inclusion criteria

The focus of a systematic review is an important issue and requires a well-formulated research question (Khan, 2003; Wright, Brand, Dunn & Spindler, 2007). Systematic reviews bringing together evidence from major randomised controlled trials (RCTs) usually include research questions containing four parts known by the acronym “PICO” (Population studied; Intervention; Comparison, alternative intervention or control; and Outcome of the intervention) (Glasziou, Irwig, Bain & Colditz, 2001; Sayers, 2008). The Cochrane Collaboration also promotes use of the PICO strategy as a framework for designing the research question for a systematic review. However, a preliminary search of the literature revealed that the nature of the studies attempting to evaluate implementation of family intervention were diverse. Some studies used quasi-experimental designs, others used observational or qualitative

methodologies, and studies seldom included a comparison or control element. Reviewing such varied studies meant that the ‘standard’ systematic or meta-analytic review methodologies designed for uniform, quantitative RCT data were not appropriate. Instead, Brown *et al.*, (2012) suggest that if some of the PICO elements are not relevant, they may be replaced with additional factors (e.g. context and location).

Consequently, studies were considered eligible for analysis if they satisfied the following requirements:

- **Population:** Staff working within a healthcare setting (e.g., practitioners, social workers, psychologists, physicians, counsellors, clinicians, nurses etc.);
- **Intervention:** Staff trained in psychosocial family-intervention;
- **Studies:** Studies that employed a broad range of methodologies (e.g. experimental, quasi-experimental, randomised or non-randomised designs) examining the implementation of family work following training;
- **Outcome:** An evaluation of implementation of family-focused practice following training.

Exclusion criteria

Unpublished theses or dissertations were not included in the review. Studies were also excluded if they were not written in English. Articles were excluded if they did not contain a psychological component to the intervention.

Data extraction

Electronic database searches initially identified 1731 possible studies that were filtered through the search process summarised in Figure 1. Of the studies initially identified, 1516 were excluded based on the article title. From the remaining 215 initially thought to be relevant, 165 studies were excluded based upon inspection of the article abstract. Within the remaining 55 articles there were 11 duplicates (articles identified through both OVID and WOK), meaning 44 full texts were reviewed. A further 25 articles did not meet the inclusion criteria and were excluded, the majority of which either suggested recommendations related to family intervention, assessed staff attitudes towards family intervention but did not evaluate implementation, or assessed the efficacy of family intervention and reported patient/family member outcomes only. A total of 26 studies met the inclusion criteria and were included in the final review.

Quality assessment

Due to the nature of the studies meeting the inclusion criteria not being RCTs, it was not relevant to assess quality using the commonly used scales by Chalmers *et al.*, (1981), Jadad *et al.*, (1996) or CONSORT statement (Moher *et al.*, 2001). All included studies were instead assessed for quality using criteria based on recommendations by Khan *et al.*, (2001) and Grimshaw *et al.*, (2003). Studies were assessed according to randomisation techniques, comparability to baseline, description of intervention, training and participants, details of follow-up, analysis of confounding variables, appraisal of measurement tools and adequate reporting of relevant results.

RESULTS

Twenty-six studies were identified as being relevant for inclusion in the current review. A brief descriptive evaluation of the 26 studies is presented in tabular format in Table 2.

Population studied – participants and setting

Fifteen of the 26 studies were carried out within mental health services, six studies were carried out within substance misuse treatment services, two studies within a hospital emergency department, two studies within primary care services and one study within a paediatric and family health care centre.

Ten studies were carried out within the U.K., seven studies in the U.S., three studies in Australia, two in New Zealand, two in Italy, one in Iran and one in Germany.

The majority of staff worked as mental health professionals (clinicians or nurses). Other job roles included Doctors, Counsellors, Health Care Professionals, Medical Directors, Nurses, Occupational Therapists, Psychologists, Paediatric Health Care Professionals, Social Workers and Substance Misuse Professionals. The number of staff trained in family intervention ranged from one (O'Farrell *et al.*, 2008) to 700 (Wills *et al.*, 2007), however, the majority of studies (58%) reported training between eight and 45 staff.

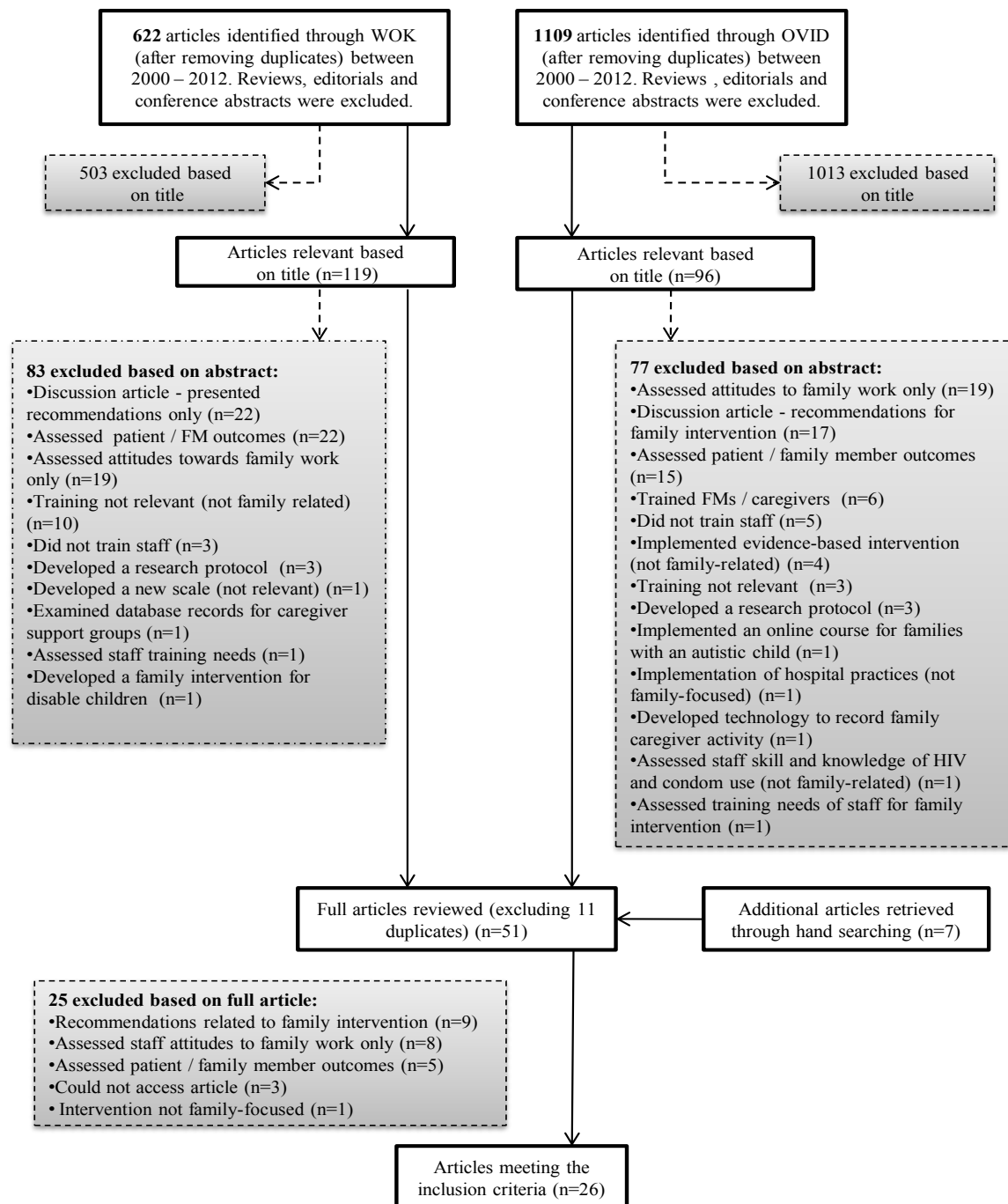


Figure 1. Systematic Review Search Process

Table 2. Summary of Studies Included in Systematic Review

No.	Author(s)	Participants / Setting	Intervention	Randomised to training	Comparison/ control group	Evaluation + instruments	Follow-up	Standardised measures	Findings and conclusions	Limitations
1	Arcidiacono, Velleman, Fioretti & Georgio (2007).	41 professionals (18 GPs and 23 Community Addiction Treatment staff - Doctors, Psychologists, Nurses, Social Workers) in Naples, Italy.	Trained to provide an evidence-based (5-Step) intervention to affected family members of people with serious drug and alcohol problems.	No	No	Data reported on staffs' opinions of intervention and implementation post-training (duration not mentioned). Focus groups held post-training.	Not mentioned.	No - open ended questions.	23 staff delivered the interventions to 52 FMs. 77% of staff thought intervention would be easy to implement in routine practice. (53% of GPs). 79% planned to use intervention again.	Feasibility study (no longer-term follow-up - only immediately following training). Only keen participants likely to have been involved. Qualitative data provided only. No standardised measures. No baseline.
2	Bailey, Burbach & Lea, (2003).	15 Mental Health Professionals across 4 Mental Health Services, Somerset, UK.	Combined Behavioural Family Therapy and Systemic- Therapy Family Intervention Training (FIRST): Whole-team training approach in family intervention for psychosis.	No	No	Questionnaire asked about number of FMs seen, number of cases open, barriers, facilitators. 10 staff later involved in focus groups.	Baseline + 3 months.	Yes (adapted from previous work).	80% of trained staff continued to work with families following completion of training. Organisational issues including availability of time, integration with caseload identified as difficulties.	Small sample size, inconsistent amount of time since training (between 3 months and 2 years, 11 months). Lack of comparison group. Short-term follow-up.

3	Brooker, Saul, Robinson, King & Dudley (2003).	96 student trainees previously trained in PSI, Sheffield & Maudsley Mental Health teams, UK.	Psychosocial intervention (PSI) Cognitive-Behavioural Family Intervention patients with first episode psychosis and their FMs.	No	No	Examined staffs' views of training. Stage 2 followed up trainees who continued to use PSI. Structured questionnaire.	Baseline + 12 months.	Yes - based on previous work.	37% staff had not completed at least one family session during 12 months. PSI more likely when organisations had implementation strategies.	Subjective estimates of skills acquisition.
4	Cohen, Glynn, Hamilton & Young (2010).	29 Mental Health clinicians (18 psychiatry residents, 9 staff psychiatrists, 1, nurse practitioner) – Mental Health Clinic, LA, USA.	EQUIP family intervention: Aimed to reduce exacerbations of Schizophrenia. Family intervention + weekly consultation with research team.	No	No	Standardised measures. Semi-structured interview + questionnaire.	Baseline + 15 months.	Yes	Uptake of family intervention failed due to barriers from all stakeholders: lacked resources, families did not respond to intervention, patients were concerned about privacy.	Did not attempt to address staff attitudes. Training only involved select staff. Only attempted to understand implementation following 15 months. Lack of comparison group.
5	Copello, Templeton, Krishnan, Orford & Velleman (2000b).	91 professionals working within 84 Primary Care practices (GPs, health visitors, practice nurses, counsellors, CPNs) + 21 professionals in pilot phase. UK.	5-Step Method piloted with 21 professionals. Professionals then received group training (n=68) or individual training (n=31).	No	Yes (individuals who delivered the intervention matched with a trained professional who had not tested the intervention)	Attitudes to family work assessed before and after training and testing of intervention. Brief questionnaire also administered following each session with family member.	Baseline + end of intervention (intervals not described). Comparison staff measured at same intervals.	Yes	Significant reductions in family members' coping scores. Those who tested the intervention produced the most significant impact on professionals' attitudes towards family work.	No comparison with untrained staff (only those trained who had not delivered intervention). Staff only required to work with one FM. No control for FMs.

6	Copello, Williamson, Orford & Day (2006b).	20 therapists (Drug workers, Psychologists, Psychiatrists) working in a range of community drug services, UK.	Feasibility study to adapt Social Behaviour and Network Therapy (SBNT) for drug users. Two-day training event + regular supervision using audiotape and visual materials.	No	No	Required to identify one focal client and apply SBNT. Substance use, social network, family cohesion, emotion and conflict measured for focal client.	Baseline + 3 months	Yes	60% therapists went on to apply SBNT following training. Post-intervention significant differences in family cohesion, satisfaction and reduction in conflict and heroin use.	No control group. Short evaluation (3 months). Therapists volunteered to participate (likely to increase compliance). Therapists only required to identify and work with one focal client.
7	Kelly & Newstead, (2004).	14 professionals (nurses, social workers, occupational therapists), Dorset NHS Trust, UK.	THORN initiative - aims to aid recovery of people with psychosis by involving FMs. Whole service collaboration. Thorn graduates released one day per week to work in family service	No	No	Questionnaire, informal interviews (data collection not mentioned).	Merged data from family intervention services since 1996. Training not reported, only lessons learned.	Yes	Many barriers encountered at the onset – staff critical, fear of change, concern about new ways of working, sometimes with hostility. Provides examples of how to overcome organisational barriers.	Brief overview of findings, no data presented. Authors' perceptions of barriers, no mention of rates of implementation of family work into routine practice.
8	Laube & Higson (2000).	8 Community Mental Health Centre staff, Sydney, Australia.	Pilot study. Cognitive-Behavioural Intervention for families of mentally ill clients of the service. Training + supervision.	No	No	Pre-post knowledge quiz - developed throughout study to ensure more relevant. Pre-post audit of clinical contact with FMs.	Baseline + post-training.	Yes – adapted from previous studies.	Improvements approaching significance in staff's quiz (in revised version). Significant increases in intended inclusion of FMs.	No follow-up (only immediately following training). Attitudes not assessed, only knowledge of mental health.

9	Liddle, Rowe, Gonzalez, Henderson, Dakof & Greenbaum (2006).	10 program staff (Program Director, Medical Director, Social Workers, Mental Health Technicians, Nurse). Day treatment program for drug abusing adolescents, Florida, USA.	Multicomponent, multilevel technology transfer intervention to train staff in Multidimensional family therapy (MDFT)	No	4-phase interrupted time series design: pre-exposure phase training phase, implementation phase (supervision + booster training, and durability phase.	Average number of family therapy sessions compared over study phases. Videotaped therapy sessions to compare fidelity.	12 month baseline, 6 month training followed by 14 month implementation phase. 18 month follow-up phase.	Yes	MDFT was incorporated into the program and changes were noted in the program environment, therapist behaviour and some client outcomes. Changes remained after supervision ceased.	No randomised design. Small sample, single drug treatment setting (though currently designing to replicate and extend findings).
10	Magliano, Fiorillo, Malangone, De Rosa & Maj (2006).	23 Italian Mental Health Centres: 2 staff from each centre trained (38 participants), Italy.	Family-focused psycho educational intervention program to persons with Schizophrenia and their families. Training + supervision + monthly telephone support.	No	No	No questionnaires mentioned; informal discussions with staff regarding implementation.	Baseline + 12 months	No	17% of participants failed to complete course due to program being too demanding. 13% did not go on to provide intervention to families (insufficient time, difficulties with workloads, moved roles).	Did not assess variables influencing staff's compliance with program (attitudes, beliefs). Relatively limited follow-up.

11	Margolis, <i>et al.</i> , (2001).	8 paediatric and family health care practices in Durham, North Carolina, USA. Number of staff not mentioned.	Linkages for Prevention Project to improve delivery of preventive services to children under two. Provided assistance in hiring and training staff + on-going consultation and feedback on implementation.	No	Yes. Interrupted time-series design. Monitored rates of preventative services in practices before and after the intervention and across groups.	Measured rates of preventive services before and after intervention.	Baseline, 12 months + 3 years.	Discussed in companion paper.	Positive changes achieved over a 3-year period and many sustained since completion. Intervention group more likely to have had an appropriate number of well-child visits compared to wait-list control.	Only measured the health of children whose parents were enrolled in a particular practice.
12	McFarlane, McNary, Dixon, Hornby & Cimett (2001).	66 Mental Health Agencies (15 in Maine, 51 in Illinois). Total of 537 trainees followed up. USA.	Multifamily psycho-education. Orientation workshops held throughout the state (Maine). Training tailored on a site-by-site basis.	No	Yes (both trained consecutively, however, few Illinois sites used on-going consultation + supervision).	Written survey, follow-up interviews.	Baseline, immediately following training + 9 months later.	Yes – adapted from previous work.	93% Maine sites implemented family services. 10% Illinois implemented the services. Maine trainees were less sceptical and interested in receiving supervision.	No randomisation to training. Progress of implementation based on 5-point scale rather than observation within sites or audit of cases.
13	Mottaghipour, Saleslan, Seddigh, Jalali, Roudsari, Tahbaz, Hosseseizade (2010).	8 professionals (GPs, Nurses and Social Workers) working within Mental Health services in Iran.	Trained professionals to conduct family education for families of patients with first-episode psychosis. Three day workshop + 12 two-hour supervision sessions.	No	No	Family sessions were tape recorded and content analysed (total time of each session, lecture, discussion). Checklist used to evaluate content.	No baseline provided. Did not specify when videotapes were analysed.	Author developed - adherence to protocol.	24 videotapes analysed (not mentioned whether all 8 staffs' sessions were evaluated). 72% adherence to protocol. Did not change over time.	No baseline measure. Not mentioned what time period videotapes were analysed. Single rater (no comparison).

14	Mottaghipour, Woodland, Bickerson & Sara (2006).	80 staff working within one hospital (responsible for psychiatric services), New South Wales, Australia	Developed a programme designed to increase knowledge and skills of workforce to work confidently with FMs, to increase support, develop appropriate resources.	No	No	Questionnaire measuring client outcomes. No. of clinical contacts attending services assessed over two weeks.	Baseline + 24 months.	Yes.	Amount of clinician's contact doubled (no data presented, unpublished).	Content of training not mentioned; not mentioned if evidence-based. Only measured two weeks of contact. Did not assess staff's attitudes. Did not report client outcomes.
15	O'Farrell, Murphy & Alter, Fals-Stewart (2008).	Hospital-based inpatient substance abuse detox unit in North East, US. One newly hired staff member.	Brief Family Treatment (BFT) - involves meeting with patient and adult FM to review and recommend potential aftercare plans.	No	No	Hospital records audit to assess % of patients asked for permission to contact family, agreed to family contact, actually had family contacted.	Baseline and 6 time periods spanning 14 months. Process evaluation carried out throughout.	No. Researcher developed.	Successful transfer of BFT from research to delivery in routine clinical practice. Process evaluation identified when and where there were implementation problems.	Lacked control group. No random follow-up data. Did not assess what happened in sessions. Cannot determine whether findings are attributable to characteristics of individual staff member.
16	Orford, Templeton, Copello, Velleman, Ibanga & Binnie (2009).	20 staff working within NHS (n=7) or non-statutory (n=13) alcohol and drug treatment services, UK.	Pilot study. Evaluated family-focused training package. Drew on 5-Step Method and SBNT. Two-day training event + regular supervision meetings over two years.	No	Yes (post-training attitudes and audit of family work compared with equivalent untrained staff).	Process notes from all meetings qualitatively analysed. Individual interviews with staff. Responses to attitude questionnaire and audit of family work.	Attitudes measured at baseline + two years. Two-week retrospective audit of family work (post-intervention only).	Attitude measure standardised. Diary-based method developed by authors.	Family work ranged between 15 – 17% (compared to 3 – 5% in non-trained teams). Attitudes to family work significantly increased post-training and higher than comparison teams.	Audit of family work took place at one time-point over 2 years. No baseline audit of family work (however, did compare with comparison teams post-training).

17	Redhead, Bradshaw, Braynion & Doyle (2011).	42 nursing staff (qualified and unqualified) working within a low-secure mental health unit, UK.	Psychosocial Intervention (PSI) incorporating family intervention. Training + follow-up supervision.	Yes – randomised controlled design (experimental or wait-list control)	Yes – wait-listed control who received training following a delay	Baseline and post-training knowledge and attitude scores (compared with wait-listed group). Random audit of care plans before and after training.	Baseline and post-training outcome measures (intervals not described).	Yes	Significant increases in knowledge and attitude scores revealed in experimental group compared with control. Mean number of PSI increased from 1.95 to 11.81.	Nursing staff volunteered to participate. Largely focused on whether unqualified nurses would achieve similar results to qualified.
18	Ritchie, Nelson & Wills (2009).	35 nurses + 1 social worker working in an Emergency Department, Hawke's Bay, New Zealand.	Staff trained in a Family Violence Intervention Programme (FVIP) to routinely screen (ask about family violence) all female patients aged 16 or over. Training + program of implementation.	No	No	Semi-structured interview conducted 12 months after program implementation.	12 months after program implementation	No - author developed.	31% participated in interviews. All believed the intervention was important. Lack of time, resources, privacy and lack of training were barriers.	Selection bias - only one third of participants consented to participate in interviews. Only focused on nurses - lack of other medical staff's opinions.
19	Schoenwald, Letourneau & Halliday-Boykins (2005).	405 therapists within 45 organisations working with youth with serious antisocial behaviour, USA.	Multi-systemic Therapy (MST). 5-day orientation to MST + quarterly booster sessions + weekly group supervision session + phone consultation.	No	Yes – caregivers in three experimental conditions (standard MST, MST + contingency management, or treatment as usual).	Caregiver rated MST therapist adherence following monthly treatment sessions.	Adherence to intervention assessed following each monthly treatment sessions	Yes	Therapists' education and training in experience in MST did not predict adherence. Caregiver ratings of therapist adherence lower for therapists viewing flexible hours required to deliver MST as problematic.	Participants applying MST elected employment in an MST program. No actual rates of MST measured, only caregiver ratings.

20	Schweitzer, Ginap, von Twardowski, Zwack, Borst & Nicolai (2007).	100 staff (70% Psychiatric Nurses), Psychiatric Teams (Cologne, Paderborn, Hannover), Germany.	18 day Multidisciplinary training approach to family systems inpatient acute psychiatry. Whole teams were trained, rotated across 3 hospitals. Ensured implementation by assigning homework.	No	No	Letter box anonymous feedback + questionnaire regarding benefits of training. Interviews with 49 staff post-training. 250 random videotapes analysed.	Staff confidence knowledge assessed baseline, post training. Audit of video-tapes analysed at baseline and 2 years following training.	No - author developed.	Post-training increases in total amount of conversations with family. Staff more confident after training. Videotape analysis revealed increases in use of systemic interview techniques.	No randomisation or control.
21	Slade, Holloway & Kuipers (2003).	6 staff (COAST) working within a specialist early psychosis service + 8 control staff working within similar community mental health teams (CMHT), UK.	Training included Thorn, and Family Therapy Course - psychosocial interventions + supervised practice with expert.	No	1. COAST access to supervision 2. Control group no access to supervision.	Author developed questionnaire and semi-structured interview.	Baseline, 6, 12 + 18 months. Control only baseline + 18 months.	No. Researcher developed.	Trained COAST staff reported improved skills in family work. No increases evident in the control staff. Both groups identified the need for adequate time to undertake family work.	Exact nature of supervision not described. Mixture of staff trained before project in both experimental group and control group. Difficult to attribute skills acquisition purely to supervision.
22	Stanbridge, Burbach & Leftwich (2009).	72 nursing staff + additional 1 day training provided for admin staff and inpatient nursing staff. Acute Mental Health Inpatient Unit in Somerset, UK.	To raise awareness of the roles carers/families play and help staff to develop skills and confidence to work in partnership with families. 3 day training	No	No	Pre-post case audit. Survey at baseline (assessing confidence, experience in working with FMs). Intended action plans qualitatively analysed.	Baseline, during and 12 month follow-up	No	Significant increases in staff confidence and skills. Post-training audit increases in consideration of the needs of FMs. Barriers due to work pressures and existing admission procedures.	No comparison / control group.

23	Templeton, Zohhadi & Velleman (2007).	15 staff from 7 specialist drug and alcohol services across one statutory Mental Health Trust, UK.	Feasibility of implementing the 5-Step intervention with specialist services. Two training sessions. Once trained, staff asked to recruit up to two FMs each.	No	No	Pre-post questionnaire. Staff asked to log how they recruited FMs and each time they carried out a family session. 14 staff interviewed.	Baseline and 10 months.	Not mentioned which standardised measure, however, based on previous work.	13 staff went on to work with FMs. Barriers to successful implementation were primarily organisational (resources, team structure, confidentiality and commissioners).	Quantitative data not reported, only qualitative. No significant increases in FMs outcomes. Feasibility study - only required staff to recruit and work with two FMs - not realistic of caseloads.
24	Turner, Nicholson & Sanders (2011).	519 primary care practitioners (nursing, education, health workers and medical professionals), Australia-wide cohort	Triple P (Behavioural Family Intervention (BFI) to promote children's healthy development and modify dysfunctional parenting practices) for child and adolescent mental health problems. 2-day training.	No	No	Proportion of all families seen who received 3 or 4 sessions). Practitioner self-efficacy and confidence in consultations with parents about child behaviour. Barriers assessed using a checklist.	Baseline + 6 months post-training	Mixed – some author developed, some standardised.	97% of practitioners reported using Triple-P in their workplace in the 6 months following training. 25% of FMs completed the full intervention. Barriers influenced practitioner self-efficacy.	Retrospective estimates of use of Triple P. Sample paid to receive professional training (likely to have high compliance). Did not measure agency-level adoption of the programme).

25	Wills, Ritchie & Wilson, (2007).	700 staff (since 2001) within a mid-sized health service, Hastings, New Zealand.	Organisation-wide intervention to improve child protection. Collaborative approach with stakeholders. 1 full day training.	No	No	Pre-post evaluation of comfort and satisfaction with training. Quarterly audits of rates fed back to staff via newsletter. Semi-structured interviews considering barriers and facilitators (with 60 staff).	Baseline, and process data between 3 and 4 years.	No - author developed.	Clinicians felt more confident to identify, assess and refer abuse. Considerable variation between rates of screening between services (6 - 100%). Barriers to routine questioning included lack of privacy to screen, lack of time, being too busy, discomfort with question, lack of confidence, fear of offending.	No randomisation. Alternatives for improved decision and referral of abuse are possible - cannot be attributed to training.
26	Zazzali, Sherbourne, Hoagwood, Greene, Bigley & Sexton (2008).	15 staff working within 13 organisations, NY, USA.	Pilot study - intended to capture key stakeholders experiences only. Trained in Functional Family Therapy (FTT) for adolescents with conduct disorder. 2 year training (3 days clinical training session + 1 hour phone consultation for 1 year). Follow-up training – 3 2-day sessions.	No	No	Semi-structured interview based on author developed framework (asked about reasons behind adoption and implementation, resources, etc.) Tape recorded and qualitatively analysed.	Staff interviewed following implementation. No baseline measures collected.	No	Tensions and variation in implementation appeared to be related to what Directors thought should occur.	Only 'keen' organisations recruited. Only two staff interviewed from each organisation. Self-reported qualitative data analysed after implementation (no baseline data).

Training in Family Intervention

Staff were trained in a range family interventions, 17 studies being evidence-based. Twelve studies trained staff in psychosocial interventions (PSI) for mental health problems (psychosis or conduct disorder), including a range of collaborative interventions designed to improve the health and social functioning of service users and their families. Interventions included Behavioural Family Intervention / Psycho-education (Magliano *et al.*, 2006; McFarlane *et al.*, 2001; Redhead *et al.*, 2011, Turner *et al.*, 2011), Cognitive-Behavioural Family Therapy (CBFT) (Brooker *et al.*, 2003; Laube *et al.*, 2000), Enhancing Quality of care In Psychosis (EQUIP) (Cohen *et al.*, 2010), Functional Family Therapy (FFT) (Zazzali *et al.*, 2008), Multi-Systemic Therapy (MST) (Schoenwald *et al.*, 2005), Systemic Therapy (Bailey *et al.*, 2003), and the THORN accredited initiative (Kelly *et al.*, 2004; Slade *et al.*, 2003). Such interventions examine the interactional dynamics of families and how they contribute to family functioning and dysfunction. The interventions aim to provide information to clients and their family about mental health issues and treatment, to look for early warning signs, to help monitor medication, and to improve communication.

Six studies trained staff in family intervention for substance misuse problems. Three studies trained staff in the 5-Step intervention (Arcidanacono *et al.*, 2007; Orford *et al.*, 2009; Templeton *et al.*, 2007). Two studies trained staff in Social Behaviour and Network Therapy (SBNT) for alcohol and drug misuse (Orford *et al.* 2009), and drug misuse specifically (Copello *et al.*, 2006b). One study trained staff in Multidimensional Family Therapy (MDFT) (Liddle *et al.*, 2006), a family-based treatment for adolescent substance abuse and related problems. MDFT involves multiple systems to help the adolescent and family develop more effective coping and problem-solving skills for better decision-making. One study trained

staff in Brief Family Therapy (O'Farrell *et al.*, 2008), an intervention for substance misusing patients in inpatient detoxification which involves meeting with the patient and a family member to review aftercare plans for the patient.

The remaining eight studies trained staff in interventions that were either not evidence-based, or the evidence-base could not be established. Two studies first involved piloting and developing the family intervention in which staff were subsequently trained. The aforementioned 5-Step Intervention was developed in one study (Copello *et al.*, 2000b), and a family intervention for patients with mental illness based on capacity building, project management and action research was developed (Mottaghipour *et al.*, 2006).

Two studies involved training staff to improve child protection as part of a Family Violence Intervention Program (FVIP), however, the theoretical model on which the program was based was not described (Ritchie *et al.*, 2009; Wills *et al.*, 2007). Similarly, the particular model or theory underpinning the training and intervention was not mentioned for four studies (Margolis *et al.*, 2001; Mottaghipour *et al.*, 2010; Schweitzer *et al.*, 2007; Stanbridge *et al.*, 2009).

Training method and duration

Ten studies involved both passive (didactic presentation) and active learning (e.g. experiential learning, modelling, role-plays) (Cohen *et al.*, 2010; Copello *et al.*, 2006b; Liddle *et al.*, 2006; Magliano *et al.*, 2006; O'Farrell *et al.*, 2008; Orford *et al.*, 2009; Schweitzer *et al.*, 2007; Stanbridge *et al.*, 2009; Turner *et al.*, 2011; Wills *et al.*, 2007). In addition to didactic lectures and role-play exercises, Magliano *et al.*, (2006) asked staff to perform homework exercises

with support of their own relatives as a way of practicing working with FMs, and three studies devoted part of the training to ensuring staff developed action plans to implement family work in their routine (Orford *et al.*, 2009; Schweitzer *et al.*, 2007; Stanbridge *et al.*, 2009). The majority of studies (62%), however, did not provide an adequate description of training to identify the training method, or the description of the training methods were provided in a companion paper.

Where details of training were provided, training duration varied widely from one day (Wills *et al.*, 2007) to two years (Orford *et al.*, 2009), however, most training duration was between three and eight days. Six studies used manuals to supplement the training (Copello *et al.*, 2006b; Orford *et al.*, 2009; Liddle *et al.*, 2006; Mottaghipour *et al.*, 2010; Schoenwald *et al.*, 2005; Templeton *et al.*, 2007).

Whole team approach to training

Eleven studies appeared to adopt a whole-team approach to training. The majority of studies (58%), however, trained a small proportion of professionals working within the services, most of whom had volunteered to receive training in family intervention or had been nominated by their line manager. The proportion of staff trained within four studies could not be established (Brooker *et al.*, 2003; Cohen *et al.*, 2010; Laube *et al.*, 2000; Mottighipour *et al.*, 2010).

Supervision

In addition to training, supervision from the expert trainers was described in 17 of the 26 studies. Six studies provided on-going clinical supervision and feedback about implementation (between 12 months and three years) (Liddle *et al.*, 2006; Margolis *et al.*,

2001; McFarlane *et al.*, 2001; Orford *et al.*, 2009; Schweitzer *et al.*, 2007; Slade *et al.*, 2003). Two studies offered trainees access to telephone consultation with a family expert as and when needed (Cohen *et al.*, 2010; Zazzali *et al.*, 2008). Magliano *et al.*, (2006) offered supervision tailored specifically to staff's concerns and provided monthly telephone support when necessary, and Wills *et al.*, (2007) offered annual supervision as necessary. Mottaghipour *et al.*, (2006) held monthly 'Working with Families Breakfasts' which were informal forums aimed at providing staff with on-going consultation, supervision and support in a friendly setting.

Additionally, two studies compared intervention groups who received on-going supervision with a control / comparison group (McFarlane *et al.*, 2001; Slade *et al.*, 2003). Finally, three studies mentioned supervision, however, adequate details were not provided (Copello *et al.*, 2006b; Laube *et al.*, 2000; Schoenwald *et al.*, 2005), or were described elsewhere (Redhead *et al.*, 2011).

Refresher training

Follow-up or refresher training was described in only six of the 26 studies. Two studies offered annual advanced training to key senior staff and internal champions (Wills *et al.*, 2007; Zazalli *et al.*, 2008). Schoenwald *et al.*, (2005) provided quarterly booster sessions to staff, and Liddle *et al.*, (2006) offered additional one-to-one training sessions for staff who had joined the program following the end of the training period. Orford *et al.*, (2009) held a two-day progress seminar one year after the initial training event, and a two-day end of project event two-years after initial training, and Ritchie *et al.*, (2009) mentioned a refresher course but did not provide any details.

Additional endeavours to ensure implementation of family-focused practice

Alongside training staff, nine studies described endeavours to encourage routine implementation of family work. These efforts included attempting to ensure support was obtained from both within the Organisation and outside community collaborations, raising the awareness of the importance of family intervention with all relevant stakeholders (patients, FMs, management, funding bodies, etc.), documentation being amended and policies and resources being developed to support family-focused practice.

Four studies used a formal organisational approach to assess and address organisational and service system barriers to implementation and to ensure community collaboration, obtain senior management support and ensure recording documentation was amended (Margolis *et al.*, 2001; Richie *et al.*, 2009; Schoenwald *et al.*, 2005; Wills *et al.*, 2007). Wills *et al.*, (2007) created resources for staff, patients and FMs (posters, laminated flowcharts, cue cards), and Margolis *et al.*, (2001) developed a three-level intervention (community, practice and family-level) in which links between practices were encouraged prior to staff training, as well as assistance in hiring of new staff to work with FMs.

Three studies held orientation workshops prior to training staff in order to ‘launch’ the intervention, or to address concerns voiced by stakeholders (patients, FMs, managers, medical colleagues) (Kelly *et al.*, 2004; McFarlane *et al.*, 2001; Orford *et al.*, 2009). Furthermore, the approach taken by Orford *et al.*, (2009) was to continuously help staff to find new ways of promoting and facilitating family-oriented work (e.g. suggesting procedural changes, including mentioning FMs in the FC’s assessment documentation and including a social network diagram).

Finally, Liddle *et al.*, (2006) included a pre-training technology transfer phase in an attempt to prepare individual professionals for change, and Stanbridge *et al.*, (2009) used a two-phased approach whereby pre-training awareness raising sessions were held, with staff being surveyed pre-training to highlight issues in confidence skills which could be subsequently tackled.

Evaluating the impact of training in family intervention

Study design

Only one study randomly assigned participants to receive training (Redhead *et al.*, 2011), employing the most robust design whereby staff were trained immediately or following a wait-listed delay. The next most robust study used a four-phase controlled interrupted time-series design to examine implementation of family work before training, during training, post-training and at follow-up (Liddle *et al.*, 2006).

Six studies used a quasi-experimental design whereby outcomes were simultaneously compared between an intervention and an equivalent control group who did not receive training and/or supervision (McFarlane *et al.*, 2001; Orford *et al.*, 2009; Schoenwald *et al.*, 2005; Slade *et al.*, 2003), or used a retrospective control group (Margolis *et al.*, 2006). One study involved matching trained professionals who had tested the family intervention with a family with those professionals who had not (who served as a control) (Copello *et al.*, 2000b). However, the majority of studies (65%) used a pre-post evaluation design. Moreover, three studies employed the weakest design whereby post-training outcomes were assessed but

baseline data were not (Arcidanacono *et al.*, 2007; Mottighiour *et al.*, 2010; Zazzali *et al.*, 2008).

Outcome measures

Outcomes included assessing staff's levels of knowledge, confidence and skills to be able to work with FMs, rates of implementation of family work, adherence to delivery of family intervention and barriers to implementation of family-focused practice. Fifteen studies used psychometrically sound standardised measures, whereas the remaining eleven studies used either researcher-developed non-standardised measures or did not provide sufficient details to establish the psychometric nature of the measures.

To evaluate the implementation of family work, or intentions to implement family work, twelve studies used independently-rated evaluation techniques, e.g. by carrying out pre-post record/case audits of family-focused practice (Liddle *et al.*, 2006; O'Farrell *et al.*, 2008; Orford *et al.*, 2009; Redhead *et al.*, 2011; Ritchie *et al.*, 2009; Slade *et al.*, 2003; Templeton *et al.*, 2007; Turner *et al.*, 2011), or analysed videotaped sessions (Magliano *et al.*, 2006, Slade *et al.*, 2003) or audiotaped sessions conducted with families (Mottaghypour *et al.*, 2010). Schoenwald *et al.*, (2005) assessed caregiver ratings of therapists' adherence to deliver family sessions. However, the majority of studies (54%) used less robust self-report questionnaires, surveys, semi-structured interviews or informal discussions with staff.

Outcomes

Eleven studies assessed post-training outcomes compared to baseline within one year: Immediately following training (3 days) (Laube *et al.*, 2000); after three months (Bailey *et al.*,

2003; Copello *et al.*, 2006b); after six months (Slade *et al.*, 2003; Turner *et al.*, 2011); after nine to ten months (McFarlane *et al.*, 2001; Templeton *et al.*, 2007); and after 12 months (Brooker *et al.*, 2003; Maglione *et al.*, 2006; Ritchie *et al.*, 2009; Stanbridge *et al.*, 2009). Eight studies assessed outcomes after one year: 14-15 months (Cohen *et al.*, 2010; O'Farrell *et al.*, 2008); 18 months (Slade *et al.*, 2003); 24 months (Orford *et al.*, 2009; Schweitzer *et al.*, 2007); 36 months (Liddle *et al.*, 2006; Margolis *et al.*, 2001); and 48 months (Wills *et al.*, 2007).

Three studies compared baseline data to post-training data throughout the study at undisclosed intervals (Copello *et al.*, 2000b; Redhead *et al.*, 2011; Schoenwald *et al.*, 2005), and four studies measured post-training outcomes only (no baseline data provided) at 12 months (Ritchie *et al.*, 2009; Zazalli *et al.*, 2008), or following an undisclosed post-training period (Arcidianacono *et al.*, 2007; Mottaghipour *et al.*, 2010). Finally, Kelly *et al.*, (2004) reported the results of a training programme which led to successful implementation of family work, however, did not report any actual data, rather overall lessons learned related to how to overcome barriers to implementation

Knowledge, confidence and skills to be able to work with family members

Fourteen studies assessed staff's knowledge, confidence and skills related to working with FMs pre and post-training, of which eleven studies reported increases following training (Brooker *et al.*, 2003; Copello *et al.*, 2000b; Liddle *et al.*, 2006; Magliano *et al.*, 2006; Orford *et al.*, 2009; Redhead *et al.*, 2011; Schweitzer *et al.*, 2007; Slade *et al.*, 2003; Turner *et al.*, 2011; Wills *et al.*, 2007; Zazzali *et al.*, 2008). Additionally, Stanbridge *et al.*, (2009) found

increased consideration of the needs of FMs post-training. Slade *et al.*, (2003) found no increases in attitudes or confidence in the control group (absence of supervision).

Finally, Copello *et al.*, (2000b) revealed that the most significant impact on staff's confidence and knowledge was found for trained professionals who had tested the family intervention, compared to trained professionals who had yet to test the intervention. For the remaining three studies, staff's knowledge, confidence and / or skills to work with FMs was either approaching significance (Laube *et al.*, 2000), or data were not reported (Kelly *et al.*, 2004; Templeton *et al.*, 2007).

Rates of implementation of family work

Fourteen of the 26 studies used objective measures to assess rates of implementation of family work, of which only five studies reported both pre and post-training rates of implementation. The most rigorous study was carried out by Liddle *et al.* (2006), who examined case records and behaviour in sessions from recorded videos over four study phases, with analysis indicating more weekly sessions with FMs during the post-training phase (14 months after training) and follow-up phase (32 months after training) compared to baseline.

Wills *et al.*, (2007) carried out quarterly audits to establish whether screening for child abuse had increased as a result of the family intervention and found that increases were evident, although there was considerable variability in the rate of screening between services (6 – 100%). Schweitzer *et al.*, (2007) revealed non-significant increases in the quality and quantity of conversational time spent with patients and FMs during a four-week post-training period, compared to the same baseline period. Additionally, results revealed that all families on the

active caseload within the service had been offered visits at home, however, routine involvement with FMs was minimal for 33% of patients and intensive family work was being undertaken with only 3% of families.

Stanbridge *et al.*, (2009) carried out a pre and post-training audit of electronic case records and found modest increases in the average number of family meetings carried out in the last month compared to baseline (2.35 vs. 2.90). Redhead *et al.*, (2011) audited a random sample of service user care plans pre and post-training. Results indicated that the mean number of PSI described in the care plans significantly increased from 1.95 to 11.81 post-training, eight months later.

Six studies using objective measures did not assess baseline rates of family work, making it impossible to determine whether increases in family work were a result of the training or other factors. Two of the six studies did, however, compare rates of family work with an equivalent non-trained control group. Schoenwald *et al.*, (2005) compared caregivers' ratings from a Treatment group, with a group who received family intervention. Results indicated that therapist training and experience in family intervention did not predict adherence to deliver family sessions; rather, adherence to family work was found to be lower for staff who viewed the flexible hours required to deliver family intervention as problematic. Margolis *et al.*, (2001) also compared implementation of family work with a retrospective control group and found increased family visits post-training compared to a retrospective control group (57% vs. 37%) by auditing case records.

McFarlane *et al.*, (2001) audited case records and revealed successful implementation of family-focused practice within sites where the family treatment model was viewed more positively at the outset (93% of sites implemented family work), compared to sites where staff were sceptical and who had provided lower ratings of the usefulness of family work (10% of sites implemented family work). Mottaghipour *et al.*, (2010) examined recorded sessions between FMs and staff in an attempt to examine the effectiveness of training in family psychoeducation and staff's adherence to protocol, with results revealing a consistent overall 72% adherence following training (follow-up duration not disclosed).

O'Farrell *et al.*, (2008) analysed patients' records, revealing that patients were asked about family contact 70-80% of the time, patients agreed for family members (FMs) to be contacted between 60 – 65% of the time, however, patients who actually had their FMs contacted were found to be around 50% of the time. Cohen *et al.*, (2010) audited case records and revealed that 73 out of 100 patients providing consent for their FMs to be contacted were indeed contacted. Out of the 73 FMs contacted via letter, only three FMs contacted the service, none of whom was referred to the psychoeducational program intended for them.

Three studies also used objective measures to assess rates of implementation of family work, however, did not provide any actual data. Mottaghipour *et al.*, (2006) planned to assess the number of clinical contacts with FMs for a two-week period at baseline and again after two years, however, the article had been published before the end of the two-year period. Magliano *et al.*, (2006) revealed that only 59% (17 / 29) of centres selected to participate went on to provide psycho-educational family intervention to patients and FMs, however, no rates of implementation were included. Finally, Laube *et al.*, (2000) revealed significant increases

in the proportion of clinical contacts including FMs post-training but again, actual rates of implementation were not included.

The remaining twelve studies examined implementation of family work using subjective measures (e.g. staff's self-report evaluation of number of FMs recruited and worked with, the amount of time spent working with FMs, and facilitators/barriers to family work). Only two of the seven studies used a pre-post evaluation to examine the amount of time currently spent working with FMs. Slade *et al.*, (2003) compared implementation of family work at baseline and post-intervention, as well as with a control group at 18 months. Disappointingly however, the article did not report data for the control group and also failed to mention whether the amount of time currently spent working with FMs changed throughout the course of the 18 month follow-up period (baseline data was only provided for staff's knowledge, confidence, skills to work with FMs). Results did reveal that the intervention group had adequate time for family work, whereas the control group reported inadequate time for family work. Implementation of family work within the intervention group was minimal for ten out of the 30 patients due to the FMs perceiving no need for contact from the services, or because the family was disengaged from their relative, and only seven out of the 30 families were in the process of being engaged with the team, with only five families involved in intensive family work.

Brooker *et al.*, (2003) asked trainees to estimate what percentage of their clinical time was spent using PSI strategies before and after training. Results showed modest rates of implementation of family work post-training, whereby 37% of staff (28/76) had not managed

to complete 12 sessions with one family since training. Furthermore, only 11% of staff had managed to work with ten families since training.

The remaining ten studies using subjective evaluation methods failed to report baseline rates of implementation of family work, however, one study (Orford *et al.*, 2009) did compare rates of implementation with an equivalent non-trained control group. Following two-years of family-focused training and supervision, Orford *et al.*, (2009) carried out a retrospective two-week audit of staff's self-reported diary activity to assess the proportion of family work in their routine behaviour. Results revealed that following training, percentages of family work ranged between 15 – 17%, compared to 3 – 5% in a non-trained group.

Arcidiacono *et al.*, (2007) showed that following training, 23 out of 41 staff went on to recruit and work with at least one affected FM. However, being a feasibility study, the focus was on the professionals' views of the strengths and weaknesses of the intervention rather than implementation. Bailey *et al.*, (2003) revealed that, in the 26 months since training, the number of FMs seen or cases currently open was on average 3.5. Although modest, this result was found to be higher than previous work carried out by the authors (between 1.4 and 1.7). However, post-training data was not compared to baseline data.

Turner *et al.*, (2011) examined staff's retrospective estimates of the proportion of families who had received three or four family intervention sessions in the six months following training. Results revealed that although 97% of staff had delivered the family intervention, 75% of families had only been seen once or twice, with only 25% of families completing the full intervention.

Templeton *et al.*, (2007) evaluated implementation of family work using a mixed-methods approach whereby staff were required to keep a log of how they recruited FMs and how many family sessions were carried out following training. Additionally, staff participated in a focus group to discuss implementation of family work. Results revealed that 15 out of 17 trained staff went on to work with just 20 FMs, and results predominantly focused on qualitative analysis of the professionals' views of the ease / difficulty of implementing family work. Furthermore, being a feasibility study, the aim was for staff to recruit and work with only two FMs. Similarly, being a feasibility study, Copello *et al.*, (2000b) developed a family intervention whereby trained staff were asked to test the intervention with only one relative. Results revealed that out of 91 trained staff, only 36 went on to test the intervention with 38 FMs. A further study carried out by Copello *et al.*, (2006b) tested the feasibility of adapting a family intervention for drug problems, rather than its original focus on alcohol problems. Trained staff were required to deliver the intervention to one FC, with results revealing 12 out of 20 trained staff went on to use the intervention with 24 drug users.

Three studies examined implementation of family work and asked staff about leadership, resources, organisational structure, culture, climate etc. (Kelly *et al.*, 2004; Ritchie *et al.*, 2009; Zazzali *et al.*, 2008), however, actual rates of implementation of family work were not reported. Instead, staffs' perceptions of implementation and barriers to implementation were examined. Furthermore, Ritchie *et al.*, only interviewed a small proportion (11/35) of the participants who had received the training in family intervention.

Barriers to implementation of family work

Thirteen studies (50%) reported barriers to the implementation of family-focused practice following training. The most common barrier was a lack of time to work with FMs (Bailey *et al.*, 2003; Brooker *et al.*, 2003; Mottaghipour *et al.*, 2010; Ritchie *et al.*, 2009; Slade *et al.*, 2003), closely followed by difficulties with work pressures and difficulties integrating family work into existing work (Bailey *et al.*, 2003; Liddle *et al.*, 2006; Margolis *et al.*, 2001; Slade *et al.*, 2003; Turner *et al.*, 2011). Other barriers included privacy issues and confidentiality (Mottaghipour *et al.*, 2006; Orford *et al.*, 2009; Slade *et al.*, 2003), lack of training and / or supervision (Mottaghipour *et al.*, 2006; Orford *et al.*, 2009; Turner *et al.*, 2011), staff critical of family work and fear of change (Cohen *et al.*, 2010; Orford *et al.*, 2009), lack of resources (Bailey *et al.*, 2003), flexible working hours required for family work (Schoenwald, *et al.*, 2005), lack of confidence working with more than one person at a time (Orford *et al.*, 2009), family work not recognised by service commissioners (Orford *et al.*, 2009), and existing administrative procedures (Schweitzer *et al.*, 2007).

Limitations of the research

Although the limitations of the reviewed studies have been discussed briefly in the preceding sections, it is important to discuss these limitations in more detail. The most apparent limitation was that 65% of the studies trained less than 45 staff, and only 15% of studies trained 100 or more staff. Such small sample sizes may result in the lack of statistical representation of the degree to which family work was implemented or a lack of generalisability of the findings. Furthermore, over half of the studies reviewed trained only a small proportion of staff working within one service or Organisation, or the proportion of staff trained within a particular service could not be determined. This has important

implications as previous research has highlighted the important role of organisational factors related to implementation. In particular, insufficient management support has been found to prevent the successful implementation of evidence-based interventions (Sanders, Murphy & Brennan, 2010; Fadden, 2006). Implementation of a new practice is a complex process which is likely to require support from the system in which the individual member of staff is based. Fadden (2006) emphasised the importance of working with middle managers to ensure that frontline treatment providers have time and caseload opportunities to carry out family work.

A further limitation evident within many of the studies was the inadequate description of training content and method or whether the intervention was evidence-based. This has important implications as previous research suggests that a focus on the principles and underlying spirit of the intervention is more important than a focus on techniques of delivery (Abramowitz, 2006; Miller, Yahne, Moyers, Martinez & Pirritano, 2004). More empirical study is needed to determine the appropriate focus of training content (Beidas & Kendall, 2010) as there is conflicting suggestions that training curricula should be focused on fewer topics to allow more in-depth knowledge (Brooker & Brabban, 2001), or that training content should be expanded (Gamble, 2004). In order to clarify this issue, it is important that authors include sufficient details of training content and method. There is a need to examine in more detail the specific types of training activities that take place in order to identify the ingredients that result in successful implementation of family-focused practice.

Within the studies that did provide details of training, duration and content varied widely and on-going supervision from expert trainers was not mentioned in 35% of the studies. This has important implications, as it has been found that attending a training workshop may start the

transfer of knowledge, however, on-going supervision may be needed for actual behaviour change and skilful implementation (Bazelmans, Prins, Hoogveld & Bleijenberg, 2004; Kendall & Southam-Gerow, 1996). Perhaps for this reason it has been argued that the ‘gold standard’ of training should include a workshop, a manual, and clinical supervision (Sholomskas, Syracuse-Siewert, Rounsaville, Ball & Nuro, 2005), as confidence in behaviour change is developed during the supervisory process (Beidas & Kendall, 2010). Fadden (2006) also stressed that on-going supervision was integral to the implementation of family work in the Meridian West Midlands Family Programme within mental health services. Although ratings-based performance feedback and coaching has been found to be effective in improving evidence-based practice performance (Miller *et al.*, 2004; Sholomskas *et al.*, 2005), very few studies reviewed here adopted such supervision strategies.

Follow-up or refresher training was described in only 23% of the studies. Beyond formal training sessions, the research has highlighted the need for booster sessions to enhance learning, particularly where services are challenged by staff turnover and need training for new staff to ensure maintenance and sustainability of the intervention. Training without follow-up may produce changes in attitudes and beliefs, but practice behaviour is more challenging to alter (Hayes *et al.*, 2004; McCarty *et al.*, 2004; Miller, Sorensen & Selzer, 2006). Follow-up contact (on-going supervision, booster training sessions) has been found to significantly enhance change in practice behaviour within addiction treatment services (Miller *et al.*, 2004; Sholomskas *et al.*, 2005). Furthermore, it has been argued that efforts to adopt interventions must be reinforced until they become integrated into routine practice (Squires, Gumbley & Storti, 2008).

Only 35% of the studies described actions other than training in order to encourage routine implementation of family intervention. Based on findings from previous research, a more holistic approach has been found to improve the successful implementation of evidence-based interventions. For example, Sanders and Turner (2005) argued that implementation is more likely to occur when the context supports behaviour change. Furthermore, working collaboratively with an Organisation can increase the perceived advantages and compatibility of evidence-based interventions, while reducing issues of complexity (Rogers, 2003).

Only one of the 26 studies reviewed randomly assigned participants to receive training, and only 27% of studies compared an intervention group with a non-randomised control group. This raises two issues. The first issue is that there may be a potential bias in intervention assignment. The second issue is that a simple pre and post design does not allow for the effects of the training to be distinguishable from the influence of other variables. Furthermore, it was disappointing that baseline data was not captured for some of the studies, and when comparisons were made with control groups, only attitudes and confidence of staff was reported rather than implementation of family work.

To evaluate the impact of the training on implementation of family work, 50% of the studies used non-standardised measures or did not provide sufficient detail to be able to determine whether the evaluation measures were standardised. Coupled with the fact that evaluation was typically limited to post-training self-report questionnaires, surveys, semi-structured interviews or informal discussions with staff, the rates of implementation reported (when actually reported) are unlikely to accurately reflect rates of implementation or behaviour change. There is a need for more psychometrically sound independently rated measures of

implementation rather than relying on ‘yes’ or ‘no’ responses that are likely to have little validity (Garner, 2009).

Over half of the studies reviewed assessed post-training outcomes compared to baseline within one year. To achieve successful behaviour change and implementation of family work in routine practice, this might be too short a time-span. Evidence from other fields has shown that it takes continued effort and exhaustive follow-up after training for a new culture to root into an Organisation, which may include operational changes, changes in policies and procedures, retraining, training of new staff members, etc. (Cameron, 2008; McLean & Moffat, 2009; Schneider, Brief & Guzzo, 1996).

Finally, a substantial number of studies were pilot or feasibility studies, meaning that the focus of the research was to ascertain professionals’ views of the strengths and weaknesses of family intervention, with implementation often seemingly to be an adjunct. Furthermore, due to aim of the studies being to examine the feasibility of family work, staff were only required to recruit and work with a very small number of FMs. The findings from these studies are therefore unlikely to represent real life challenges of managing large caseloads of families.

DISCUSSION

The goal of the current systematic review was to examine the current status of the literature regarding implementation of family-intervention following training. Since a very limited number of studies carried out within substance use treatment services could be identified, the search strategy included studies carried out within the wider healthcare system. Studies were

reviewed whereby staff had been trained in family intervention and the implementation of family work had subsequently been evaluated.

The studies reviewed allow us to draw some conclusions about the current status of the literature. Firstly, scientific rigour was generally limited within the reviewed studies. Methodological limitations included small sample sizes, relatively brief post-training follow-up periods, subjective evaluation methods, lack of randomisation to training, and a general underutilisation of control groups. Additionally, a large number of studies failed to describe, in sufficient detail, important aspects of the training method and duration or the actual work undertaken with FMs (for example, ‘seen’ for at least one session). The three most robust studies reviewed were carried out by Orford *et al.*, 2009; Liddle *et al.*, (2006) and Redhead *et al.*, (2011). These three studies adopted either a randomised controlled design or quasi-experimental design in an attempt to fully elucidate the impact of family-focused training on staff attitudes and practice behaviour before, during and after training, and / or compared to an equivalent non-trained group. Such designs are examples of the type of implementation research that are needed to significantly enhance the field. Although Liddle *et al.*, experienced a high degree of staff turnover during the projects’ 48 months, making it impossible to conclude whether the improvements in rates of family work found during the implementation phase were due to the training, or as a result of the Organisation simply hiring more competent staff throughout the project. Nonetheless, this study was one of the few studies reviewed to have evaluated the sustainability of the effects of training in family intervention using a robust longitudinal study design.

Second, related to the need for more controlled studies, Dennis, Fetterman & McLellan (2000) recommends the use of mixed-methods evaluation research. Orford *et al.*, (2009) and Templeton *et al.*, (2007) are two examples reviewed here that evaluated both quantitative and qualitative data in an attempt to understand the ‘full picture’ of implementation of family work.

Perhaps the two most striking findings from the current review, however, were the disparity in research that has been conducted and the absence of a theoretical basis for evaluation of implementation of family work. The review highlighted the wide variation between the training methods employed, training content and duration, evaluation outcome measures and overall research design. It was mentioned earlier that twelve of the reviewed studies trained staff in psychosocial interventions (PSI) for mental health problems, with the aim of implementing PSI into staff’s practice behaviour to improve client and family outcomes. Yet, no two studies (even those carried out by the same authors or research groups) had the same overall goals or used the same techniques to train staff and evaluate subsequent implementation of family work. Such heterogeneity makes it difficult to integrate the overall findings and conclusions in terms of what the best ways are to achieve successful implementation of family work.

With regards to the second point about a lack of theory-driven evaluation approaches, the findings from the current review are consistent with Chen and Rossi (1989), who argued that most evaluation efforts are not based on any particular theory or model, but are instead driven by a concern with research design (describing programs and counting outcomes). The findings here highlight that much effort has been concentrated on staff’s knowledge and skills

development, and that training staff in family intervention can be effective in increasing knowledge, confidence and skills to be able to work with FMs. However, there has been much less focus on strategies to prepare individuals, teams and services to implement the knowledge and skills developed into routine practice. The majority of studies reviewed here used ‘summative’ evaluation to assess implementation of family work. Summative evaluation involves identifying a problem, implementing an intervention, and assessing its effects as either a success or failure, with little concern about how and why outcomes occurred (Gorman, 1993). In contrast, Gorman suggested that more theory-driven evaluation approaches are needed, whereby the nature of the intervention being assessed and the context in which it is being implemented are evaluated. It appears that attention during evaluation needs to focus on why this problem exists, and how a solution might be found. Such an evaluation focuses not only on the intervention and outcome effects, but also on theoretical concepts including the implementation process and any dominant processes or external factors impeding such implementation. One study reviewed here that did ensure such an approach was carried out was by Orford *et al.*, (2009), who integrated action research and process evaluation in an attempt to help the trained teams with continuous improvement in becoming family-focused. By gathering and sharing process information over two years, the evaluation was able to capture what worked and what did not, so others attempting to implement family work within a similar service environment could learn from the findings.

One possible reason for the overreliance on more traditional summative evaluation is that theory-driven approaches are likely to be more time-consuming and more expensive, requiring a more co-operative manner during the implementation process (Gorman, 1993). However, a theoretical understanding of the problem is more likely to inform future policy

and intervention strategies (Chen & Rossi, 1989).

A number of other conclusions can also be put forward. Firstly, the results highlighted major obstacles to the implementation of family work within routine practice. Nearly half of the studies reviewed reported issues that have also been found elsewhere related to Organisation structure and culture (Dixon *et al.*, 1999; Zazzali *et al.*, 2007); insufficient management and support (Smith & Velleman, 2002) and funding issues and time limitations (Michie *et al.*, 2007; Tarrier *et al.*, 1999). It is not surprising, therefore, that changes in practice towards becoming more family-focused were modest, and rates of implementation of family work following training were relatively small (something that the authors generally acknowledged themselves). This supports previous research whereby a multitude of factors have been associated with the successful implementation of evidence-based practice. For example, that many staff trained in psychosocial interventions do not apply their skills in practice (Gray *et al.*, 2001) and that impetus from training courses can be lost easily (Leng, 1999).

Secondly, given the nature of the reported barriers to implementation, it seems the complexity of implementing family work is unlikely to be addressed through brief training and supervision sessions alone, particularly when only a small number of staff are trained. The results here instead point out the importance of a whole-service / Organisational approach to training in which the culture and climate of the staff's workplace is acknowledged and integrated into the implementation plan. Beidas and Kendall (2010) argued that a systems-contextual approach is warranted, whereby the quality of training, staff behaviour, organisational support and client variables are examined simultaneously as implementation occurs within a system. Oxman, Thomson & Davis (1995) also argued that there is no 'magic

bullet’ to change professional practice and the effectiveness of a particular intervention is sensitive to context (Wensing, Van der Weijden & Grol, 1998).

Finally, the current review highlighted the dearth of studies within substance misuse treatment services that have evaluated the implementation of family work following training. Instead, the majority of research identified through the search tended to concentrate on testing the efficacy of family intervention within specialist settings by reporting patient outcomes, or attempting to increase staff’s knowledge and confidence to be able to work with FMs through training. Where implementation was mentioned, it tended to be limited to a paragraph within the discussion section in which barriers to implementation were discussed, and/or suggestions of ways to overcome such barriers were suggested for areas of future research. The scarcity of studies supports Gold, Glynn and Mueser (2006), who argued the best ways to implement evidence-based intervention is a relatively new area of study in the addiction field.

Limitations of the current review

It is important to recognise the limitations of this systematic review. The review was restricted to English language journals, meaning it is possible that relevant articles have been published in other languages. It is also possible that the search strategies employed may not have retrieved all relevant articles; bibliographic databases are often poorly indexed, meaning additional free text headings are often needed (Bodrero-Hoggan, 2002). It appears that optimal database search strategies have been developed for identifying randomised controlled trials or reviews, however, it is more difficult to retrieve other experimental designs, e.g. quasi experiments. It is also important to point out that seven studies relevant for inclusion were not identified through database searches, but instead by reading through the reference

lists of related studies. It may be that implementation was addressed within other articles, however it may not have been the focus of the study meaning a keyword search might not have identified such studies. Finally, the author was the only individual responsible for searching, retrieving and reviewing the articles.

WHAT CAN BE CONCLUDED FROM THIS SYSTEMATIC REVIEW?

This review has highlighted that evaluations and methods of improving implementation of family-focused practice have tended to receive limited attention compared to the volume of studies assessing the efficacy of family intervention, with research investigating ways to ensure family work is implemented into routine addiction treatment still in its infancy. Efforts to implement routine family-focused practice by training and supervising staff working within routine addiction treatment services were rare, with few published studies and limited evidence of results from robust pragmatic study designs. Research purely presenting post-training self-reports of the implementation of family-focused practice is likely to bear little or no relationship to actual practice behaviour and is, therefore, of limited value in judging the impact of such training.

The challenges to achieving successful implementation of family-family focused practice within substance misuse treatment are significant, however, the results here suggested a variety of strategies that can be used to tackle barriers to implementation. The results highlighted the importance of involving stakeholders (individual staff members, teams, services and Organisations) to advance family work and allocate resources for this purpose. Furthermore, strategies to increase family work within practice must be formally evaluated using robust methodological techniques. More evidence of successful implementation should

instead come from samples of routine practice behaviour, ideally selected at random, and should be collected over a substantial period of time following training (Miller *et al.*, 2006). Success following training needs to go further than simply measuring changes in staff knowledge, beliefs and attitudes. Instead, changes in staff's routine practice needs to be assessed, as well as any shifts towards becoming more family-focused in the culture and philosophy of the services and organisations.

Future research directions and aims of this research

Although training in family work appears to be increasing, robust evaluation of such efforts within addiction treatment is lacking. It seems this area is important for research and the research reported within this thesis aims to fill some of these gaps. The remainder of this thesis reports the results of a quasi-experiment integrating action research to evaluate whether providing a package of family-focused training and on-going supervision to all teams working within a non-statutory addiction treatment Organisation would be successful in promoting a whole-organisation shift from an individualistic treatment philosophy towards a more family-focused way of working. The next chapter reports the framework and methods employed in conducting the research.

CHAPTER TWO

RESEARCH FRAMEWORK AND METHODOLOGY

The previous chapter highlighted that there is much more to be done to understand how to successfully implement family intervention into routine addiction treatment practice. The literature review revealed the paucity and disparity of research studies that have trained addiction treatment providers in family intervention, and even fewer that have examined the implementation of family work into routine practice using methodical evaluation techniques. This relative paucity suggests that this area is important for research if we want to develop an evidence base for implementation. This chapter presents the methods adopted within this research in an attempt to fill some of these gaps.

The chapter first outlines the aims of the research. The overall design and timeline for the research is then presented, including the pilot study and main quasi-experiment. The participating Organisation and setting are then described in order to provide an overview of the staff and teams prior to the research. The family-focused training package delivered to staff working within the Organisation, how and when the participants were assigned to receive the training package, and the measures used to collect and analyse the quantitative and qualitative data are described.

AIMS OF THE RESEARCH

The research reported in this thesis aimed to evaluate whether providing a package of family-focused training and on-going supervision to all teams working within a non-statutory

addiction treatment Organisation would be successful in promoting a whole-organization shift from an individualistic treatment philosophy, towards a more family-focused way of working.

The main aims of the research were to:

1. Develop an understanding of participating staff's attitudes and views towards family-focused practice before, during and after receiving a family-focused training package;
2. Monitor the implementation levels of family-focused practice across the Organisation at key time-points during the project;
3. Explore any contextual factors that affected the project and the way the project effects varied across the project teams;
4. Compare the impact of the training package within teams receiving immediate training versus teams who were wait-listed and received the training following a delay.

It was hypothesised that the family-focused training package would lead to positive improvements in staff attitudes towards family-focused practice. Furthermore, following family-focused training and supervision, the proportion of family-focused practice would be significantly increased within staff's daily routines. However, no changes in attitudes or levels of family work would be evident within teams 'waiting' to receive the training package.

DESIGN

The design needed to provide robust and credible evidence to evaluate the impact of the training package on the implementation of family-focused practice under ‘real world’ conditions. Although randomized-controlled trials (RCTs) are seen as the gold standard for determining intervention effects, conducting research within an applied setting meant that individual randomisation to training was not possible. Instead, a two-phase interrupted time-series design was employed whereby teams (rather than individuals) were randomised to training. Such a design has become the standard method of causal analysis in applied research (Glass, 1997), as time-series designs share many similarities with the traditional experimental RCT, but specifically lack the element of individual random assignment.

The interrupted time-series design meant that the training package was rolled-out to teams working within the Organisation over a number of time periods, whilst measuring the impact over the different time periods. By the end of the study, all teams had received the training package, although the order was pre-determined. Such a design has stronger methodological rigour in comparison with pre and post quasi-experiments (Wagner, Soumerai, Zhang & Ross-Degnan, 2002).

Overall timeline of the research

Figure 2 presents the overall sequence of events within this research and when the evaluation outcome measures were administered. The section following the timeline provides more detail regarding the phases of the research, however, a brief summary is provided here to aid interpretation.

It can be seen that the research was carried out between October 2008 and May 2011. The family-focused training events are highlighted, as well as when evaluation measures were administered. The timeline is then divided into two main columns: Phase one (Pilot phase) and Phase two (main quasi-experiment). The Pilot phase involved two teams within the Organisation being trained, during which time the instruments and measures used to evaluate the impact of the training package were pilot tested. The remaining four teams were randomly assigned to training in Phase two, whereby two teams received immediate training, whereas the remaining two teams were wait-listed and received the training following a nine-month delay.

The grey shaded areas illustrate when the teams received the family-focused training package. Within each grey segment, the initial training event is firstly highlighted, followed by eight on-going supervision meetings, and finally, a one-day follow-up training event.

The timeline also indicates when data collection using the evaluation measures took place, before, during, and immediately following the training package, and at follow-up.

Month & Year	PHASE ONE	PHASE TWO (Quasi-experiment)	
	Pilot Teams (Teams A & B)	Immediately Trained Teams (Teams C & D)	Delayed Trained Teams (Teams E & F)
Oct 2008	Baseline attitude questionnaire	<i>Random assignment to training</i>	
	Initial training event		
Nov 2008 to July 2009	On-going supervision period (eight consultancy meetings)		
	Diary-snapshot developed and piloted		
Jul 2009	Post-intervention attitude questionnaire and diary-snapshot	Baseline attitude questionnaire and diary-snapshot	Baseline attitude questionnaire and diary-snapshot
		Initial training event	
Oct 2009	Follow-up training event		
Sept 2009 to Apr 2010	Follow-up diary-snapshot (Nov 2009 & February 2010)	On-going supervision period (eight consultancy meetings) Diary-snapshot (Nov 2009 & February 2010)	Baseline diary-snapshot (Nov 2009 & February 2010)
May 2010	Follow-up attitude questionnaire and diary-snapshot	Post-intervention attitude questionnaire and diary-snapshot	Baseline attitude questionnaire and diary-snapshot
		Follow-up training event	
Jul 2010			Initial training event
Aug 2010 to Mar 2011	Follow-up diary-snapshot (Sept 2010 & Dec 2010)	Follow-up diary-snapshot (Sept 2010 & Dec 2010)	On-going supervision period (eight consultancy meetings)
			Diary-snapshot (Sept 2010 & Dec 2010)
Mar 2011	Follow-up attitude questionnaire and diary-snapshot	Follow-up attitude questionnaire and diary-snapshot	Post-intervention attitude questionnaire and diary-snapshot
May 2011			Follow-up training event

Figure 2. Overall Sequence of Events and Timings of Data Collection

The two-phases of the project***Phase one (Pilot study)***

A pilot study was conducted that focused on developing and pilot testing the adequacy of the instruments and measures used to evaluate the impact of the training package. Pilot studies are useful in highlighting any deficiencies in the evaluation design or procedure, which can be addressed before time and resources are spent on a larger scale study (Thabane *et al.*, 2010). Furthermore, well-designed and well-conducted pilot studies are used to inform researchers about the best research process (van Teijlingen, Rennie, Hundley & Graham, 2001).

The pilot study was concerned with questions such as: What differences should the training package have within the Organisation? What are the best ways to capture any changes towards a more family-focused way of working? This phase allowed the testing of evaluation measures to ensure they were capable of answering these research questions.

During this Pilot phase the research protocol was developed and tested to examine whether this was realistic and workable. The pilot study was also used to identify any problems using the proposed evaluation methods. Two teams were chosen by the Organisation to receive the training package during the Pilot phase (see assignment to training and supervision section below).

Phase two (quasi-experiment)

Phase two employed a wait-listed quasi-experimental design, whereby the training package was sequentially rolled-out to staff over two separate time periods: half of the teams (two teams) were randomly chosen to receive ‘immediate’ training and supervision, and the

remaining half (two teams) to receive ‘delayed’ training nine-months later. Outcomes from immediately trained staff were compared with equivalent staff during a baseline wait-list comparison period, with any differences between the two groups being attributed to the effect of the training package.

By the end of Phase two, all frontline staff and managers working within the Organisation had received the training package. This design allowed the impact of the training to be examined at key time-points throughout the study, particularly at the point of teams shifting from baseline to training, and from training to follow-up. Figure 3 presents the overall quasi-experimental design within Phase two.

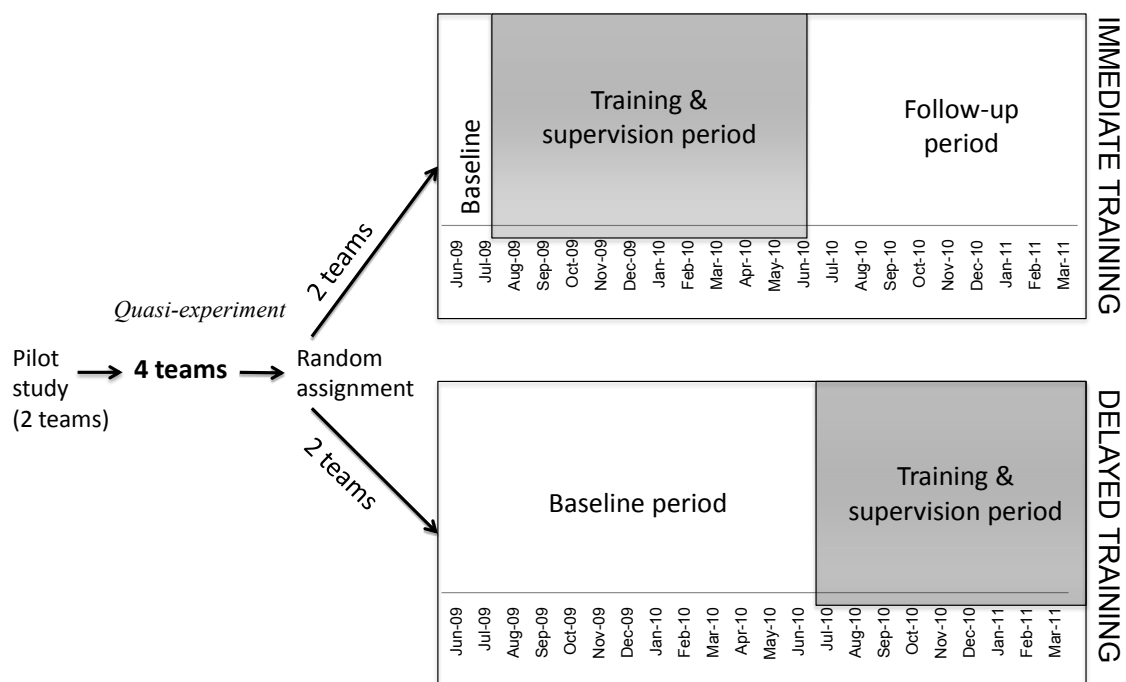


Figure 3. Phase Two - Quasi-Experimental Design

Integrating action research

The overall project design can be described as a quasi-experiment integrating action research. Action research is also recognized by many other names, including participatory research, collaborative inquiry and action learning (O'Brien, 2001). Action research is “learning by doing” (MacIsaac, 1995), whereby a problem is identified and an attempt is made to resolve the problem. Action research emphasizes the importance of scientific study in which a researcher studies the problem systematically and ensures the intervention is informed by theoretical underpinnings (O'Brien, 2001).

The final stage within action research is to examine how successful the efforts were in addressing the problem. The findings and conclusions reported within this thesis attempts to do just this, by evaluating whether the training package successfully promoted routine family-focused practice within the Organisation. This combination of ‘action’ and ‘research’ was thought to benefit both the Organisation and the body of knowledge on which this thesis was based.

Participants and setting

The participating Organisation was established in 1975 as a research project studying the effectiveness of methods of working with people with alcohol problems in a residential setting. Working primarily in the Midlands, UK, the Organisation has diversified and is now the largest provider of alcohol services in the Midlands. The majority of the service teams deal solely with alcohol misuse as the presenting problem, however, also provide advice for people with drug and gambling related problems.

Since its beginnings, the Organisation had a clear method for its work with individuals with alcohol problems. Before participating in this project, there was a general expectation that the staff would see a relatively small number of referrals for FMs (termed as ‘third party’ referrals). This occasional support offered to FMs, however, tended to be opportunistic and lacked focus or a ‘framework’. Routinely involving FMs in practice would, therefore, be a significant philosophical and operational shift for the Organisation as a whole.

The Organisation was made up of seven individual teams (see Table 3), commissioned separately, to form a local alcohol treatment system to meet local population needs. The teams worked within the NTA’s four-tiered framework of provision for alcohol treatment by providing a range of treatment services across Tier 2 (information, advice, screening and assessment) and Tier 3 (structured, care-planned treatment for those with more complex needs).

Of the seven teams, one had previously received training in family-intervention as part of a Involving Family Members (IFM) pilot project (see Orford *et al.*, 2009) and who had previously demonstrated significantly more positive staff attitudes towards a greater involvement of family member following a two-year on-going period of family-focused training and supervision. Due to being trained previously, this team was not part of the current research, however, since Orford and colleagues considered the team as being capable of acting as a demonstration site for family-oriented substance misuse treatment, the previously trained team were used as a comparator at key stages within this project; the six remaining teams within the Organisation were involved in the project. Throughout this thesis, the six

project teams will be referred to as Teams A, B, C, D, E and F, with the previously trained IFM team being referred to as Team ‘G’.

Table 3. Characteristics of the Six Project Teams

	PILOT TEAMS		IMMEDIATE TEAMS		DELAYED TEAMS		COMPARISON TEAM
	Team A	Team B	Team C	Team D	Team E	Team F	Team G
Mean years in role (range)	4.71 (0.67 - 10)	3.75 (0.25 - 15)	3.23 (0.25 - 7)	2.96 (0.33 - 7)	2.82 (0.02 - 6)	7.49 (0.75 - 19.17)	3.29 (0.33 - 10.00)
Job type	<i>(N)</i>						
Manager/Assistant Manager	1	1	1	1	1	1	1
Senior Practitioner / Counsellor		2	3	4	2	1	3
Alcohol / Drug Worker / Practitioner / Counsellor	2	7	1	4	2		5
Support Worker	1		1	1		1	1
Arrest Referral Worker				1			
Primary Care Practitioner	2		1	2	1	2	
Social Work Trainee			1				
Family Alcohol Worker		2		1			
Brief Intervention Worker			1			1	
TOTAL	N=6	N=12	N=9	N=14	N=6	N=6	N=10

Steering Committee Group and Research Team

The Steering Committee Group was a collaborative group responsible for driving the project. The group was made up of five members: the author, two researchers from the University of Birmingham (who had over ten years experience of working within the field of substance misuse), one Senior Counsellor working for the Organisation (who had received previous training in family intervention within the aforementioned IFM project), and the Practice Development Manager within the Organisation (who reported to the Chief Executive).

The Group met approximately every three months throughout the duration of the project in order to discuss any important project issues and make appropriate decisions regarding the vision and strategic direction of the project.

The Research team responsible for delivering the family-focused training and support package was made up of one researcher (having considerable experience of training addiction treatment providers to work inclusively with concerned and affected FMs) and the Senior Counsellor working within the Organisation. The author attended all elements of the training and support package.

The family-focused training package

All frontline treatment providers and managers within the Organisation were invited to receive a nine-month package of family-focused training and on-going supervision consisting of a two-day initial training event, eight 90-minute monthly supervision (consultancy) meetings at their team base, and a one-day follow-up training event (between 9-12 months after initial training).

The training package focused on two different forms of family-intervention for substance misuse problems: The 5-Step Method (Copello *et al.*, 2000b) and Social Behaviour and Network Therapy (SBNT) (Copello *et al.*, 2002b); both with origins in the Stress-Strain-Coping-Support (SSCS) model (Orford *et al.*, 1992; 1998; 2005). The SSCS model and the interventions derived from it offer a way for treatment providers to understand families, how to respond to their needs, and how to engage them in treatment (Orford *et al.*, 1998; 2005).

The training package aimed to provide staff with the skills to be able to flexibly apply the two interventions into their treatment practice. The findings from the earlier IFM project highlighted the need for flexibility with both 5-Step and SBNT so that techniques from either intervention can be combined in order to meet the needs of a particular case.

The 5-Step Method (Copello *et al.*, 2000b)

As noted earlier, the 5-Step Method is an evidence-based family-intervention that offers a flexible way to work directly with concerned and affected FMs to attempt to address their needs by providing support in their own right. The 5-Step approach can be delivered to FMs in their own right, irrespective of whether their substance using relative is engaged in treatment. Previous research (see literature review) has revealed that FMs who have been provided with support in the form of the 5-Step, have reported significant decreases in symptoms of stress with regards to substance misuse in their family.

Social Behaviour and Network Therapy (SBNT) (Copello *et al.*, 2002b)

Contrary to 5-Step, SBNT involves working with the substance user to engage positive network members (FMs, friends, colleagues etc.) in the treatment process, in an attempt to

bring about a positive change in substance misuse. Although originally developed for alcohol misuse, recent studies have successfully trained staff in SBNT for alcohol and drug misuse (Orford *et al.* 2009), and drug misuse specifically (Copello *et al.*, 2006b). Results from previous research applying SBNT have revealed positive outcomes in substance use, dependence and problems, and better mental health (Copello *et al.*, 2002b; Orford, 2005; UKATT Research Group, 2001).

Training duration and content

Two-day initial training event

The initial training event took place at the Organisation's Head Office. The training was organised to include didactics, demonstrations and active skills-practice activities (role play). Skill building around family-focused practice was a clear goal of the training, but with an emphasis on developing staff's understanding of the need to implement family-focused work within their routine. Staff also received supplementary author-developed manuals and hand-outs related to 5-Step and SBNT.

Day one of the training firstly involved 'surveying the territory' whereby staff considered family work already taking place within their service, how they would like to work with families, and any problems they anticipated when working with families. Discussions took place within small groups which were later fed back to the larger group.

The next part of the training involved exploring the 'value of involving family / social networks in treatment', asking staff to consider how things currently happening in their lives

may impact on others in their network. The significance of ‘positive social networks for change’ was discussed, drawing on evidence from previous research using SBNT.

Next was a presentation entitled ‘how do we do it?’ This section of the training attempted to emphasize to staff the relative ease of involving FMs, and how involving FMs can be beneficial. Group discussion took place regarding how to make aspects of the services more family friendly (e.g. considering the building and overall environment, administrative procedures such as invitation letters to FCs / FMs etc.). Staff were also asked to consider the service ‘through the eyes of a family member’.

The final part of Day one involved two ‘mentors’ providing the staff with some brief positive feedback on their experiences of working with FMs following training. The mentors were two members of staff previously trained and supervised in family work as part of the IFM project. There was also a brief question and answer session with the mentors.

Day two firstly involved presentations and discussions around the 5-Step approach, with each of the five steps being introduced followed by a DVD illustrating each step. SBNT was then introduced, with key terms such as ‘think network’ ‘active agent for change’ being discussed. The central components of SBNT were discussed, in terms of mobilising positive social support and creating the right conditions to support change for the substance user beyond contact with the service. Furthermore, the potential for the approach to help FMs affected and concerned by the addiction problem was discussed.

Following the 5-Step and SBNT presentations, staff had the opportunity to put their skills into

practice using the two approaches. Skilled practice-exercises using role play allowed staff to practice working with a family member (e.g. contacting a family member by telephone to discuss their relative's treatment, or discussing a family member's methods of coping etc.). Staff were subsequently provided with feedback from the trainers and their peers.

The final part of the training involved preparing staff for the 'next steps' to be able to effectively work with FMs. In pairs, staff were asked how they now felt about involving FMs, how confident they felt working with FMs, and what they will do next to improve family-focused work. Anonymous training evaluation forms were completed by the staff regarding their satisfaction with the training.

On-going supervision (consultancy) meetings

Following the initial training event, eight 90-minute consultancy meetings with the teams were arranged. These meetings, taking place at the teams' base, offered on-going supervision and provided an opportunity for staff to raise any issues or concerns about involving FMs in their daily routine practices. The teams were offered refresher-training drawing on the family-based interventions, with skilled practice using role-play often taking part to enable staff to build confidence in tackling new and sometimes challenging scenarios involving FMs in a session.

One-day follow-up training event

Following the eight consultancy meetings, the teams were invited to attend a one-day follow-up training event at the Organisation's Head Office. This was an opportunity for teams to receive refresher training related to working with FMs. This event was tailored to the staff's

requirements: staff had been asked to provide feedback during their consultancy meetings on areas they would like to be included within the follow-up training event.

Supplementary training materials

As part of the package of training and supervision, staff also received written materials in the form of professional manuals for their perusal. Additionally, staff were provided with copies of the 5-Step Self-help Manual. It was explained within the training event that the Self-help Manual could be provided to FMs to read in their own time, or to read and work through with their practitioner. Additional copies could be requested as necessary.

Other family work activities, events and procedures

In addition to the training package provided as part of the research initiative, it is also important to acknowledge the other family work related activities, events and procedures that started to take place within the Organisation as a whole. Firstly, towards the end of the Pilot Phase, the Organisation's management team introduced a new family-member assessment form, whereby details for FMs attending the services, in their own right, were now documented. Prior to the Pilot phase of the research, records were only documented for the individual substance user or gambler. Secondly, following the Pilot phase of the research, the Organisation's management introduced a one-day family-focused induction training event for all new staff (who would not have received the two-day training event as part of the research initiative). This induction training also involved a tailored event for administrative and support staff. The induction events were delivered by the Research team member (Senior Counsellor within the Organisation) who also delivered the aforementioned two-day initial training.

Assignment to training and supervision

Two teams were selected by the Organisation to receive training in the Pilot phase (Teams A & B). This decision was based on organizational commitment related to contract delivery. The remaining four teams were then randomised to receive either ‘Immediate’ training (Teams C & D) or ‘Delayed’ training (Teams E & F).

Evaluation measures

To evaluate the impact of the project on the implementation of family-focused practice, a mixed-methods approach was adopted. The mixed-methods approach involved collecting and analysing both quantitative and qualitative data in the context of a single study (Brewer & Hunter, 1989; Tashakkori & Teddlie, 2003). It was anticipated that outcomes following the training might be the result of a combination of factors (e.g., staff turnover, funding, resources etc.), therefore, a mixed-methods approach was thought to be appropriate. Creswell & Plano Clark (2007) argued that combining quantitative and qualitative approaches is likely to provide an improved understanding of a particular research problem than either approach alone. Additionally, a mixed-methods approach minimizes the biases inherent when relying on only one method of data analysis (Spratt, Walker & Robinson, 2004).

Quantitative research methodologies typically answer *where*, *what*, *who* and *when* questions, yet alone, cannot adequately answer *why* and *how* successful implementation of evidence-based practice occurs (Crabtree & Miller, 1999; Denzin & Lincoln, 2000; Silverman, 2000). Instead, “adding qualitative flesh to the quantitative bones is a good strategy” (Sydostricker-Neto, 1997; pg 46), and allows the researcher to evaluate the facts and figures as well as the

stories behind them (Silverman, 2006). It has been argued that analysis of complex organisational systems demands a mixture of data collection methodologies in order to capture the complexity which they attempt to portray (Paul, 1996). Furthermore, Rocco, Bliss, Gallagher and Perez-Prado (2003; pg. 19) proposed that “.....useful research says something important about the phenomena under study. It is insightful, and its explanations are plausible. Many researchers find that to conduct this level of research involves mixing methods”. Collecting and consulting both quantitative and qualitative data allowed an iterative evaluation, with information from the two approaches constantly feeding the evaluation process.

Quantitative measures

Attitudes towards family work

There is increasing evidence that the values and beliefs of the individual service provider play an important role in the degree to which successful implementation is adopted in common practice (Greenhalgh, Robert, Macfarlane, Bate & Kyriakidou, 2004). Attitudes have been described as ‘the cornerstone of therapeutic activity’ (Watson, Maclaren & Kerr, 2007). It was important, therefore, to examine changes in attitudes towards family-focused addiction treatment as a result of participation in the project.

The Attitudes to Addiction Related Family Problems Questionnaire (AAFPQ) was used to assess staff’s attitudes towards family work. The AAFPQ is an adaptation of the original ‘Alcohol and Alcohol Problem Perception Questionnaire’ (AAPPQ) (Cartwright, 1980). The questionnaire measures attitudes of addiction treatment professionals (helping agents) towards

working with FMs. The AAFPQ was selected due to its use in the previous IFM study, and having demonstrable reliability and validity.

The AAFPQ (see Appendix 1) has 28 questions divided into six subscales: 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”*); support from the service (e.g. *“I feel adequately supported within my service to work with relatives of alcohol or drug misusers”*); legitimacy (e.g. *“I feel my clients believe I have the right to ask them if they need any help dealing with alcohol or drug misusers in their family”*); motivation (e.g. *“Helping the relatives of alcohol or drug misusers is just as important as helping the misusers”*); self-belief (e.g. *“I sometimes feel uncomfortable working with relatives of alcohol or drug misusers”*); and impact on the substance user (e.g. *“Helping alcohol or drug misusers and their relatives to communicate better is an effective way of helping the misuser”*).

Each AAFPQ subscale has a computed standard score. The sub-scales are then summed to give a total score. Each question response is arranged on a seven-point Likert scale ranging from ‘strongly agree’ to ‘strongly disagree’. Questionnaire items within the self-belief subscale are negatively worded, therefore, the scores for this subscale are reversed.

To examine staff attitudes towards family work, the AAFPQ was administered at multiple time-points: baseline data was firstly collected from all teams, allowing staff’s pre-training attitudes to be assessed. Attitudes towards family work was also collected immediately post-training (approximately nine-months following baseline), and in some cases during the

follow-up period (approximately 18 months following baseline). The precise timing of the data collection is presented within the Project Timeline (see page 78).

Proportion of family-focused practice taking place

In addition to staff attitudes, it was also important to monitor staff's routine practice behaviour in an attempt to evaluate whether the proportion of FMs attending the services had increased overtime, as a result of the project. It was hypothesized that the training package would lead to increases in the proportion of family-focused practice across the teams.

To determine differences across teams that might involve 'trading off' time from some activities towards others (Williams, 1988), a diary-based measure was thought to be the best way to capture the proportion of family work taking place within the teams at key points within the project. A benefit of using diary methodology is that it permits the examination of events and experiences in their natural environment (Reis, 1994). It was decided that capturing a 'snapshot' of staff's practice behaviour over time would demonstrate whether more FMs were being involved and included within the Organisation overtime as a result of the project. A suitable measure capable of capturing this data was, therefore, developed.

Development of the diary-based measure

To steer the development of the measure, previous research that had successfully utilised data from diaries was consulted. 'Time use research in the social sciences' (Pentland, Harvey, Lawton & McColl, 2002) was particularly useful. Previous research involving diary keeping or 'time-use' methods has been common for a number of years. Sorokin and Berger (1939) devised the 'time-budget' schedule, which involved categorising overt activities for the

purpose of investigating aspects of human behaviour. Converse (1968; pg 43) later defined a time-budget as “a log or diary of the sequence and duration of activities engaged in by an individual over a specified period, most typically the 24 day.”

In developing an appropriate measure for the purposes of this research it was first important to decide how many days the staff's activity would need to be captured. Published research using diary analysis has collected data for one or two days (Williams, 1988; Stopher, 1992; Yau & Joy, 2009); conversely, other studies have collected data every day over a two or three month period (Anhøj & Møldrup, 2004; Josling, 2001; McLaws, Oldenburg, Ross & Cooper, 1990), six-month period (Fox, Everard, Marsh & Milner, 1999) and one-year period (Travers, 2011). This previous research revealed significantly higher rates of self-reported events using one-week diaries rather than those completed over a six-month period (Turner, Smedley & Cherry, 2001). Similarly, Carp and Carp (1981) found a one-day diary was not an adequate substitute for a one-week diary. Based on these results, it was decided that staff would be requested to record their activity for one-week.

For analytical purposes, it is sometimes desirable to condense large amounts of diary-data into categories or ‘hyper codes’ (Andorka, 1987). Using predetermined codes or categories helps to ensure that the data collected are related to the activities of interest to the project (Clark, Elliot & Harvey, 1982). Furthermore, the use of categories attempted to ensure staff fully understood what they were being asked to record.

Three main categories were created for staff to use when recording their diary activity:

- 1) Face-to-face meeting;

- 2) Telephone conversation;
- 3) Other (e.g. group work, sent information to a family member).

These categories were then separated into sub-categories (see Figure 4). Although the diary-based method was driven by the categories, there was space to record activities and events in their own words should the staff wish. The measure was entitled the ‘diary-snapshot’, intending to capture a ‘snapshot’ of staff’s routine practice behaviour within the teams over a one-week period.

The measure aimed to capture all relevant practice behaviour (both individual activity and family-focused activity), in order to examine whether the *proportion* of family-work (i.e. the number of ‘encounters’ with family members, whether these were brief or extensive) increased overtime. The diary-snapshot was administered to staff randomly throughout the duration of the project. The timings of the diary-snapshot data collection is presented in the timeline (see page 78). The precise number of staff completing the measure at key points throughout the project is addressed within Chapter three (Pilot study results) and Chapters five and six (Phase two - quasi-experiment results). Figure 4 presents an example of a completed diary-snapshot.

Day	Who did you see/speak to?	Comments	Categories
Mon	A	Initial assessment with focal client	<u>Face to face meeting:</u> A = focal client face-to-face B = focal client + family member face-to-face C = family member face-to-face <u>Telephone calls:</u> D = focal client telephone call E = family member telephone call <u>Other</u> F = professional face-to-face (concerned about family member) G = professional telephone (concerned about family member) H = group work with focal client I = group work with family member J = offered support to family member K = other (<i>e.g. handed out self-help manual</i>)
	C	Sister of drinker second appointment	
	E	Daughter of FC called for information	
	H	Cutting down group	
	K	Posted self-help manual to wife of FC	
Tues	B	Focal client + wife assessment	
	B	Focal client + daughter second session	
	A	Focal client assessment	
	C	Father of drug user support session	
	D	Focal client telephone support	
Wed	G	GP called to refer Wife of drinker	
	A + J	Focal client alone (suggested bringing Wife to next session)	
	A	Focal client final session	
	B	Daughter and Father (drinker) second session	
Thurs	B	Drinker and husband initial assessment	
	C	Sister of drug user info session	
	A	Focal client alone	
	A	Focal client final session	
	A	Focal client	
Fri	A	Focal client assessment	
	B	Mother and son (FC) support	
	B	Granddaughter and FC support	
	E+K+J	Wife telephone info (manual sent + offered appointment)	
	D	Client telephone support	

Figure 4. An Example of a Fully Completed Diary-Snapshot

Qualitative analysis

In addition to the aforementioned quantitative data, qualitative data was also collected throughout the duration of the project. It was hoped that the qualitative findings would aid the interpretation of the quantitative results. Analysing the words and detailed views of the staff throughout the project attempted to fully understand how the staff felt the project had impacted on their role, team and the Organisation as a whole. These findings, coupled with

the quantitative findings aimed to generate a complex, holistic picture of the process of the intended shift towards becoming a more family-focused Organisation.

The discussions from the supervision meetings were recorded, transcribed and analysed using Framework Analysis (Ritchie & Spencer, 1994). Anonymity was assured by removing all names of staff, FCs and FMs. Data from all six project teams was combined to examine common factors that facilitated and impeded the implementation of family-focused practice.

Framework Analysis allows large amounts of qualitative data to be systematically organised, displayed and verified. The method is similar to Grounded Theory, however, is more appropriate when researching specific questions within a limited timeframe and using a pre-determined sample (Srivastava & Thomson, 2009). Furthermore, Framework Analysis allowed factors facilitating or impeding family work at visible stages of the project to be pinpointed.

CHAPTER THREE

PILOT PHASE: QUANTITATIVE ANALYSIS AND RESULTS

This chapter reports the quantitative analysis and results from the Pilot phase of the research carried out between October 2008 and July 2009. Teams A and B were chosen by the participating Organisation to receive the nine-month family-focused training and supervision package as part of the initial pilot study. During this Pilot phase, the research protocol and measures used to evaluate the impact of the family-focused training package were developed and pilot tested.

INTRODUCTION

As mentioned in the previous chapter, action research was an integral aspect of the overall research design. Originally proposed by Lewin (1946), action research is *“a spiral of steps, each of which is composed of a circle of planning, action and fact-finding about the result of the action”* (pg. 206). There have since been many definitions of action research (Peters and Robinson, 1984;), however, there is a general agreement that action research involves real-life contexts in which an intervention is applied by the observer (researcher) on the environment being observed (Kock, McQueen & Scott, 1995). This Pilot phase was, therefore, the first step within the two-phase cyclic process of planning, data collection and analysis, whereby the measures used to evaluate the impact of the training package were piloted and refined before being used within the main quasi-experiment (Phase two).

It was hypothesised that the family-focused training package would lead to: (i) improved staff attitudes towards greater involvement of family members (FMs) in addiction treatment, and (ii) an increased involvement of FMs within the trained teams. Results showing staff attitudes towards family-focused practice are firstly reported, based on comparisons between baseline and post-intervention attitude scores. The results from the author-developed diary-snapshot are then reported to examine whether the proportion of family-focused practice increased as a result of the family-focused training package.

The chapter concludes by discussing the lessons learned during this Pilot phase and implications for Phase two.

METHOD

Participants

Table 4 displays the characteristics of the staff making up Teams A and B. Data from the two teams was combined, meaning that eighteen staff provided baseline attitude data and nineteen staff provided post-intervention attitude data (there had been some staff changes during the course of the project). The two pilot teams were thought to be representative of the rest of the teams within the Organisation. Baseline comparisons of characteristics of the staff working within the two teams were conducted to examine any differences between the two teams at baseline. Chi-square analysis was used to examine whether the staffs' job roles across the teams were equivalent (i.e. whether there were equal proportions of managers, senior staff, support staff etc.), and Mann-Whitney U tests compared the number of years staff had worked in their current role. Table 4 shows that there were no significant differences between the two teams at baseline.

Evaluation measures

Attitudes towards greater involvement of family members in addiction treatment

To assess staff attitudes towards greater involvement of FMs in addiction treatment, the Attitudes to Addiction Related Family Problems Questionnaire (AAFPQ) was used (Copello, et al., 2000b). The AAFPQ was administered to as many team members who were available before and after the nine-month training and supervision period.

Table 4. Baseline Staff Characteristics - Pilot Phase

	Team A		Team B		Statistic
	<i>(n=5)</i>		<i>(n=13)</i>		
<u>Job role</u>	<u><i>n</i></u>	<u><i>%</i></u>	<u><i>n</i></u>	<u><i>%</i></u>	$\chi^2(3)$
Manager / Assistant Manager	1	20	2	15	=3.46, N = 18, p = .399
Senior Counsellor / Practitioner	0	0	2	15	
Counsellor / Practitioner	3	60	9	70	
Support Worker	1	20	0	0	
	<u>Mean (S.D)</u>		<u>Mean (S.D)</u>		Statistic
Length of time working in role (years)	3.21 (3.80)		4.89 (4.61)		$U(18) = 42.00,$ $z = .938$ $p = .464$

Changes in levels of family-focused practice

To assess whether the proportion of FMs receiving support across the teams had increased as a result of the family-focused training package, a diary-snapshot measure was developed and used.

Procedure

Figure 5 shows the Timetable of Events during the Pilot phase. The grey-shaded areas indicate when the events took place and when the quantitative data was collected. Ethical approval for the research was granted by the University of Birmingham Research Ethics Committee (Reference number ERN_09-420) (see Appendix 2).

Baseline attitudes using the AAFPQ were collected via an on-line questionnaire prior to the two-day initial training event. All staff (managers and front-line staff) were requested to complete the measure before the initial two-day training event. If staff had failed to do so, they were requested to complete the on-line questionnaire on the morning of the training event, prior to receiving any input from the research team. All staff provided informed consent to participate in the research. Participants also received a Participant Information Sheet (see Appendix 3) explaining the nature of the research. Post-intervention questionnaires were administered and collected in person by the author during the teams' final supervision meeting, nine-months following the initial training event.

Due to the time taken to develop the diary-snapshot measure, in addition to the time required to obtain ethical clearance to use the measure, unfortunately, it was not possible to collect baseline diary data for Teams A and B. Once ethical clearance had been granted, the diary-snapshot measure was first administered during the fourth month of the nine-month training and supervision period. All managers and front-line staff were provided with full instructions of how to complete the diary-snapshot (Appendix 4), a Consent Form (Appendix 5), and Participant Information Sheet (Appendix 3). It was important to stress to staff that any data collected would be anonymous (names of the staff, FCs and FMs would be removed).

Furthermore, staff were made aware that all individual data collected was purely for research purposes, would not be provided to the Organisation, and was not a measure of staff performance.

Through discussions with the teams during their third consultancy meeting, it was decided that two eligible¹ staff from each team would be randomly selected to complete the measure every week during the remaining supervision period (twenty weeks in total). It was thought that by selecting only two staff per week from the eligible ‘pool’ of staff in each team, sufficient data would be generated and the amount of work related to completing the measure was minimised. The random function in Microsoft Excel was used to randomise staff.

The author telephoned each randomly selected member of staff to request they complete the diary-snapshot measure during the following week. If, for any reason, the member of staff was unavailable for the particular week they had been selected, an alternative member of staff was then randomly selected for replacement and approached. The author and member of staff agreed a mutually convenient time to report the results following the completion of the measure. This often took place over the telephone, however, occasionally took place in person on the day of the teams’ monthly supervision meeting.

¹ Only staff providing counselling sessions were included in the sample. Other members of staff, e.g. admin and IT staff were not asked to complete the measure. Managers were only included in the sample if they had a client base.

	Project timetable month										
Event	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	July-09	Oct-09
Initial two-day training event											
Consultancy meeting ²											
Follow-up training event											
Quantitative evaluation measures											
Baseline AAFPQ											
Post-intervention AAFPQ											
Diary-snapshot (weekly)											

Figure 5. Pilot Study - Timescale of Events and Data Collection

² Note: each team attended eight consultancy meetings that spanned over a nine-month period.

ANALYSIS

SPSS version 19 for Mac OS was used for all statistical analyses. A significance criterion of $p < 0.05$ was used in all the statistical tests.

Changes in attitudes towards greater involvement of family members

As some of the AAFPQ sub-scales were found to be non-normally distributed, scores for all sub-scales and total score were first logarithmically transformed in order to meet the assumptions of parametric statistical tests. Once log-transformed, to test the hypothesis that receiving the family-focused package of training and supervision would lead to positive increases in staff attitudes towards greater involvement of FMs, independent-measures t-tests were used to compare baseline and post-intervention scores.

Changes in the levels of family-focused practice

To test the hypothesis that participation in the nine-month package of family-focused training and supervision would lead to increased levels of family-focused practice, diary-snapshot data was collected across twenty weeks during the second half of the on-going supervision period. This data was then collated into four time-points: T1 (weeks 1-5); T2 (weeks 6-10); T3 (weeks 11-15); and T4 (weeks 16-20). This allowed data from a larger sample to be analysed.

Differences in the proportions of family-focused practice taking place at the four time-points were calculated using the two-proportion z-test. Using this test, it was possible to investigate significant differences in proportions (%) of activity drawn from two time-points. Appendix 6 shows the formulae used to calculate the differences in proportions of practice. The

hypothesis was that there would be a linear increase in the level of family-focused practice, relative to the amount of on-going supervision received.

Family-focused practice comprised the following categories:

- 1) Family member(s) face-to-face;
- 2) Focal client and family member(s) face-to-face;
- 3) Family member(s) telephone call,
- 4) Group work with family members(s);
- 5) Contact with professional face-to-face (concerning family member(s));
- 6) Contact with professional on telephone (concerning family member(s));
- 7) Other (staff asked to state other, e.g. handed out self-help manual to family member, offered support to family member etc.)

The data were analysed in terms of:

- Overall work involving FMs (all categories 1 – 7);
- Joint work involving a focal client and family member(s) (category 2);
- Family members receiving support in their own right (FMs attending the service in the absence of the substance user) (categories 3, 4, 5 & 6);
- Other work involving FMs (category 7).

RESULTS

Changes in attitudes towards greater involvement of family members

Table 5 presents baseline and post-intervention data for all available staff. Means and standard deviations are presented for both untransformed scores and log-transformed scores (the latter being used for the *t*-tests).

Following the training package, independent-measures *t*-tests revealed significant increases compared to baseline for Knowledge ($t(35) = -2.23, p < .05$), Confidence ($t(35) = -2.36, p < .05$), Support from the service ($t(35) = -2.48, p < .05$) and Total AAFPQ score ($t(35) = -2.39, p < .05$). Legitimacy, Motivation, Self-belief and Impact on the user all increased post-intervention, however, were not statistically significant.

Table 5. Baseline and Post-intervention AAFPQ Total and Subscale Means (and Standard Deviations)

AAFPQ sub-scale	Baseline (<i>n</i> =18)		Post-intervention (<i>n</i> =19)	
	<i>Untransformed</i>	<i>Log transformed</i>	<i>Untransformed</i>	<i>Log transformed</i>
Knowledge	16.28 (3.37)	2.77 (0.22)	18.32 (2.16)	2.90 (0.12)*
Confidence	15.83 (3.76)	2.73 (0.25)	18.10 (2.18)	2.89 (0.12)*
Support	19.61 (4.02)	2.96 (0.20)	22.34 (3.01)	3.10 (0.14)*
Legitimacy	16.72 (2.85)	2.80 (0.17)	17.86 (2.29)	2.87 (0.13)
Motivation	25.28 (2.44)	3.23 (0.10)	26.21 (2.44)	3.26 (0.10)
Self-belief	21.44 (3.90)	3.05 (0.19)	23.25 (3.86)	3.13 (0.17)
Impact on the user	18.22 (3.04)	2.89 (0.18)	19.43 (1.54)	2.96 (0.81)
Total score	133.39 (18.72)	4.88 (0.14)	145.51 (12.41)	4.98 (0.86)*

Notes: *Significantly greater than before training ($p < .05$).

Changes in levels of family-focused practice

Table 6 shows the proportion of family-focused practice (a count of ‘encounters’ with family members) taking place within the teams across the four time-points.

Table 6. Frequency and Proportion of Family-Focused Activity

Time-point	N	Total work	Overall family-focused work	Joint work with focal client and family member	Family member(s) in their own right	Other family-focused work
T1	16	272	85 (31%)	9 (3%)	14 (5%)	62 (23%)
T2	17	299	96 (32%)	14 (5%)	29 (10%) ¹	53 (18%)
T3	17	249	83 (33%)	28 (11%) ¹²	17 (7%)	38 (15%)
T4	17	259	140 (54%) ¹²³	52 (20%) ¹²³	46 (18%) ¹²³	42 (16%)

Notes: ¹Significantly greater than T1. ²Significantly greater than T2 ³Significantly greater than T3, ⁴Significantly greater than T4.

Analysis of the diary-snapshot data revealed that overall, family-focused practice (the proportion of encounters with family members) had increased over time; where the proportion of work involving a family member at T4 (54%) was significantly greater than T1 (31%), T2 (32%), and T3 (33%). Figure 6 below displays the overall proportion of family-focused practice across the four time-points.

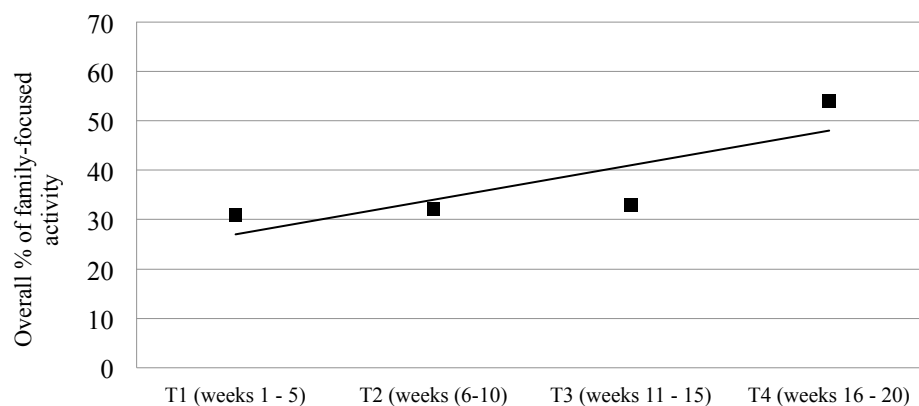


Figure 6. Overall Proportion (%) of Family-Focused Activity

Analysis also showed that joint work with a FC and family member(s) had increased overtime, and was significantly greater at T3 (11%) compared to T1 (3%) and T2 (5%). Furthermore, levels of family-focused practice at T4 (20%) were significantly greater than all previous T1, T2 and T3 (Figure 7).

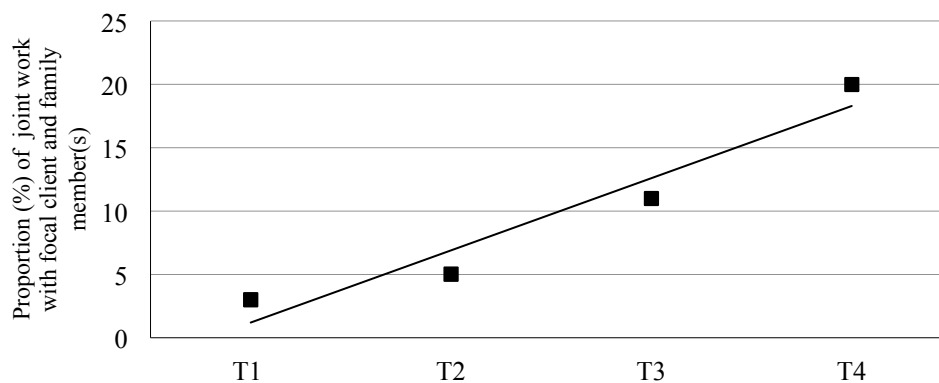


Figure 7. Proportion (%) of Joint Work with a Focal Client and Family Member

Analysis revealed that the proportion of FMs being supported in their own right had increased overtime, with significantly greater levels at T2 (10%) compared to T1 (5%). No differences were revealed between T3 (7%) and T1 or T2. However, the proportion of FMs being supported in their own right at T4 (18%) was significantly greater than T1, T2 and T3.

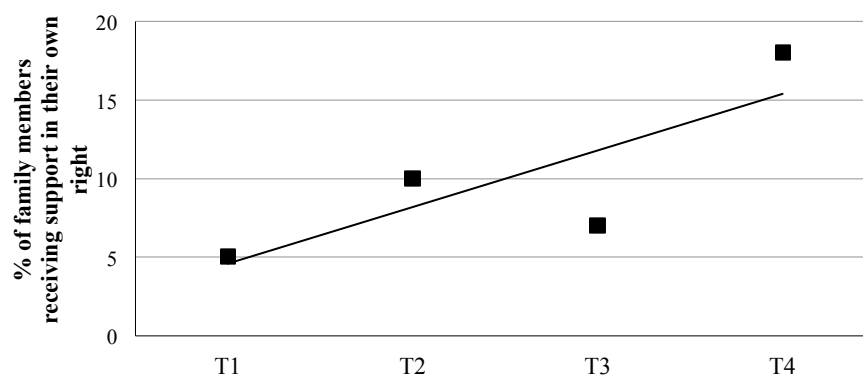
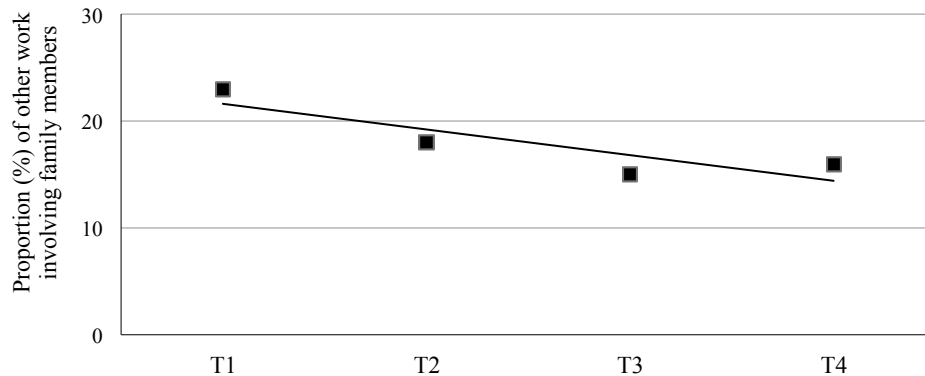


Figure 8. Proportion (%) of Family Member(s) Receiving Support in Their Own Right

Analysis revealed no significant differences over time in the proportion of other family-focused work (e.g. sending out information and self-help manuals to FMs, offering appointments to FMs) (Figure 9).

**Figure 9. Proportion (%) of Other Family-Focused Activity**

DISCUSSION

The quantitative results from the Pilot phase of the research provided encouraging results for the package of family-focused training and supervision being able to promote the implementation of family-focused practice within addiction treatment services. As predicted, following the training and supervision package there were significant improvements in staff attitudes towards family-focused practice. Although not all sub-scales showed significant increases, all sub-scales moved in the desired direction. These findings are consistent with those from the Involving Family Members (IFM) project (Orford et al., 2009) and Orford, Templeton, Copello, Velleman and Ibanga (2010b) who also showed staff attitudes were significantly more positive following family-focused training and continued support.

Findings also revealed that the newly developed diary-snapshot method had enabled a consistent way of recording the proportion of family-focused practice taking place within the teams. Although overall increases in family-focused practice were slow to appear (no significant increases between T1, T2 and T3), during the final five-week diary-audit, family-focused practice was taking place more than half of the time (54%). These results suggest that family-focused practice is likely to be slow due to the historical individualistic policies, values and priorities of the Organisation. Schneider, Brief and Guzzo (1996) argue that “thousands of elements define a climate, and climate changes only when many of these everyday policies, practices, procedures, and routines change” (pg. 9).

The increases in family-focused practice support previous research (Orford *et al.*, 2009), whereby FMs were involved 3-5 times as often following family-focused training and support. Interesting however, the post-training proportion of family work taking place within Teams A and B in this study were much higher than those found within Orford’s previous study, which saw increases up to between 15-17% during a retrospective two-week audit. Data from phase two will be able to shed more light on the proportion of family-focused practice achievable following training by also providing baseline data prior to staff receiving family-focused training.

Lessons learned from the Pilot phase

Conducting this pilot study provided the opportunity to refine the data collection and evaluation methods for use in the main quasi-experiment in Phase two. As mentioned in the previous chapter, this pilot study was important to examine and identify strategies that worked well, and those that might be modified. This first cycle of the action research involved a

reflective process to highlight and resolve any problems encountered before embarking on Phase two. This section, therefore, reports the main lessons that were learned during the first cycle of the research.

The first and most valuable lesson learned was the need for a more sensitive ‘family-specific’ attitude measure. While the AAFPQ had demonstrated significant increases in staff attitudes, discussions with staff during the on-going supervision meetings had highlighted potential important questions that were missing from the AAFPQ. To provide an example, it appeared that staff often prioritised work with FCs over FMs. To understand whether this was in fact the case, or if the package of training and supervision was capable of influencing this, more questionnaire items were required. For example, whether staff feel there are conflicts of interest when working with jointly with FCs and their FMs; whether stress and strain can be alleviated for the family as a whole if FMs are actively involved; whether involving FMs enables the treatment provider to gain a clearer picture of the environment in which the service user is living; or whether involvement of FMs in addiction treatment should be the norm. Such observations during the Pilot phase highlighted the need to develop a family-specific measure, with items and language being specifically tailored rather than relying on previously adapted measures. The development and validation of this family-specific scale is fully reported in the next chapter.

The second lesson learned was that the data collection methods using the diary-snapshot would require adjustments for use in Phase two. The first adjustment was related to the frequency of data collection. As Phase two involved making comparisons across four teams over a substantially longer period of time, collecting diary-data from two staff per week, per

team, for the remainder of the project was not thought to be feasible. Moving into Phase two, it was decided, therefore, that the diary-snapshot measure would be administered at three-monthly intervals across all six teams. Furthermore, eight³ staff from each team would be randomly selected to complete the measure at each three-monthly interval. These decisions were largely based on the need to ensure the data was a representative picture of routine behaviour taking place among the teams, but also to minimise time-constraints and burden on the staff completing the measure.

A second adjustment related to the diary-snapshot was that ‘yesterday’ diary data would be utilised during Phase two, rather than the ‘tomorrow diary’ format used in the Pilot phase. During the Pilot phase, it had been found on some occasions that staff had forgotten or were too busy to complete the measure. Moreover, on occasions staff had been absent from work due to illness for all or part of the week, meaning that data for a particular week had not been captured when intended, or was only partially completed. It was thought that by asking staff to recall their activity for the previous week, some of these issues could be resolved. For example, if a member of staff was absent or too busy to complete the measure, another member of staff could be randomly selected instead. It was recognised that this format may have limitations due to staff’s memory recall, however, it was hoped that this method would aim to ensure data was collected from sufficient numbers of staff.

³ The six project teams varying in the number of staff employed at each site. Eight staff constitutes the smallest team and is, therefore, a way of retrieving consistent data across all teams.

Limitations

Although these findings offer some indication of the likely impact of the training and supervision package in Phase two, it is important to note some methodological issues within this phase. Firstly, the Pilot phase involved a relatively short period of evaluation, during which time the teams were always ‘aware’ their activity and attitudes were being monitored. Phase two will instead involve a longer period of evaluation, with periods of time in the absence of training and on-going supervision. Such baseline and follow-up periods in the absence of training, supervision and presence of the research team, will allow the evaluation of family-focused practice without *reminding* staff of the benefits of working family-inclusively. It is possible that there will be a loss of enthusiasm for the high levels of family member involvement achieved following this initial Pilot phase. Phase two will be more fully able to assess whether increases in attitudes and practice levels are sustained long after the training period has ended.

A second limitation within this Pilot phase was the absence of baseline diary-snapshot data. This was due to the time taken to develop the measure and to gain ethical approval to administer the measure. Again, Phase two will be able to more fully evaluate the increases in family-focused practice achievable through training and supervision by collecting multiple baseline and post-intervention follow-up data.

Finally, the diary snapshot relied on self-reported data which may have been prone to errors arising from incomplete recording and insufficient co-operation from the staff (Corti, 1993). There was also no guarantee that respondents were completing the diary each day and a failure to do so may have resulted in accurate recall being compromised. Notwithstanding

these limitations, the quantitative data reported here was able to provide promising early findings of the impact of the family-focused training package. By incorporating a randomised-controlled element and longer-running evaluation, the quantitative results from Phase two, coupled with the qualitative analysis across both Phases one and two, aimed to provide a more complete picture of the impact of the training across the Organisation.

Conclusion

The results from the Pilot phase highlighted important issues and generated key lessons. The findings helped to inform the refinement of the evaluation outcome measures for use within Phase two. The results here suggested that family-focused training and on-going supervision can enhance staff attitudes and practice behaviour towards becoming a more family-oriented addiction treatment Organisation. The long-term effectiveness and sustainability of the impact from the training and supervision can only really be answered with continued follow-up, which later chapters will discuss.

CHAPTER FOUR

THE DEVELOPMENT AND VALIDATION OF A NEW FAMILY- FOCUSED ATTITUDE MEASURE

It was discussed in the previous chapter that one of the main lessons learned during the Pilot phase of the research was the need for a more sensitive measure to assess staff attitudes towards greater involvement of FMs in addiction treatment. This chapter describes the development and initial validation of the ‘Attitudes to Involving Family Members in Treatment Questionnaire’ (AIFMTQ). The strength of this measure was that it was developed specifically based on family-focused data rather than being adapted from an existing non-family standardised instrument. The conceptual development, factor structure, internal reliability, content and construct validity of the new measure are reported.

INTRODUCTION

One of the earliest UK studies to examine attitudes in relation to substance misuse was the Maudsley Alcohol Pilot Project (MAPP) funded by the Department of Health and Social Services (DHSS) in 1973 to help to examine generic practitioners’ willingness to engage with clients with alcohol problems (Cartwright, Shaw & Spratley, 1975). Cartwright and colleagues later developed and tested a model of ‘therapeutic commitment’ designed to measure the therapeutic attitudes of non-substance specialist staff to working with people with alcohol problems.

The Alcohol Problems Perception Questionnaire (AAPPQ) (Cartwright, 1980) has since been widely used and adapted for use with health professionals and social care staff to measure staff attitudes to working with other client groups such as men with violence-related problems (Manley & Leiper, 1999), and those who gamble (Orford *et al.*, 2003). An adapted version of the AAPPQ, the AAFPQ, has also been used to measure attitudes and motivation to work with FMs and has been shown to retain its validity and reliability in a modified format (Templeton *et al.*, unpublished data, 2001). Furthermore, using the AAFPQ, Copello *et al.* (2000a) found that attitudes and motivation towards working with family member (FMs) improved as a result of training and taking part in a specialist-training package.

While studies applying adapted measures such as the AAFPQ have shown extremely promising results, including providing evidence of reliability and validity, measures such as the AAPPQ were originally constructed specifically to test hypotheses involving factors such as service providers' knowledge of drinking problems, their methods in dealing with drinkers and their opinions about their rights and responsibility in responding to drinking problems. Although still highly relevant when assessing attitudes to working with FMs, discussions with staff highlighted that additional 'family-specific' items were needed if we are to obtain a more accurate representation of this area.

METHOD

The current study was performed in the West Midlands. Permission was granted by Warwickshire NHS Research Ethics Committee (reference number 09/H1211/9) (Appendix 7)

and Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) Research and Innovation (R&I) (Appendix 8).

Questionnaire development

Initial item generation

Questionnaire item generation started with discussions between the author and two researchers from the University of Birmingham (who had over ten years experience within the area of family-focused addiction treatment practice). Discussions involved sharing ideas to conjure up potential areas relevant for the new measure. To aid the development of relevant questionnaire items, qualitative feedback from staff during the Pilot phase of the research was consulted as well as the findings from the previous IFM study (see Orford *et al.*, 2009). This ‘brainstorming’ phase identified approximately 35 areas.

Design of items and item modification

The initial brainstorming formed the basis of the item generation. A further review of areas initially thought to be relevant highlighted some overlapping questions, which were then reworded and condensed into 30 items, making up the first draft of the measure. The questionnaire responses were recorded on a 7-point Likert scale ranging from 7=strongly agree, to 1=strongly disagree. The initial draft measure was reviewed for face and content validity by an expert panel. As content validity is based on judgement by an expert panel expected to have widespread knowledge and experience of the concept being measured (Wind, Schmidt & Schaefer, 2003), the panel comprised five persons working within both statutory and non-statutory specialist addiction treatment sectors.

The expert panel was instructed to read and comment on each questionnaire item, feeding back on whether the vocabulary of the items was clear and easy to understand and whether the questions failed to cover any relevant areas. Notes were made to ensure that no information was lost. The expert panel suggested two additional areas of importance: the first, asking participants about working with FMs where there may be a suspicion of domestic violence; the second, asking participants about working with FMs where there may be the possibility of a child protection issue. Following these recommendations, two additional questions were added to the original 30 items.

As well as providing support and guidance initially in the development of the questionnaire items, the expert panel were also consulted once data collection and analysis had been completed to offer suggestions when interpreting results. The expert panel later recommended four items be rephrased / reworded. This is further examined in the Discussion section.

Application in routine services

Recruiting of participants

A total of 141 specialist addiction staff or researchers (statutory and non-statutory sectors) were recruited to complete the pilot measure. Eighty-six staff (across eight separate services) were recruited from the Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT). These staff were chosen partly due to existing links between the NHS Trust and the University, as well as being identified as working in services likely to be commissioned to focus on the individual alcohol or drug user, with minimal involvement of FMs in treatment.

Each service was firstly approached by the author to provide the staff with information on the current project. The author then attended a team meeting at each service where each participant was asked to sign a Consent Form showing willingness to participate, followed by completion of the questionnaire. Eleven participants were studying towards a MSc. qualification in Treatment of Substance Misuse at the University of Birmingham. The MSc. students were approached during a coffee break in one of their lectures at the University. Questionnaires were then collected along with consent forms the following week during their lecture. Twenty-eight participants were recruited via the author's supervisor at addiction training events and conferences. These participants were briefed about the nature of the study and asked to complete the questionnaire at the beginning of the day, before receiving any training on family-interventions.

The sample had varying job roles: 31 Substance Misuse Counsellors, 4 Clinical Psychologists, 6 Community Drug Workers, 10 Community Psychiatric Nurse (CPN), 2 Doctors, 2 Drug & Alcohol Specialist Nurse, 20 Drug Workers, 10 Registered Mental Health Nurse, 20 Substance Misuse Workers (Clinician/Practitioner/Nurse), 6 Addiction Researchers, 3 Psychiatrists, 3 Psychotherapists, 1 Alcohol Arrest Referral Worker, 3 GP Liaison Nurse, 3 Substance Misuse Team Managers, and 17 Social Workers.

Participants had been working within addiction services in their current role for, on average, 60.5 months (S.D. = 59.2, range 1 = 384 months). Fourteen (9.9%) reported no previous experience of involving FMs in treatment in their current job role, while 68 (48.2%) had worked with 1- 10 FMs, 20 (14.2%) had worked with 11-20 FMs, 18 (12.8%) had worked with 21-60 FMs, and 3 (2.1%) had worked with more than 60 FMs in their current job role.

Eighteen (12.8%) respondents failed to report the amount of FMs they had worked with in their current job role.

The remaining 16 participants were different as they were chosen to make up the ‘criterion group’. These participants were either actively working to promote family-focused addiction services, or were working within the team who previously received training as part of the IFM project, who had previously been shown to have positive attitude scores towards greater involvement of FMs in treatment sessions using the AAFPQ) (Orford *et al.*, 2009). The criterion group were approached individually, given an explanation of the objectives of the study and were asked to complete the questionnaire and consent form. All participants were fully briefed as to the outcome measures of the questionnaire.

STATISTICAL ANALYSES

Statistical Package for the Social Sciences (SPSS) 16.0 was used for all statistical analyses. A principal components analysis (PCA) was used to determine if the scale captured more than one dimension of attitude. Because it was unknown in advance whether potential factors would correlate with one another, promax oblique rotation was used. Reliability analysis using Cronbach’s alpha was conducted to establish internal reliability.

The criterion-group method was used to establish construct validity. Scores for each subscale as well as total scale scores were calculated for each participant. Responses for negatively worded items needed to be reversed so that higher scores indicated higher positive attitudes towards working with FMs in treatment sessions. The criterion group scores (n=16) were contrasted with those of the rest of the community sample (n=125). It was anticipated that the

criterion group would have higher scores in view of their current role. It was also anticipated that the community sample would have less positive attitude scores as many would be working within services predominantly set up to focus on the individual drug or alcohol user.

To examine the convergent validity, the AIFMTQ was correlated with the AAFPQ. High correlations between the two scale scores would be evidence of convergent validity.

RESULTS

Principal components analysis (PCA) and subscale exploration

Before conducting the PCA, several standard diagnostic tests to determine whether data were well-suited were conducted. For these data, the Kaiser-Meyer-Olkin (KMO) measure for sampling adequacy was 0.874 and significance for Bartlett's test was $p < 0.0001$ (chi-square 2173.52, d.f.= 496), both indicating that the data were well-suited for PCA.

The initial PCA sought factors with Eigenvalues greater than 1. Eight initial factors emerged, which together accounted for 66.4% of the variance. These eight rotated factors, however, were not readily interpretable as some factors were specific to only one or two items and some items loaded on more than one factor. Subsequent forced-factor rotation solutions seeking two, three factors and so on, up to eight factors were obtained. These solutions were all examined to determine which provided a structure with fewest multiple loadings with item loadings of at least 0.35 as a criterion. The four-factor rotation was identified as the most interpretable solution.

Importantly, the meaning of the items loading onto each factor was examined to determine whether they were a coherent grouping and might be considered to be measuring a single underlying construct. Such groupings were discussed between the author and the two researchers from the University of Birmingham (the same group responsible for the initial item generation), to determine the extent to which the data reflected the attitudes of staff working within individualistic addiction treatment practice.

The loadings for the 32 items are shown in Table 7 below. Each item was assigned to one factor based on the highest coefficients from the rotated factor matrix, with only five items loading onto more than one factor (Table 7). Submitting the four scales to the reliability procedure was the next step. Maximum likelihood factor analysis was used to check that those sets of items constituted satisfactory scales and to guide any necessary scale reduction. All items for Factors two, three and four were retained in the final measure due to all items loading relatively highly, as well as being perceived to have meaning within each sub-scale.

Factor one, however, was different as we were looking for guidance about reducing the number of items to a smaller number (also looking at the content of the items and hoping to get diversity of content in the reduced scale). Each of the 17 original items loading onto Factor one was reviewed on the basis of its weight within the scale, its corrected item-total correlation value and its meaning in order to reduce scales and create a clear-cut factor structure. As a result of this reduction, ten of the original items were dropped due to low item-total correlation, as well as alpha increasing once each item was deleted. One further factor analysis established that a stable, four-factor, 22-item measure was obtained accounting for

51.9% of the total variance. The measure was entitled the ‘Attitudes to Involving **FMs** in Treatment Questionnaire’ (AIFMTQ).

All items retained in the final 22-item measure are italicised in Table 7. The final version of the measure presenting the correct order of the questions, as well as coding instructions can be found in Appendix 9.

Final 22-item AIFMTQ

The four subscales were judged to be coherent and to represent a separate scale related to attitudes to involving FMs in addiction treatment. The first subscale included seven items and the substance of these items included how involving FMs in treatment creates a more coherent approach, helps to get a clearer picture, helps to identify positive coping strategies, is helpful in complex cases, is an essential part of good treatment and is as important as working with the user. This factor was entitled the *General Orientation* scale. It appears to reflect the strength of feeling that FMs should be included in the course of treatment.

The second factor included six items, which was termed *Confidence in Managing Interpersonal Issues*. It describes how individual staff may or may not feel ‘out of their depth’ involving FMs in sessions and perhaps handling open conflicts within a session, whether to attempt to involve FMs if there was a hint of a child protection issue, how individuals may or may not have difficulties remaining neutral when working with the user and FM, as well as the appropriateness and logistical difficulties of asking FMs to be involved in sessions.

The third factor included five items, referring to concerns and confidentiality issues of involving FMs in treatment sessions, whether FMs can be too dominating or may take over a session, whether there may be conflicts of interest for the practitioner when seeing both misusers and their FMs and whether suspicion of domestic violence is a contrary indication for involvement of FMs in a session. This factor was called *Lack of Concern about involving FMs*.

The fourth factor included four items. The substance of these items included FMs just wanting to have the user's addiction problem fixed, the needs of users and FMs can be incompatible, involving a FM may make the user feel resentful, and FMs often think it is the user's problem and don't wish to be involved themselves. This fourth factor was entitled *Perceived Compatibility of FM and User's Needs*.

Table 7. Factors Loadings and Variance for All Items

Table 7. Factors Loadings and Variance for All Items		Loading onto factor				Mean (SD)	% Variance	
		1	2	3	4			
Factor 1								
23. Involving FMs is very helpful even in complex cases.		.86				5.24 (1.19)	27.0	
32. It creates a more coherent approach towards tackling the problem if a family member is involved.		.85				5.19 (1.15)		
27. Stress and strain can be alleviated for the family as a whole if FMs are actively involved.		.83				5.26 (1.15)		
14. I find that involving a family member helps to identify positive coping strategies for the family as a whole.		.82				5.41 (1.05)		
22. Working with FMs is as important as working with the user.		.78				5.02 (1.22)		
29. Involving FMs improves the relationship between the service and FMs.		.77				5.12 (1.02)		
21. Involving FMs means they will be better prepared to deal with relapses.		.77				5.28 (1.15)		
7. I find I get a clearer picture of the addiction problem when I involve FMs.		.76				5.32 (1.21)		
28. Making sure that FMs are well informed about the user's problems is an essential part of good treatment.		.73				4.89 (1.34)		
1. I believe that involving FMs should be the norm		.70				5.28 (1.40)		
6. It is important to encourage open communication about the problem between the user and a family member.		.70				5.55 (1.05)		
26. I am confident that I can work with users and their FMs together in a positive way.		.69	.49			5.51 (1.03)		
25. In my view all services should have the resources available to consider FMs in their own right.		.65				5.77 (1.06)		
8. I always ensure that I make time to talk to FMs when they approach the service.		.60				5.59 (1.11)		
4. Services should be responding to the needs of FMs in their own right.		.52				5.58 (1.15)		
18. Services should be flexible enough to respond both to the user and his/her FMs.		.46				5.59 (1.32)		
12. I always draw up a network diagram when I assess a user.		.38				4.26 (1.52)		
Factor 2								
16. I find it difficult to remain neutral when working with the user and his/her FMs.			.68			4.91 (1.12)	8.5	
3. I don't feel confident about handling open conflicts between the user and his/her FMs.			.59			4.57 (1.24)		
13. I feel out of my depth when working with more than one person in the room.			.59			5.17 (1.21)		
17. It is often inappropriate to ask users about involving their FMs.			.57			4.92 (1.32)		
15. I would never attempt to involve FMs if there was a hint of a child protection issue.			.56			4.90 (1.23)		
20. I find there are too many logistical difficulties in involving FMs in sessions.			.48	.41		4.68 (0.96)	8.2	
Factor 3								
10. Conflicts of interest usually arise for the counsellor/practitioner when FMs are involved in sessions.				.69		4.14 (1.15)		
5. I feel that FMs can be too dominating in sessions.				.68		3.69 (1.15)		
24. FMs often take over sessions, nagging and point scoring.				.63	.54	3.93 (0.95)		
2. I have concerns about confidentiality issues if FMs are included in treatment.				.61		3.55 (1.34)		
9. Suspicion of domestic violence is always a contrary indication for involving FMs				.59		4.21 (1.12)	8.2	
Factor 4								
31. The needs of users and their FMs are very often incompatible.			.41		.71	3.99 (1.05)		
30. FMs just want to have the user's addiction problem fixed and think anything else would be unhelpful.					.69	4.13 (1.06)		
11. I feel that involving a family member may make the user feel resentful.				.48	.67	4.18 (1.01)		
19. FMs often think it is the user's problem and don't wish to be involved themselves.					.64	4.25 (1.21)		

Extraction Method: Principal Component Analysis.

Rotation Method: Promax with Kaiser Normalization.

Reliability and validity of the AIFMTQ

Internal reliability

The tests of internal reliability resulted in a Cronbach's alpha coefficient of .89 for the total scale and for Factor 1, .93; Factor 2, .66; Factor 3, .69 and Factor 4, .69. It can be concluded that Cronbach's alpha was between .66 and .93 for all four subscales and for the main measure as well. Moss *et al.* (1998) suggest that an alpha score of 0.6 is commonly acceptable, although this benchmark is not as rigorous as the more widely recognised 0.7 threshold (Nunnally, 1978). One of the possible explanations for the lower alpha values for subscales 2, 3 and 4 is the fact that they consist of a smaller number of items (Moss *et al.*, 1998). Moss also suggests a low alpha value does not necessarily mean that the scale will not work well.

Construct validity

Data for sub-scales two and four were non-normally distributed for the Criterion group, meaning an independent Kruskal-Wallis test was used to compare the Criterion group's responses with the Community sample. Table 8 shows that, as predicted, the criterion group reported significantly more positive attitudes towards involving FMs for total attitude score, sub-scales 1, 2 and 3. There was, however, no significant difference between the groups for sub-scale 4.

Table 8. Comparison of Community and Criterion Samples

AIFMTQ Sub-scale	Community sample (N=125) Mean Rank	Criterion sample (N=16) Mean Rank	Kruskal-Wallis Test	P value
General Orientation (sub-scale 1)	65.49	114.03	20.089	0.000
Confidence in Managing Interpersonal Issues (sub-scale 2)	67.78	96.12	6.881	0.009
Lack of Concern About Involving FMs (sub-scale 3)	66.93	102.78	11.037	0.001
Perceived Compatibility of FM and user's needs (sub-scale 4)	70.33	76.22	0.298	0.585
Total AIFMTQ score	66.13	109.06	15.691	0.000

Convergent validity

To examine the convergent validity of the AIFMTQ, based on the research evidence supporting its validity, the AAFPQ was chosen as a comparison measure. To support the validity of the AIFMTQ it was hoped a significant correlation should occur with the AAFPQ scale. Means and standard deviations were calculated for baseline scores for both scales for 33 staff working for the Organisation soon to be participating in the project.

Pearson's product moment correlation coefficients were calculated for the AIFMTQ and AAFPQ sub-scales and total scores. The strength or magnitude of correlations was assessed using the scale developed by Cohen (1988). The overall convergent validity of the two measures was moderate ($r=.38$, $p<.05$). Sub-scale inter-correlations were also calculated

showing that correlations with the AAFPQ scale were particularly high and significant for Factors 1 ($r=.48$, $p < .01$) and 3 ($r=.40$, $p < .05$). These correlation coefficients can be used as evidence of further validity for the AIFMTQ due to the statistical significance of the correlation.

DISCUSSION

The AIFMTQ was developed to assess staff attitudes towards working with FMs in addiction treatment. As recommended by Lightfoot and Orford (1986), it was developed specifically for the context in which the staff are, or will be working. Items were developed accordingly to specifically measure attitudes towards working with FMs. Item generation was based on data provided during the Pilot phase of the current project and findings from the IFM project (Orford *et al.*, 2009).

In order to assess staff attitudes before, during and after the training package, it was important to devise a sensitive measure of attitudes to working with this particular client group, rather than adapting a previous measure to try to fit the context of the research. It is believed that this measure has the potential utility to assist the implementation of family-inclusive practice by examining staff's attitudes to subsequently tackle any issues highlighted.

Four subscales were generated using exploratory factor analysis. Of the 32 items in our original questionnaire, 22 items met the validity and reliability criteria set to be retained in the final version. The internal consistency of the questionnaire, analysed with Cronbach's alpha, was considered good for the total scale and Factor one and considered satisfactory for Factors two, three and four.

The content validity phase revealed useful information that led to necessary additions and amendments of questionnaire items, mostly by removing or amending any items that may have been ambiguous to the respondent.

To provide construct validity, it was expected that the criterion group would generate significantly higher (more positive) scores on the AIFMTQ compared to the community sample. This prediction was based on the fact that the Criterion group were either already practicing in a family-focused addiction treatment service, or were actively working in research to promote the importance of emphasis on family-inclusive treatment practice. Sub-scales one, two and three did support this notion. The fourth sub-scale, however, did not generate significantly more positive scores in the Criterion sample. At this stage, therefore, it is important to point out that there remained some uncertainty about sub-scale 4.

There were two options available regarding sub-scale 4. One was to delete this sub-scale leaving an 18-item measure. The other was to explore ways of improving the sub-scale. Further scrutiny of the scale items was, therefore, required in order to offer improvements. Members of the expert panel who had originally reviewed the items once again suggested possible amendments to three out of the four items, which constituted sub-scale four. Question 31 ‘the needs of users and their FMs are very often incompatible’ was changed to ‘the needs of users and their FMs are incompatible;’ Question 11, ‘I feel that involving a FM may make the user feel resentful’ was changed to ‘I feel that involving a FM will make the user feel resentful’ and Question 19, ‘FMs often think it is the user’s problem and don’t wish to be involved themselves’ was changed to ‘FMs think it is the user’s problem and don’t wish

to be involved themselves.’ It is believed that by making these subtle changes, removing or replacing words such as maybe and often, respondents are asked to answer much more extreme questions. To provide an example, it is possible the original wording of these items allowed respondents from both groups of the sample to respond ‘strongly agree’ when asked for example ‘*may* make the user feel resentful’. Instead, when asked ‘*will* make the user feel resentful’ it is believed it would be very unlikely for participants from the Criterion group to choose such a response, as the whole context of the question is changed. At the present stage, therefore, sub-scale four needs further testing before it can be recommended. Including these four items in the measure to assess the total score is, however, recommended.

As the original aim was to develop a measure that goes beyond that of previous scales, removing the items making up the fourth sub-scale would mean removing crucial concepts that have been identified in previous research as potential barriers to involving FMs in addiction treatment. That is, previous research has shown there is a lack of response to the underlying needs of FMs due to services not having the theoretical and practical tools with which to respond to these needs (Copello *et al.*, 2000a).

In order to further develop training and interventions aimed at rectifying these potential barriers in future, there is a need to firstly identify this problem through assessment of staff attitudes regarding the needs of the FMs and compatibility of these needs in addiction treatment, which these items allow.

The aim was to develop a sensitive measure to assess staff attitudes to involving FMs in addiction treatment, most importantly one that goes beyond adapted measures of this target

construct that already exist. Has this been achieved? At this stage in the development of the scale, it can be concluded that the AIFMTQ complements the AAFPQ. To avoid “contributing to the needless proliferation of assessment instruments” (Clarke & Watson, 1995), it is summarised here what the AIFMTQ is thought to offer empirically, compared to existing adapted measures such as the AAFPQ.

First, the AIFMTQ fills the need for a sensitive reliable and valid scale to measure staff attitudes specifically related to involving FMs in addiction treatment; it is believed that this is the first study of its kind to develop a tool specifically to measure staff attitudes to involvement of FMs within addiction treatment sessions.

Second, this measure coupled with qualitative information of the key facilitators and barriers to involving FMs in treatment sessions (Chapter 7) will help to further develop training and interventions aimed at promoting greater involvement of FMs within addiction service provision.

Finally and most importantly, the development of the AIFMTQ has shown that there are components other than those identified in the AAFPQ which have been found to be important issues when assessing positive or negative attitudes towards involving FMs in treatment sessions. These include, to name but a few; items asking about potential conflicts of interest between FMs and service users; if stress and strain can be alleviated for the family as a whole if FMs are actively involved; the importance of encouraging open communication about the problem between the user and a FM; and involving FMs enables the practitioner to gain a clearer picture of the environment in which the user is living. These are all areas that have

been identified as extremely important to understand, but were lacking in existing measures attempting to assess staff attitudes to involving FMs in addiction treatment. These important sensitive additional components the AIFMTQ appear to be the result of contextualizing the items to fit the reality of the current climate of individually focused practice with a need to shift towards more family-focused addiction services.

Limitations

It is important to point out the limitations of the scale development reported here. Firstly, there was considerable dependency in the sample (i.e., 72% of staff worked within one NHS Trust) with the possibility that staff members from one setting have more similar attitudes than members at different facilities. Although it would have been useful to have participants from a wider range of addiction settings, it is worth pointing out that the staff worked across eight separate services (community alcohol teams, community drug teams, and drug intervention programme teams) in different localities of the city. Previous research has shown that the climate and culture related to work attitudes, perceptions, and behavior varies by Organisational unit or team (Glisson & James, 2002; Frambach & Schillewaert, 2002).

Secondly, it could be argued that the relatively small sample size is a limitation. It is widely understood that the use of larger samples in applications of factor analysis tends to provide more precise estimates of population loadings. Samples of at least 100 (Gorsuch, 1983; Kline, 1979) have, however, been suggested in the literature for development of a new scale, or the number of subjects should be the larger of five times the number of variables, or 100 (Hatcher, 1994). Although a larger data set would have been favoured, the data set here does achieve these criteria.

Finally, to fully confirm that the four-factor solution is stable, confirmatory factor analysis is required. As scale development is an on-going process, this will be carried out during the next stages of refinement of the AIFMTQ.

Conclusion

At this stage of scale development, it can be concluded that the AIFMTQ is a reliable measure, with the practical advantage of being relatively short with 22 items. It is believed that this measure will allow the assessment of attitudes towards greater involvement of FMs in treatment sessions to detect impeding/enhancing factors related to subsequent implementation of family-focused addiction practice.

Being based on an actual study promoting the involvement of FMs in services, the scale does go more deeply than the AAFPQ into certain topics that have been discussed to be important. The development and further implementation of this tool aims to further promote the role of families and wider social networks in routine service provision by showing that positive attitudes towards greater involvement of FMs in treatment sessions can assist FC engagement in treatment, improve substance-related outcomes and family functioning, and lead to the reduction of impacts and harm for FMs and others affected (Copello & Orford, 2002a).

CHAPTER FIVE

PHASE TWO: STAFF ATTITUDES TOWARDS FAMILY WORK

INTRODUCTION

This chapter reports the quantitative results from the main quasi-experiment in phase two of the research. A wait-listed quasi-experimental design was chosen whereby the family-focused training package was sequentially rolled-out to staff over two separate time periods: half of the teams (Teams C & D) were randomly chosen to receive ‘immediate’ training and supervision, and the remaining half (Teams E & F) were wait-listed and received ‘delayed’ training, nine-months later. By the end of phase two, all frontline staff and managers across the Organisation had received the family-focused training package.

Staff attitudes were collected from all eligible staff working with the four teams at the same key time-points before, during and after receiving the training package using the AAFPQ and the newly author-developed AIFMTQ. Comparisons between Immediate and Delayed groups were assessed throughout the quasi-experiment, allowing the impact of the training package to be evaluated.

Additionally, as mentioned in Chapter two, attitudes towards family work among the four quasi-experiment teams were compared with an additional team within the Organisation (Team G), who after receiving two-years of family-focused training and on-going supervision, had demonstrated significantly more positive staff attitudes towards a greater involvement of

family member. Thus, Team G were considered as a team capable of acting as a demonstration site for family-oriented substance misuse treatment (Orford *et al.*, 2009).

The analysis and results are reported here, however, the discussion of the results regarding staff attitudes following training is presented in the next chapter, whereby the relationship between attitudes and the proportion of family-focused practice taking place within the teams, as a result of the training package, is discussed.

METHOD

Design

As explained in Chapter two, the remaining four teams within the Organisation (Teams C, D, E & F) participated in the main quasi-experiment during phase two. Quasi-experimental procedures are an alternative to RCT's and are suitable when investigating the effects of interventions in practice (Howard, Moras, Brill, Martinovich & Lutz, 1996). Teams C & D were randomly assigned to receive immediate training, and the remaining two teams (E & F) were randomly assigned to receive the delayed training package after a nine-month wait-list period.

Figure 10 depicts the overall timeline of events within phase two. The shaded area indicates the nine-month training and on-going supervision period. The timeline also displays teams' baseline, post-training and, where relevant, follow-up period.

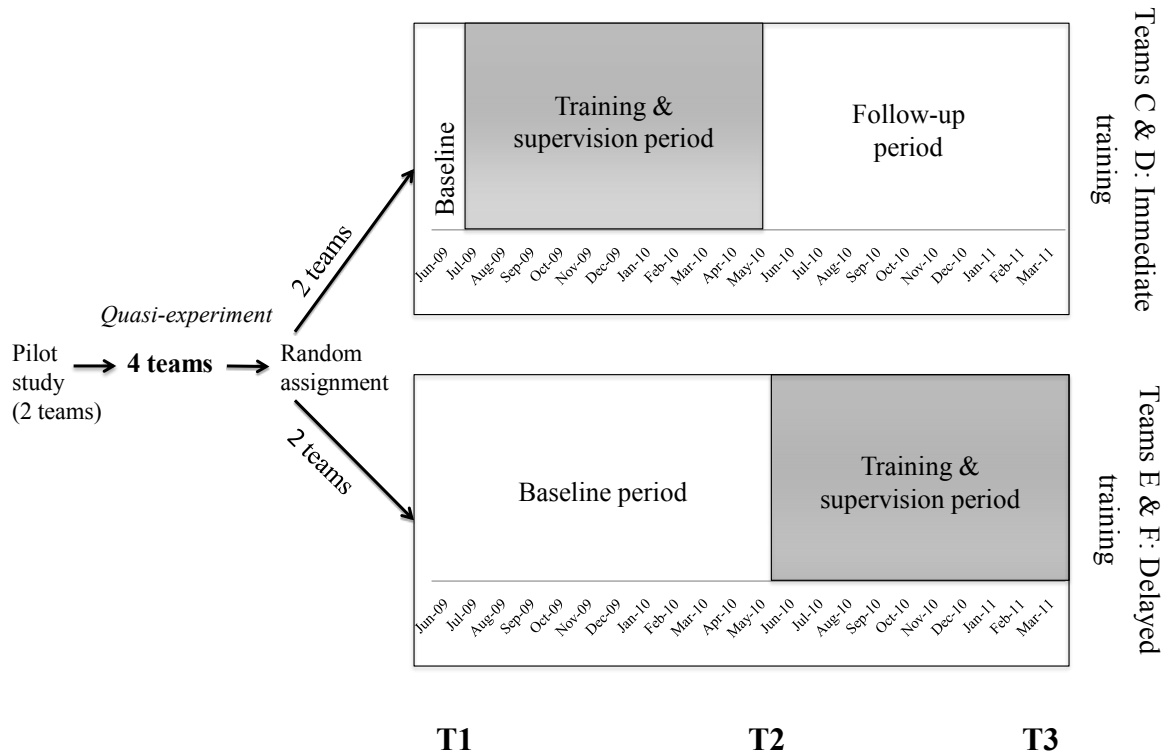


Figure 10. Phase Two Quasi-Experiment Timeline (Attitude Measures)

Participants

All staff making up the teams were encouraged to attend the training and on-going supervision sessions, however, only staff working in a counselling or supportive role with focal clients (FCs) and family members (FMs) were required to complete the attitude measures. That is, it was not relevant for administration or technical staff to complete the measures.

Baseline characteristics of the staff across the four teams are provided in table 9. Mann Whitney U tests revealed that the Immediate and Delayed groups were well matched at

baseline, and no significant differences in the number of years worked in role, or the number of FMs previous seen in the last 12 months were revealed.

Table 9. Baseline Characteristics of Phase Two Study Sample

	Whole sample (n = 35)	Allocated to immediate training (n = 23)	Allocated to delayed training (n = 12)	Statistics for comparison of groups
Median years worked in role (range)	3.5 (0.01– 19.99)	2.33 (0.3 – 6.67)	4.16 (0.01–19.99)	U (35)=168, z=1.80, p=0.76, N.S.
Number of family members seen in the last 12 months	6.54 (0 – 24)	5.74 (0 – 24)	8.22 (0 – 20)	U (31)=127, z=1.24, p=0.24, N.S.

Materials

The materials were the two attitude questionnaires (AAFPQ and AIFMTQ), Participant Information Form, and Participant Consent Form. All materials were presented within a composite questionnaire pack.

Procedure

To assess changes in staff attitudes towards family-focused practice as a result of the training package, the two attitude questionnaires were administered to both Immediate and Delayed groups at the same three time-points (T1, T2 and T3) throughout phase two (see Figure 10 above). Baseline measures were first collected in July 2009 (T1), which allowed the underlying trend in attitudes to be assessed prior to either group receiving training. The Immediate group then went on to receive the nine-month training package, whilst the Delayed group were unaware of when they would receive the training package.

Following the nine-month training and on-going supervision, the immediately trained staff completed post-intervention attitude measures in May 2010 (T2). During the same month, the Delayed group provided a second baseline attitude measure before going on to receive the nine-month training package. Additionally, attitude data using the two questionnaires was collected from the previously trained Team G at T2, being just over two and a half years since the conclusion of the comparison team's training. Being the half-way time-point within the main quasi-experiment meant that T2 was an important juncture; the immediately trained teams' nine-month training period had very recently ended, and the Delayed teams' training period was soon to commence.

Following the completion of the Delayed group's training in March 2011 (T3), they provided post-intervention attitude measures. The immediately trained group also provided follow-up attitude data at the same time-point, at which stage their training and supervision had concluded nine-months earlier.

STATISTICAL ANALYSES PLAN

SPSS version 19 for Mac OX was used for all statistical analyses.

Descriptive statistics were first used to assess the means and standard deviations for the groups' total attitude and subscale scores across T1, T2 and T3. Shapiro-Wilk tests revealed that some of the sub-scales for the two questionnaires were non-normally distributed. As a result, all attitude data were logarithmically transformed to approximate a normal distribution before statistical analysis.

Once the data met the assumptions of parametric testing, a 3 x 2 Independent Measures ANOVA was used to assess changes in staff attitudes as a result of receiving the family-focused training and supervision. Post hoc *t*-tests were conducted to further investigate any significant differences.

The first independent variable (I.V.) was Time, with three levels (T1, T2, or T3). The interval between the three time-points was approximately nine-months. As described in the procedure section, the data collected at these time-points were either baseline, post-intervention or follow-up, depending on when teams were randomised to receive the training. Due to staff turnover between time-points, Time was a between-subjects variable, as some staff providing data throughout the study were not available for all three time-points.

The second I.V. was Group. This I.V. was also a between-subjects variable with two levels (Immediate and Delayed), showing when groups received the family-focused training and supervision.

The dependent variable (D.V.) was staff attitude scores (total and sub-scale scores) for the AAFPQ and AIFMTQ.

Additionally, a one-way independent measures ANOVA was conducted to examine differences in attitudes towards family work between the Immediate, Delayed and Comparison Group (previously trained Team G) at T2. Having just completed the nine-month training and on-going supervision, it was hypothesised that there would be no differences in attitudes between the immediately trained teams and comparison team. However, since the

Delayed team were yet to receive the training and supervision package, it was hypothesised that comparison team's attitude scores would be significantly greater than the Delayed teams.

RESULTS

For clarity, the results section is divided into two sections:

1. Staff attitudes towards greater involvement of family members for the Immediate and Delayed teams. Each of the two questionnaires is reported in turn.
2. Staff attitudes towards greater involvement of family members – differences between the quasi-experiment teams and previously trained comparison Team G.

1) Staff attitudes towards greater involvement of family members

Two-way independent ANOVAs were conducted for each sub-scale and total attitude score for the two questionnaires. There was homogeneity of variance between groups for all ANOVAs, as assessed by Levene's test for equality of error variances. Main effects of Time examined whether staff attitudes increased over time as a result of receiving the family-focused training package.

Main effects of Group examined whether there were any differences in staff attitudes according to whether staff received immediate or delayed training. A significant interaction Time x Group interaction would indicate differences in attitudes among the Immediate and Delayed teams at the three time-points.

For purposes of clarity, the results from the two questionnaires are reported in turn. The results from the standardised AAFPQ are firstly presented followed by the results for the author-developed AIFMTQ.

Addiction-Related Family Problems Questionnaire (AAFPQ)

Table 10 presents the untransformed mean AAFPQ sub-scale and total score for each group across the three time-points. The log-transformed mean sub-scale and total scores can be found in Appendix 10. No significant group differences at baseline for the AAFPQ sub-scale and total scores were revealed (all p s > .05). The description of each sub-scale has been previously described in Chapter two (page 91).

Main effects

Group

There were no significant main effects of Group for any of the AAFPQ sub-scales or total AAFPQ score; indicating that there were no differences between staff receiving immediate or delayed training during phase two.

Time

The ANOVAs revealed a significant main effect of Time for staff's Knowledge ($F(2,112) = 6.52, p < .01$), Confidence ($F(2,112) = 9.29, p < .001$), Support ($F(2,112) = 12.75, p < .001$), Self-belief ($F(2,112) = 4.69, p < .05$), and Total AAFPQ score ($F(2,112) = 7.15, p < .01$); indicating that staff attitudes towards greater involvement of FMs positively increased throughout phase two. No significant main effects of Time were revealed for Legitimacy

($F(2,112) = .1.16, p > .05$), Motivation ($F(2,112) = .92, p > .05$), and Impact on the substance user ($F(2,112) = 1.08, p > .05$).

Time x Group interactions

No significant Time x Group interactions for any of the AAFPQ sub-scales or total AAFPQ score were found. These findings indicate that staff attitudes during phase two were the same regardless of whether staff received immediate or delayed training.

Post hoc tests

Significant main effects of Time for Knowledge, Confidence, Support, Self-Belief and Total AAFPQ were followed by post-hoc *t*-tests.

Immediately trained teams

Post hoc *t*-tests examining differences in attitudes for immediately trained staff at baseline (T1) and immediately following training (T2) revealed significantly higher scores at T2 for Knowledge ($t(46) = -1.85, p < .05$), Confidence ($t(46) = -3.62, p < .01$), Support ($t(46) = -3.25, p < .01$), and Total AAFPQ ($t(46) = -2.07, p < .05$). Self-belief scores increased following training, however, were not significant. Post hoc *t*-tests also revealed that post-training increases in attitudes were sustained following the conclusion of the training package, with no significant differences in any of the subscale or total scores between T2 and T3. Furthermore, attitude scores continued to increase following the end of the training, with significantly greater scores being revealed at follow-up (T3) compared to baseline (T1) for Knowledge ($t(45) = -3.10, p < .01$), Confidence ($t(45) = -4.12, p < .001$), Support ($t(45) = -3.90, p < .001$), Self-belief ($t(45) = -2.30, p < .05$), and Total AAFPQ score ($t(45) = -2.30, p < .01$).

Table 10. Untransformed Mean (and Standard Deviation) AAFPQ and Subscale Scores for the Immediate and Delayed Groups

AAFPQ sub-scale	Immediate group (Teams C & D)			Delayed group (Teams E & F)		
	T1 (<i>n</i> =23)	T2 (<i>n</i> =25)	T3 (<i>n</i> =24)	T1 (<i>n</i> =12)	T2 (<i>n</i> =14)	T3 (<i>n</i> =20)
	Baseline	Post-intervention	Follow-up	Baseline	Baseline	Post-intervention
Knowledge	14.87 (3.65)	16.44 (2.84)*	17.63 (2.52)**	15.50 (3.03)	16.57 (2.50)	17.40 (2.60)*
Confidence	13.61 (2.86)	16.08 (2.29)**	16.72 (2.52)***	14.58 (3.68)	16.07 (3.08)	16.40 (2.85)*
Support	17.17 (2.08)	20.20 (3.61)**	20.52 (3.45)***	16.92 (2.50)	20.36 (4.72)*	21.75 (4.39)**
Legitimacy	15.35 (2.81)	15.92 (1.96)	16.85 (2.55)	16.00 (2.70)	16.36 (2.79)	16.25 (2.81)
Motivation	23.26 (3.97)	22.96 (3.49)	23.71 (3.37)	23.00 (3.57)	25.36 (2.73)	24.45 (3.78)
Self-belief	19.78 (3.90)	21.00 (3.92)	21.92 (2.93)*	19.08 (4.01)	22.36 (3.77)*	21.70 (3.67)*
Impact on the user	16.78 (2.21)	17.00 (2.10)	17.20 (2.17)	17.00 (2.00)	18.21 (2.39)	17.95 (2.37)
Total AAFPQ score	120.83 (16.13)	129.60 (14.54)*	134.55(15.85)**	122.08 (15.45)	135.29 (17.67)*	135.90 (18.88)*

Notes: *Significantly greater than baseline ($p < .05$). **Significantly greater than baseline ($p < .01$). ***Significantly greater than baseline ($p < .001$).

Delayed Teams

For those staff receiving delayed training, post-hoc *t*-tests examined differences in attitudes during the wait-listed baseline period (in the absence of any training and supervision between T1 & T2). Significantly greater scores were revealed at T2 for Support ($t(24) = -2.21, p < .05$), Self-belief ($t(24) = -2.13, p < .05$) and Total AAFPQ ($t(24) = -2.00, p < .05$). Knowledge and Confidence scores had increased at T2, however, were not significant.

No significant differences were revealed between T2 (baseline) and T3 (immediately following training) for any of the subscales or Total AAFPQ score. However, post hoc *t*-tests examining differences between T1 and T3 revealed significantly greater scores at T3 for Knowledge ($t(30) = -1.91, p < .05$), Confidence ($t(30) = -1.78, p < .05$), Support ($t(30) = -3.43, p < .01$), Self-belief ($t(30) = -1.99, p < .05$) and Total AAFPQ ($t(30) = -2.15, p < .05$).

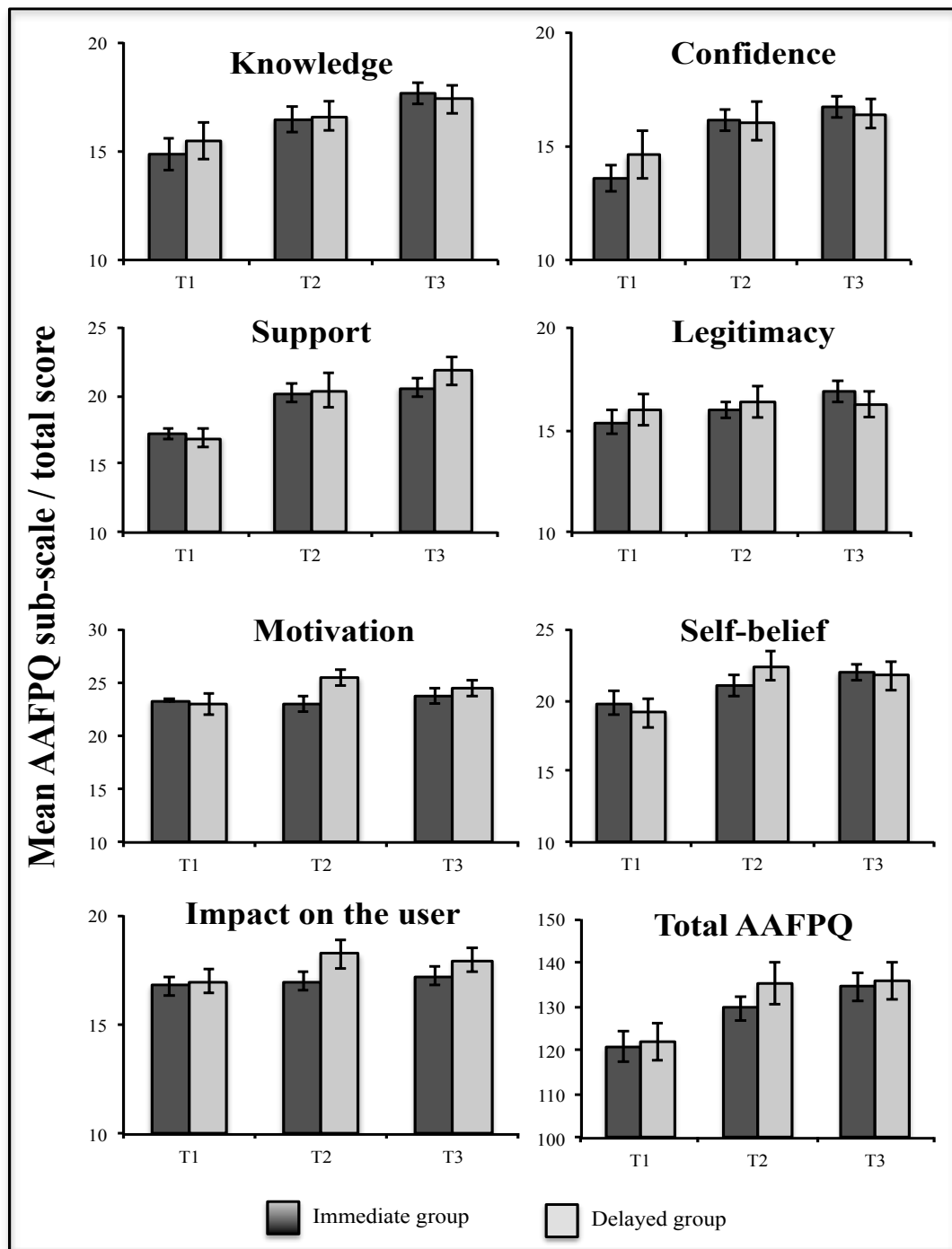


Figure 11. Mean AAFPQ sub-scale and total scores

(Note: Bars indicate standard error of the mean)

Attitudes to Involving Family Members in Treatment Questionnaire (AIFMTQ)

Table 11 reports the untransformed means and standard deviations for the AIFMTQ subscales and total scores. The log-transformed means and standard deviations are presented in Appendix 11. No significant group differences at baseline for the AIFMTQ sub-scale and total scores were revealed (all $ps > .05$). The description of each sub-scale has been previously described in Chapter four (pages 122-123).

Main effects*Group*

Unlike the results from the AAFPQ, the two-way independent measures ANOVAs revealed a significant main effect of Group for three of the four AIFMTQ subscales: General Orientation to family work ($F(1,108) = 5.72, p < .05$), Lack of Concern about involving FMs ($F(1,108) = 13.03, p < .001$), Perceived Compatibility of family member(s) and substance user's needs ($F(1,108) = 6.29, p < .05$), and Total AIFMTQ score ($F(1,108) = 11.75, p < .01$). These findings indicate differences in staff attitudes between those receiving immediate or delayed training during phase two. Post hoc t -tests showing where these group differences were found are presented in the post hoc tests section below.

Time

The ANOVAs also revealed a significant main effect of Time for General Orientation to family work ($F(2,108) = 4.90, p < .01$), Perceived Compatibility of family member(s) and substance user's needs ($F(2,108) = 3.102, p < .05$), and Total AIFMTQ score ($F(2,108) = 5.88, p < .01$); indicating that staff attitudes towards greater involvement of FMs positively increased throughout phase two. No significant main effects of Time were revealed for

Confidence in Managing Interpersonal Issues ($F(2,108) = 2.35, p > .05$), or Lack of Concern about involving FMs ($F(2,108) = 1.70, p > .05$), however, all showed increases over time.

Time x Group interactions

Comparable to the findings for the AAFPQ, there were no significant Time x Group interactions for any of the AIFMTQ sub-scales or total score; indicating that staff attitudes over time were the same regardless of whether they received immediate or delayed training.

Post hoc tests

Significant main effects of Time and Group for were followed by post-hoc tests *t*-tests.

Time

Immediately trained teams

Significant main effects of Time for General Orientation, Perceived Compatibility and Total AIFMTQ were followed by post-hoc *t*-tests. Results revealed that attitudes for immediately trained staff at baseline (T1) and immediately following training (T2) revealed no significant differences, however, all scores had increased following training. Nor were any significant differences revealed between post-training (T2) and follow-up (T3), however, scores continued to increase following the conclusion of the training package.

Post hoc *t*-tests did reveal that follow-up scores at T3 were significantly greater than baseline (T1) for General Orientation ($t(42) = -1.77, p < .05$) and Total AIFMTQ score ($t(42) = -1.71, p < .05$).

Delayed teams

For those staff receiving delayed training, post-hoc *t*-tests examined differences in attitudes during the wait-listed baseline period (in the absence of any training and supervision between T1 & T2). Comparable to the AAFPQ, significantly greater scores were revealed at T2 for Total AIFMTQ ($t(23) = -2.04, p < .05$). Scores for General Orientation and Perceived Compatibility had increased at T2, however, were not significant.

Significant differences were revealed between T2 (baseline) and T3 (immediately following training) for General Orientation to family work ($t(32) = -1.65, p < .05$). Scores for Perceived Compatibility and Total AIFMTQ score were greater at T3 compared to T2, however, were not significant.

Post hoc *t*-tests examining differences between T1 and T3 revealed significantly greater scores at T3 for General Orientation ($t(29) = -2.33, p < .01$), Perceived Compatibility ($t(29) = -2.52, p < .01$) and Total AIFMTQ ($t(29) = -2.98, p < .01$).

Group

Significant main effects of Group for General Orientation, Lack of Concern, Perceived Compatibility and Total AIFMTQ score were followed by post-hoc *t*-tests. As mentioned previously, there were no between group differences at T1 (baseline for both groups). Post hoc *t*-tests examining differences between groups at T2 revealed significantly greater scores for the delayed group compared to the immediately trained group for Lack of Concern ($t(37) = -2.06, p < .05$) and Total AIFMTQ score ($t(37) = -2.45, p < .01$). Such findings do not

support the hypothesis that the immediately trained teams' scores would be significantly greater following immediate training, compared to staff waiting to receive training.

Post hoc *t*-tests examining differences between groups at T3 also revealed significantly greater scores for the delayed group compared to the immediately trained group for General Orientation ($t(40) = -2.21, p < .05$), Lack of Concern ($t(40) = -3.57, p < .01$), Perceived Compatibility ($t(40) = -2.46, p < .01$) and Total AIFMTQ score ($t(40) = -2.91, p < .01$).

Table 11. Untransformed mean (and standard deviation) sub-scale and total AIFMTQ scores for the immediate and delayed group

AIFMTQ sub-scale	Immediate group			Delayed group		
	T1 (<i>n</i> =22)	T2 (<i>n</i> =25)	T3 (<i>n</i> =22)	T1 (<i>n</i> =12)	T2 (<i>n</i> =14)	T3 (<i>n</i> =20)
	Baseline	Post-intervention	Follow-up	Baseline	Baseline	Post-intervention
General orientation	36.55 (5.87)	37.52 (4.62)	39.36 (5.12)*	38.09 (6.14)	40.00 (5.08)	43.15 (5.48)** ^ #
Confidence managing interpersonal issues	28.14 (4.91)	28.72 (5.02)	30.00 (4.57)	28.27 (3.50)	31.79 (5.59)	32.35 (6.29)
Lack of concern involving family members	18.41 (3.11)	18.96 (4.95)	18.86 (4.26)	19.45 (3.36)	22.29 (3.99)*#	23.20 (3.61)##
Perceived compatibility of needs	16.73 (2.60)	17.32 (4.06)	18.05 (2.89)	17.55 (2.94)	19.07 (3.29)	20.30 (2.98)** ##
Total AIFMTQ score	99.82 (11.90)	102.52 (13.48)	106.27 (12.91)*	103.36 (12.04)	113.14 (11.73)*##	119.00 (15.47)** ##

Notes: *Significantly greater than baseline ($p < .05$). **Significantly greater than baseline ($p < .01$).

^Significantly greater than T2 ($p < .05$).

#Significantly greater than Immediate group at equivalent time-point ($p < .05$). ##Significantly greater than Delayed group at equivalent time-point ($p < .01$).

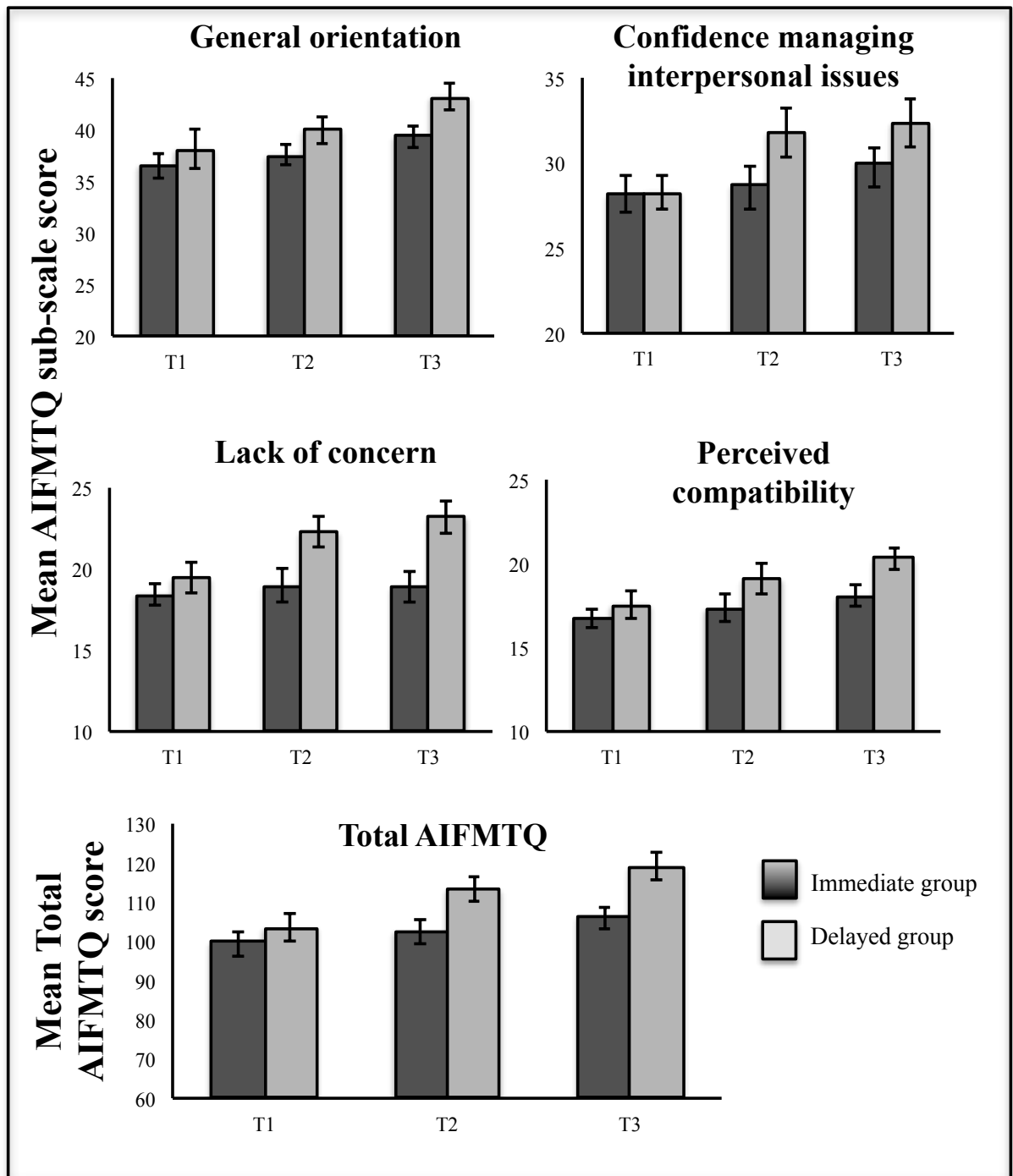


Figure 12. Mean AIFMTQ sub-scale and total scores

(Note: Bars indicate standard error of the mean)

2) Comparisons between the quasi-experiment teams and previously trained teams' attitudes

It was mentioned in Chapter two that one team working within the Organisation (Team G) had participated in a pilot project (see Orford *et al.*, 2009), in which frontline staff and line managers had received two-years of family-focused training and on-going supervision. Following the two-years of training and supervision, findings revealed significant increases in the staff attitudes towards a greater involvement of FMs, and Orford *et al.*, posited that the positive changes that had occurred “would not be easily reversed, with family work now being ‘normalised’ into their routine practice” (pg. 22). Therefore, it was hypothesised that attitudes towards family work from staff working in Team G at T2 would be significantly greater than the Delayed group, who were yet to receive any family-focused training or supervision. However, that there would be no differences in attitudes among Team G and the two immediately trained teams who had now completed the nine-month period of training and on-going supervision.

Table 12 presents the untransformed AAFPQ sub-scale and total score means (and standard deviations) for the Immediate, Delayed and Comparison teams. The log-transformed scores can be found in Appendix 12. A one-way independent measures ANOVA was conducted to examine differences across the three groups in attitudes towards family work. There was a significant effect of group for Motivation ($F(2,45) = 3.84, p < .05$), Self-belief ($F(2,45) = 2.73, p < .05$) and Total AAFPQ score ($F(2,45) = 2.99, p < .05$).

Post hoc comparisons using Dunnett's test (with the previously trained teams as a control) indicated that the mean score for the comparison group was significantly greater than the

immediately trained group for Motivation, Self-belief and Total AAFPQ score (all $ps < .05$). No significant differences in mean scores were revealed between the comparison group and the Delayed group.

Table 13 presents the untransformed AIFMTQ sub-scale and total score means (and standard deviations) for the Immediate, Delayed and Comparison teams. The log-transformed scores are presented in Appendix 13. A one-way independent measures ANOVA was conducted to examine differences across the three groups in attitudes towards family work. There was a significant effect of group for General Orientation ($F(2,45) = 3.23, p < .05$), Lack of Concern involving FMs ($F(2,45) = 3.32, p < .05$), and Total AIFMTQ score ($F(2,45) = 2.99, p < .05$).

Post hoc comparisons using Dunnett's test (with the previously trained teams as a control) indicated that the mean score for the comparison group was significantly greater than the immediately trained group for General Orientation, Lack of Concern and Total AIFMTQ score (all $ps < .05$). No significant differences in mean scores were revealed between the Comparison group and the Delayed group.

Table 12. Untransformed AAFPQ sub-scale means (and standard deviations)

AAFPQ sub-scale	Quasi-experiment teams		Previously trained team
	Immediate group (<i>n</i> = 25)	Delayed group (<i>n</i> = 14)	Comparison group (<i>n</i> = 9)
Knowledge	16.44 (2.84)	16.57 (2.50)	17.89 (3.02)
Confidence	16.08 (2.29)	16.07 (3.08)	17.89 (3.03)
Support	20.20 (3.61)	20.36 (4.72)	23.22 (3.38)
Legitimacy	15.92 (1.96)	16.36 (2.79)	18.22 (3.35)
Motivation	22.96 (3.49)	25.36 (2.73)	25.78 (3.11)*
Self-belief	21.00 (3.92)	22.36 (3.77)	24.66 (3.24)*
Impact on the user	17.00 (2.10)	18.21 (2.39)	18.00 (3.12)
Total AAFPQ score	129.60 (14.54)	135.29 (17.67)	145.67 (19.89)*

Table 13. Untransformed AIFMTQ sub-scale means (and standard deviations)

AIFMTQ sub-scale	Quasi-experiment teams		Previously trained team
	Immediate group (<i>n</i> =25)	Delayed group (<i>n</i> =14)	Comparison group (<i>n</i> =9)
General orientation	37.52 (4.62)	40.00 (5.08)	42.22 (5.24)*
Confidence managing interpersonal issues	28.72 (5.02)	31.79 (5.59)	31.89 (6.47)
Lack of concern involving family members	18.96 (4.95)	22.29 (3.99)	22.67 (4.80)*
Perceived compatibility of needs	17.32 (4.06)	19.07 (3.29)	18.00 (4.03)
Total AIFMTQ score	102.52 (13.48)	113.14 (11.73)	114.78 (17.98)*

Notes: *Significantly greater than the Immediately trained group ($p < .05$).

The results presented here are discussed in the next chapter, after the proportion of staff's family-focused practice taking place among the teams during phase two is reported. As previous research suggests that changes in attitudes are likely to be important in bringing about changes in behaviour (Henry & Mark, 2003), it was important to examine the relationship between attitudes and the proportion of family-focused practice taking place within the groups as a result of the training package.

CHAPTER SIX

PHASE TWO: FAMILY-FOCUSED PRACTICE

INTRODUCTION

This chapter also reports the quantitative results from the main quasi-experiment in phase two of the research. The previous chapter reported staff attitudes towards family work following at key time-points within phase two. This chapter examines the impact of the training package on the proportion of family-focused work delivered within the teams. Levels of family-focused practice were collected using diary-snapshot methods at three-monthly intervals throughout phase two. Multiple comparisons between the Immediate and Delayed groups were then examined at key time-points before, during and after receiving the family-focused training package. Additionally, comparisons were made with the previously trained Team G and the quasi-experiment teams at the half-way stage of phase two.

The relationship between attitudes towards family work and levels of family-focused practice was then examined to investigate whether positive increases in attitudes predicted increases in the proportion of family work taking place within the teams.

A discussion of the results reported in this chapter, as well as those from the preceding chapter is then presented.

METHOD

Design

As explained in the preceding chapter, four teams (Teams C, D, E & F) participated in the main quasi-experiment during phase two. Teams C & D were randomly assigned to receive immediate training, and the remaining two teams (E & F) were randomly assigned to receive the delayed training package after a nine-month wait-list period. Using the diary-snapshot, levels of family-focused practice were examined at three-monthly intervals during phase two. This meant that diary data were collected across all four project teams at seven time-points (D1 – D7). The seven time-points are depicted in figure 13 and were the same for both Immediate and Delayed groups. The grey-shaded area indicates the nine-month training and supervision period for each pair of teams.

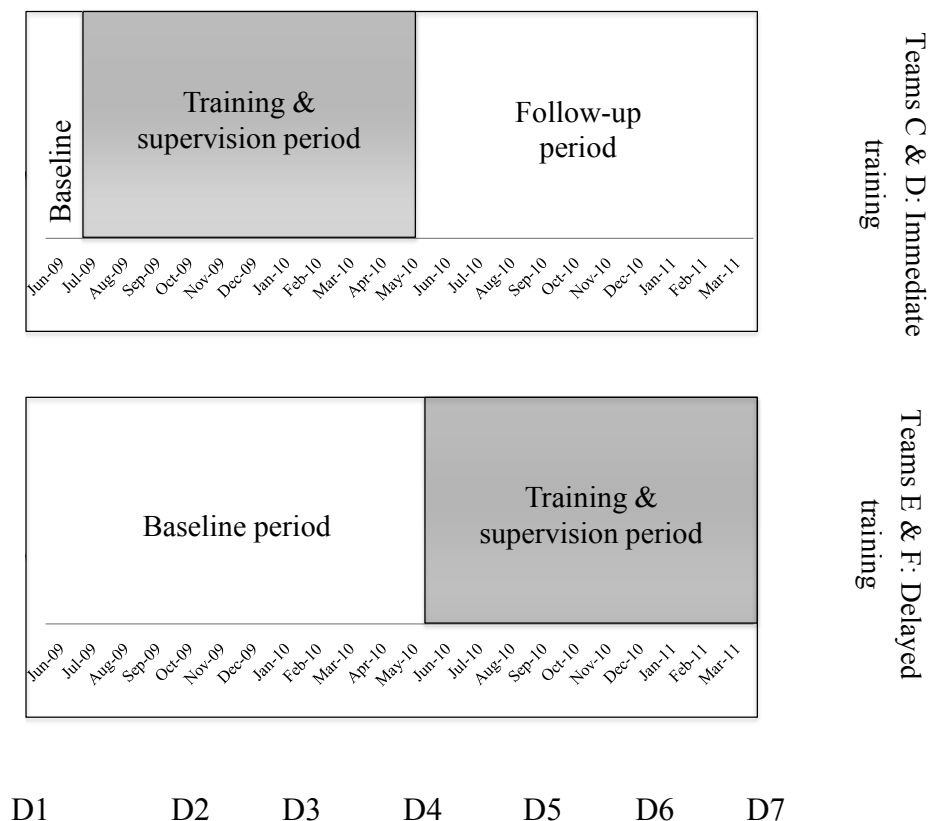


Figure 13. Phase Two - Diary-Snapshot Timeline (Seven Time-Points).

Diary-snapshot data were collected from a random sample of eight⁴ staff from each of the four teams during phase two. Microsoft Excel was used to randomly select staff. Staff were not aware of this frequency; instead, were advised that they may be asked to provide information on their practice behaviour at any stage during the project.

Time-points D4 and D7 were slightly different, however; being key points within the project. D4 was the half-way stage of phase two, and D7 was the final time-point within the research. Consequently, it was decided that it was important to understand activity taking place across the entire teams, rather than just a snapshot. Diary-activity data was, therefore, collected from all staff available within the four teams at these two key time-points. Additionally, diary-data were compared at D4 (the half-way stage in phase two) between the Immediate, Delayed group and the previously trained team G.

STATISTICAL ANALYSES

SPSS version 19 for Mac OX was used for all statistical analyses.

To compare the levels of family-focused practice taking place within the groups overtime and between groups, two-proportion z-tests were used to compare proportions of family-focused practice. The statistical analyses were the same as those used within the Pilot phase of the research.

⁴The teams varied in size meaning that at times some teams were made up of less than 8 staff. Although it was intended that 8 staff would be randomly selected, on occasions only 4 or 5 staff were available to complete the diary-snapshot.

Henry and Mark (2003) suggested that often it is assumed that attitudes will trigger changes in individual behaviours. It was, therefore, important to understand whether there was a relationship between these two factors. To examine whether attitudes towards family work predicted the proportion of family-focused practice taking place within the teams, a simple linear regression assessed whether total AAFPQ scores (x) were a predictor of the total proportion of family-work (y) taking place within the four project teams. Data collected at the halfway stage of phase two (T2) were examined with this method.

It was hypothesized that there would be a significant relationship between the two variables, with increases in attitude scores predicting higher levels of family work.

RESULTS

For clarity, the results section is divided into three sections:

- 1) Proportion of family-focused practice taking place within the quasi-experiment teams.
- 2) Comparisons of the proportion of family-focused practice taking place between the quasi-experiment teams and the previously trained Team G.
- 3) The relationship between attitudes and family-focused practice behaviour.

1) Proportion of family-focused practice taking place

This section reports the findings from the diary-snapshot during phase two, showing proportions of family work taking place within the teams at key time-points. Diary data were collected at the same time across staff working within the Immediate and Delayed teams across a total of seven time-points. Table 14 presents when diary-snapshot data were collected.

The shaded boxes indicate the periods during which the teams received the training and supervision package. Frequency and percentage data are presented for the two teams across the seven time-points.

For clarity, data collected from the immediately trained teams is firstly presented, followed by data for the delayed teams. Finally, comparisons between the groups at key time-points during phase two are discussed.

Immediately trained teams

It can be seen from table 14 that baseline data (prior to training) were collected at D1. The teams who were randomly assigned to immediate training (Teams C & D) went on to receive training and supervision; during which time diary data were collected at approximately three monthly intervals (D2 and D3). Following the conclusion of the nine-month period of training and on-going supervision, diary data were again collected (D4). Follow-up diary-data continued to be collected at three-monthly intervals (D5, D6, & D7); D7 being nine-months since the end of the training and supervision period.

It was hypothesised that the training and supervision package would lead to increases in the proportion of family work taking place within the teams, with increases being sustained following the end of the training package. Results supported the hypothesis, with overall proportions of family work taking place during the training and supervision period (D2 & D3) and post-training (D4) being significantly greater than baseline (T1). Furthermore, results revealed that proportions of family work continued to rise following the conclusion of the training package; with D7 being significantly greater than all six previous time-points.

The proportions of joint work involving a FC and family member were significantly greater post-training (D4) compared to baseline. Although there was some variation during follow-up, levels of joint family-work being carried out between D4 and D7 were generally sustained in the absence of training and supervision.

The proportion of FMs receiving support in their own right and other work involving FMs also showed steady increases throughout phase two (again showing some variation); with levels generally being significantly greater at post-intervention and at follow-up compared to baseline.

Table 14. Frequency and Percentage of Family-Focused Activity Taking Place within Immediate and Delayed Groups During Phase Two

Immediate Group (Teams C & D)							Delayed Group (Teams E & F)						
Time-point	N	Total work	³ Work involving FMs	Joint work with FC & FM	FM(s) alone	Other family work	Time-point	N	Total work	Work involving FMs	Joint work with FC & FM	FM(s) alone	Other family work
D1	14	124	18 (15%)	10 (8%)	6 (5%)	2 (2%)	D1	11	162	39 (24%) ³⁴⁵	29 (18%) ²³⁴⁶	4 (2%)	6 (4%)
D2	14	140	45 (32%) ^{1*}	5 (4%)	30 (21%) ^{15*}	10 (7%)	D2	13	148	23 (16%) ⁴	9 (6%)	10 (7%) ¹	4 (3%)
D3	7	76	28 (37%) ^{1*}	3 (4%)	18 (24%) ^{15*}	7 (9%) ¹	D3	9	146	20 (14%)	7 (5%)	7 (5%)	1 (1%)
D4	22	132	42 (32%) ^{1*}	21(16%) ^{26*}	15 (11%) [*]	6 (5%) [*]	D4	11	193	17 (9%)	14 (7%)	1 (1%)	2 (1%)
D5	10	103	29 (28%) ^{1*}	14(14%) ¹²	5 (5%)	10 (10%) ^{1*}	D5	10	91	9 (10%)	6 (7%)	2 (1%)	1 (1%)
D6	10	98	30 (31%) ¹	5 (5%)	19 (19%) ^{1*}	6 (6%) ¹	D6	11	103	26 (25%) ³⁴⁵	5 (5%)	8 (8%) ¹⁴	13 (13%) ¹²³⁴⁵⁷
D7	18	193	89 (46%) ^{12345*}	26(13%)	34 (18%) ^{1*}	29 (15%) ¹	D7	16	223	61 (27%) ²³⁴⁵	33 (15%)	7 (3%)	21 (9%) ³⁴

Notes: ¹Significantly greater than time-point 1. ²Significantly greater than time-point 2 etc. ^{*}Significantly greater than the Delayed group at the equivalent time-point.

³Frequency of work involving family members denotes a count of ‘encounters’ with family members regardless of whether these were brief or extensive.

Delayed teams

For those teams who were wait-listed to receive the training following a nine-month delay, it can also be seen from table 14 that baseline data were collected at D1 through to D4. The Delayed teams then went on to receive training and supervision, during which time diary data were collected at approximately three monthly intervals (D5 and D6). Following the conclusion of the nine-month period of training and on-going supervision, diary data were again collected (D7).

It was hypothesised that there would no increases in the proportion of family-focused practice during the wait-listed baseline period. Results supported the hypothesis, revealing that levels of family-focused activity reduced slightly during the baseline period, with levels of family-work at D3 and D4 being significantly lower than that D1. It was also hypothesised that levels of family-focused activity would increase during the training and supervision period compared to baseline. Again, this hypothesis was supported, with results revealing significantly greater levels of family-focused practice at D6 and D7 compared to the baseline period.

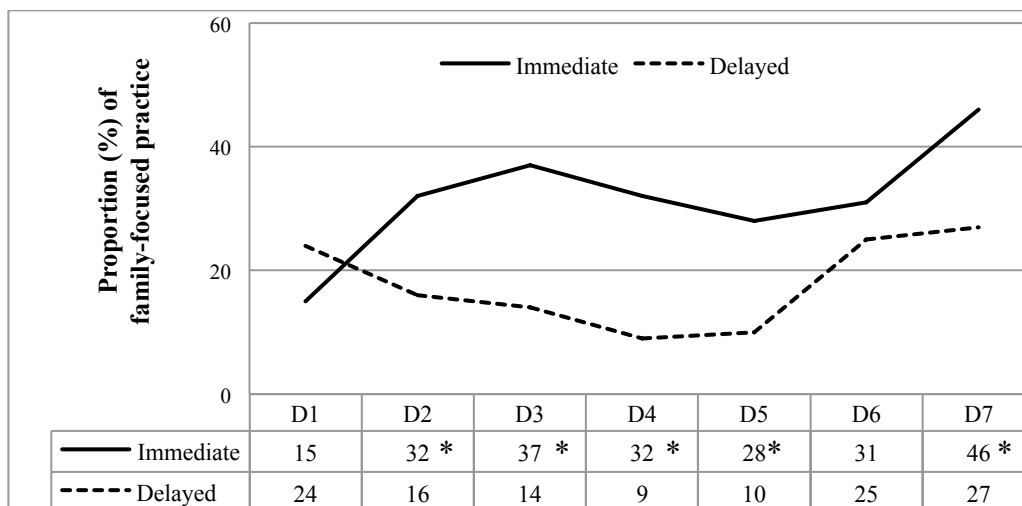
The proportions of joint work involving a FC and family member were not significantly greater post-training compared to baseline, in fact proportions were greatest at baseline, compared to all other time-points.

The proportion of FMs receiving support in their own right continued to be low throughout phase-two (between 1 – 8%), however, were greatest during the latter stages of the training and supervision period.

Finally, there no differences in other work involving FMs during the baseline period, however, increases were revealed during the latter stages of the training period, with levels at D6 and D7 being significantly greater than the baseline time-points.

Between-group differences

Between-group differences in proportions tests revealed that there were no differences in the levels of family-focused activity across the Immediate and Delayed groups at baseline (D1). Significant differences in levels of family-focused practice started to emerge, however, between the two groups early in phase two, with the Immediate group engaging in significantly greater levels of family-focused activity at D3 and D4. Furthermore, the immediately trained group continued to engage in significantly greater levels of family work during their follow-up period at D5 and D7, compared to the Delayed group during and post-training (figure 14).



Notes: *Significantly greater than Delayed comparison group at the equivalent time-point.

Figure 14. Proportion (%) of Family-Focused Practice During Phase Two

2) Comparisons of family-focused practice with previously trained staff

To compare the levels of family-focused practice taking place between the quasi-experiment teams and the previously trained Team G, two-proportion z-tests were again used. Table 15 presents the frequency and proportion of sessions involving FMs, joint work with FC and family member(s), family member(s) in their own right and other family work taking place at D4 (the half-way stage during phase two).

Table 15. Proportion of family work taking place (half-way stage of phase two): Quasi-experiment teams and comparison team

Team/Group	N	Joint work with FC & FM(s)	FM(s) alone	Other family work	¹Total family work	Total work
Immediate training (Teams C & D)	22	21 (16%)*	15 (11%)	6 (5%)	42 (32%)*	132
Delayed training (Teams E & F)	11	14 (7%)	1 (1%)	2 (1%)	17 (9%)	193
Previously trained (Team G)	9	8 (7%)	8 (7%)	1 (1%)	17 (14%)	122

Notes: *Significantly greater than comparison team (previously trained Team G) ($p < .05$)

¹Frequency of work involving family members denotes a count of 'encounters' with family members regardless of whether these were brief or extensive.

Note that at this time-point, the comparison team (Team G) had previously received a two-year package of family-focused training and support (completed just over two and a half years earlier), and the immediately trained team had very recently completed a nine-month period of training and supervision; whereas, the Delayed teams were yet to receive the training package.

Results revealed that the immediately trained teams were engaging in significantly greater levels of overall family work compared to Team G (32% vs. 14%). Furthermore, immediately trained teams were engaging in significantly greater joint work with a FC and family member(s), compared to Team G (16% vs. 7%). No differences were revealed between the team previously trained in family work and those yet to receive family-focused training.

3) Do positive attitudes towards family work predict increases in family-focused practice behaviour?

To examine whether attitudes predict the proportion of family work taking place, attitudes and diary-snapshot data provided from 31 staff across the Immediate and Delayed groups at T2 (D4) were examined. Note that both the Immediate and Delayed groups' overall attitudes towards family-focused practice had significantly increased at T2 compared to T1 (in the absence of the training package for the Delayed teams). Furthermore, significant increases in the proportion of family work taking place were also revealed at T2 compared to T1 for the immediately trained group. Yet, levels of family-focused activity taking place within the Delayed teams had not increased during the baseline period between T1 and T2.

Simple linear regression using the enter method was used to examine the relationship between attitudes to family work (x) (Total AAFPQ score) and the total proportion of family work taking place among the two groups (y) at T2 (D4). There was a weak significant negative relationship between attitudes and family-focused practice ($t = 2.83$, $d.f. = 30$, $p = 0.008$); however, the regression equation produced a very poor fit with the data ($R^2 = 0.12$), indicating that attitudes towards family work were not a good predictor of family-focused practice behavior ($F(1,29)$, $p = 0.056$) (figure 15).

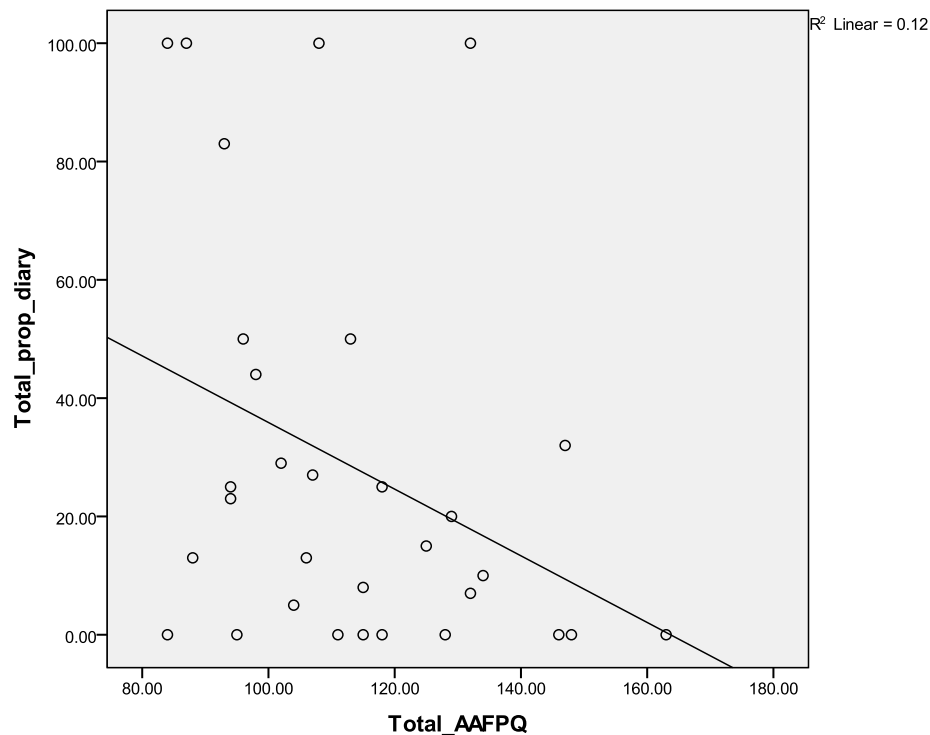


Figure 15. Relationship between attitudes and proportion of family-focused practice

DISCUSSION

This section examines and discusses the results from the current and preceding chapter. The results from the quasi-experiment which compared the impact of immediate and delayed family-focused training and supervision on staff attitudes and practice behaviour towards greater involvement of FMs in addition treatment are discussed. With regards to staff attitudes towards greater involvement of FMs, the findings were consistent with those from the Pilot phase, the previous IFM project (Orford *et al.*, 2009), and other previous research (e.g. Redhead *et al.*, 2011; Schweitzer *et al.*, 2007; Stanbridge *et al.*, 2009) in that attitudes

significantly improved following a programme of family-focused training and supervision. Yet, interestingly, these increases were not confined to training periods alone; instead, significant increases in attitudes were also revealed during the wait-listed baseline period for the Delayed group.

These findings mean that the ‘training’ aspect of the project cannot be fully accountable for changes in staff attitudes over time during phase two. Instead, there are a number of explanations for increases in attitudes in the absence of the training package. The first possibility is that the overall project design produced a social desirability effect or ‘Hawthorne Effect’ (a term coined by French, 1953), that perhaps the Delayed group exhibited a quasi-placebo effect, given some impetus to change their attitudes merely by completing the questionnaires. Related to this matter is the possibility of observer bias and lack of a double-blind, meaning that staff were exposed to the study hypotheses and project endpoints (either ‘consciously’ or ‘unconsciously’) which could plausibly have accounted for the improvement in attitudes prior to training. Such methodological issues are challenging to control when conducting research within an applied setting.

A more positive second possibility, however, is that the increased attitude scores, in the absence of the training and supervision, occurred as a result of a secular or Organisational culture change, affecting all staff working within the teams. That is, the presence of the research team promoting family work at the level of the individual teams had started to create an overall positive shift in philosophy and practices within the Organisation, with the introduction of family-oriented procedures and practices within the trained teams infusing or ‘contaminating’ teams waiting to receive training. Taking the real-life setting of the quasi-

experiment into consideration, this second possibility is the preferred explanation, since five out of the seven teams within the Organisation had received some training and supervision throughout the Delayed group's wait-listed period.

A further positive finding related to staff attitudes towards family work was found, whereby attitudes continued to rise during follow-up (in the absence of any training with the research team) within those teams who had received immediate training. In fact, by and large, the subscales and total scores for both questionnaires were at their highest at follow-up, approximately nine-months following the conclusion of the training package. This is also encouraging considering there had been large changes within the immediately trained teams, resulting in high staff turnover during phase two. During the latter stages of the training and supervision period, Team C had unfortunately experienced large amounts of redundancies as a result of losing their service delivery contract. Conversely, the numbers of staff working within Team D had considerably increased during their follow-up period, meaning that the results at follow-up incorporated the attitudes of new staff joining the Organisation, who were unlikely to have received training to work with FMs.

The findings here also revealed that the newly developed AIFMTQ detected differences in attitudes among the Immediate and Delayed group throughout phase two, whereas the AAFPQ did not. Interestingly, the Delayed group were found to be less concerned about involving FMs at baseline, compared to those staff trained immediately, who had recently concluded their nine-month training period. Additionally, the Delayed group's total AIFMTQ score was significantly greater than the Immediate group at the half-way stage of phase two, prior to the Delayed team receiving training. No such group differences were revealed from

the AAFPQ results, suggesting that the newly developed measure was working as intended, as a more sensitive measure being specifically developed to examine important areas of addiction treatment practice.

The comparisons between the quasi-experiment teams and the previously trained Team G revealed that, following nearly a two and a half year period since receiving a two-year family-focused package of training and support, Team G staff attitudes were greater in all sub-scales and total score for both questionnaires compared to the immediately trained group, and all but one sub-scale for both AAFPQ and AIFMTQ. These results provide longer-term support for Orford *et al.*, (2009) suggesting that Team G are, in fact, a team capable of acting as a demonstration site for family-oriented substance misuse treatment. Those staff working within Team G were found have significantly more positive attitudes towards family work, be more motivated, and have more self-belief in their ability to work effectively with FMs compared to those immediately trained staff who had recently completed the nine-month training period. These results could imply that either two-years of training leads to more positive attitudes compared to nine-months; and / or that initial implementation of family work is followed by full sustained implementation, consistent with Fixsen *et al.*, (2007), who argued that “implementation is a process, not an event”. As noted earlier, the immediately trained teams’ attitudes did continue to rise during follow-up, meaning that the comparison at the half-way stage of the project was too soon. The suggestion that nine-months training might be too short a time for successful implementation of family work is also discussed in the subsequent chapters.

The audit of diary activity using the diary-snapshot revealed significant increases in the implementation of family-focused practice within the teams during phase two, with increases evident during, immediately following the training package, as well as at the nine-month follow-up period. Results showed that the proportion of family-focused practice taking place within the Immediate group was at its highest at the final follow-up period (46%), approximately nine-months after the training package had concluded. This is a positive finding highlighting that the effects of the project were sustained over a substantial period of time, despite a large proportion of new staff joining the Organisation.

Another important finding, however, was the weak relationship between attitudes and practice behaviour. Consistent with Lewin, Glenman and Oxman (2009), competence in a skill does not necessarily predict its actual use; with the present results showing that increases in attitudes did not reliably predict or lead to increased levels of family-focused practice. The regression model suggested that attitudes only accounted for 12% of the variance in practice behaviour. The results highlighted that, despite being very positive towards family work prior to receiving training and supervision, the Delayed teams were engaging in very low levels of family-focused practice, which were consistently lower than the Immediate groups (despite having significantly more positive attitudes). These results suggest that other factors are at play in terms of enhancing or impeding family work. Beer, Eisenstat and Spector (1990) argued that even when the ‘grass-roots’ of an Organisation are positively changed, necessary structures and systems must also be aligned with the new practices that have been developed at the periphery, and when beliefs align with practices, the practices are more likely to be implemented (Charlesworth *et al.*, 1993).

Limitations

It is important to note the limitations of the analysis and results reported in this chapter. Firstly, these findings are unlikely to be representative of all professionals working in similar services. It is also possible that staff members from one team have more similar attitudes than members at different localities. Furthermore, the development of the diary-snapshot is still in its early stages and is not standardised. Additionally, the regression model was based only on one-time-point.

It could be considered a limitation that the training package was examined among the larger groups as a whole, rather than examining intra-team differences among the Immediate or Delayed groups, and whether those attending all elements of the training were more positive towards family work than those attending a limited number of consultancy meetings. However, the quasi-experiment attempted to examine the overall picture of the impact of the training package over time, even though not all staff may have been trained.

Finally, the explanations for some of the findings reported here are difficult when considering the quantitative results alone. The next chapter examines the qualitative results of the staff's experiences of the project, whereby common factors which appeared to be enhancing or impeding family work are presented. Taken together, the findings can then be integrated, with their implications being more fully discussed in the final discussion chapter.

CHAPTER SEVEN

QUALITATIVE ANALYSIS AND RESULTS

This chapter reports the qualitative analysis and results from the research. The chapter has two broad aims and is divided into two sections. The first section reports the experiences of the frontline staff and managers regarding the common factors that appeared to be facilitating or impeding family work. Data captured during the eight supervision meetings among the six project teams were pooled and qualitatively analysed.

The second section of the chapter reports the qualitative analysis of discussions with the Steering Group Committee during the project. In conducting action research within an Organisation, it was important to have ongoing discussions with a Steering Group Committee. Such discussions allowed critical discussion and reflection to ensure the findings from the research were useful to those delivering the services and those who were governing the Organisation. It was mentioned in Chapter two that the Steering Group Committee met approximately every three months throughout duration of the project. The second section of this chapter, therefore, reports the principal lessons learned for the Steering Group members throughout the course of the project, as well as the strategies used to overcome obstacles related to family work.

STAFF EXPERIENCES OF WORKING FAMILY-INCLUSIVELY FOLLOWING TRAINING

INTRODUCTION

There is a wealth of literature suggesting that the implementation and sustainability of an intervention is dependent upon the perceptions of the users (in this case the trained staff) of that intervention (e.g. Crais, Roy & Free, 2006; Kitson, Harvey & McCormack, 1998; Millhouse-Pettis, 2012). Such studies have consistently identified the importance of service provider beliefs about effectiveness of interventions (Gotham, 2004, Gadowski, Wolff, Tripp, Lewis & Short, 2001; Forman et al., 2002); service provider confidence and self-efficacy (Kaner, Lock, McAvoy, Heather & Gilvarry, 1999; Nilson, Aalto, Bendtsen & Seppa, 2006; Prinz & Sanders, 2007); and concern regarding client acceptance (Addis, Wade, Hatgis, 2006; Spinola, Stewart, Fanslow & Norton, 1998). Furthermore, a lack of adequate guidelines to help organisations prepare staff to implement evidence-based interventions has also been highlighted (Glasner-Edwards & Rawson, 2010; Oxman & Flottorp, 2001; Sholomskas *et al.*, 2005).

Recent studies specifically examining staff experiences of implementing family work within addiction treatment services have highlighted barriers and enablers of family-focused work at the level of the service provider; the substance user and family; and the Organisation (Lee *et al.*, 2012; Williamson, Smith, Orford, Copello & Day, 2007). Few studies have, however, used qualitative methods to examine staff experiences of implementing family work across an entire Organisation, following a substantial period of family-focused training and on-going supervision. Therefore, the aim of the qualitative analysis reported in this section was to

‘unpack’ some of the processes involved in implementing family-focused practice. The results here also aided the interpretation of the quantitative results reported in Chapters three and five.

Qualitative approaches undertaken alongside randomised controlled designs to change organisational practice are uncommon (Lewin *et al.*, 2009). Yet, qualitative approaches are particularly useful in the evaluation of the effects of interventions involving behavioural change processes that are difficult to capture using quantitative methods alone (Curry, Nembhard & Bradley, 2009). Applying qualitative methodologies provides the necessary in-depth and exploratory tools to achieve a clear picture of the implementation processes and contextual influences (Patton 1987; Ritchie 2003). It was hoped that by analysing the words and detailed views of the trained staff, a more complete picture of the varying rates of implementation of family intervention would be generated.

METHOD

Design and procedure

In an attempt to fully elucidate the common factors helping to enhance or impede family work, the results and analysis reported in this section aimed to bring together the experiences from all six teams trained throughout the project. Qualitative data were collected throughout the eight-month supervision period for each of the six teams, meaning that data from a total of 48 group discussions capturing during the consultancy meetings were combined.

The consultancy meetings were intended to provide on-going supervision related to family work, as a way to ensure staff were confident and comfortable with working with family members (FMs). The meetings also provided the chance for staff to voice any concerns, and to work through any issues using role-play, refresher training and discussion with their peers. Each consultancy meeting lasted approximately 90 minutes. Staff were made aware that their views and comments would be noted down or recorded anonymously. Staff were also made aware that group data would be analysed, rather than input from individual members of staff.

Each consultancy session was exploratory in the sense that staff were encouraged to discuss their views and experiences in an open way, with any questioning from the research team being responsive to the staff experiences and attitudes. The research team occasionally prompted discussion, however, by and large, it was expected that staff would raise agenda items for each meeting.

Table 16 displays when each consultancy meeting took place and how many staff attended each meeting. During the Pilot phase detailed notes and verbatim were documented by the author. During Phase two, a digital recording device was used to record the meetings in order to ensure maximum accuracy of the discussions. The recordings were then fully transcribed. Anonymity was assured by removing all names of staff, FCs and FMs.

Research setting and sample

The characteristics of the staff at the beginning of their nine-month training and supervision period was presented in Chapter two (see Table 3, page 83). All members of the team were invited to attend the eight consultancy meetings. Some teams had high staff turnover, meaning

the consultancy meetings were often the first time new members of the teams had heard about the project. Some staff were unsure what the consultancy meetings were about, or why they were being asked to attend. The meetings were, therefore, a chance for these staff to hear about the project, family work in general, and any new developments taking place within their service.

Choice of qualitative methodology

As the prime intention was to describe and interpret what was being discussed among the teams over the course of the eight-month supervision period, Framework Analysis (Ritchie and Spencer, 1994) was thought to be the most appropriate qualitative methodology for this process. Framework Analysis was explicitly developed in the context of applied policy research and is an approach that is particularly helpful for policy-relevant research by providing outcomes or recommendations (Yin, 2003). Although the findings from this particular project could be tested elsewhere, Framework Analysis is a useful method when the primary concern is to describe and interpret what is happening in a specific setting (Srivastava & Thomson, 2009). Framework Analysis also allows large amounts of qualitative data to be systematically organised and displayed.

Table 16. Consultancy Meeting Month and Number of Staff Attendees

PILOT TEAMS						IMMEDIATE TEAMS						DELAYED TEAMS					
<u>Team A</u>			<u>Team B</u>			<u>Team C</u>			<u>Team D</u>			<u>Team E</u>			<u>Team F</u>		
Meeting no.	<i>N</i>	Month / Year	Meeting no.	<i>N</i>	Month / Year	Meeting no.	<i>N</i>	Month / Year	Meeting no.	<i>N</i>	Month / Year	Meeting no.	<i>N</i>	Month / Year	Meeting no.	<i>N</i>	Month / Year
1	5	Nov-08	1	6	Nov-08	1	5	Sep-09	1	16	Sep-09	1	7	Jul-10	1	8	Aug-10
2	7	Dec-08	2	13	Jan-09	2	5	Oct-09	2	18	Oct-09	2	7	Aug-10	2	5	Sep-10
3	5	Jan-09	3	11	Feb-09	3	5	Nov-09	3	19	Nov-09	3	4	Sep-10	3	6	Oct-10
4	4	Feb-09	4	9	Mar-09	4	5	Dec-09	4	19	Jan-10	4	4	Oct-10	4	8	Nov-10
5	7	Mar-09	5	10	Apr-09	5	9	Jan-10	5	16	Feb-10	5	5	Nov-10	5	10	Dec-10
6	7	Apr-09	6	9	May-09	6	6	Mar-10	6	12	Mar-10	6	3	Dec-10	6	5	Jan-11
7	7	May-09	7	8	Jun-09	7	3	Apr-10	7	13	Apr-10	7	5	Jan-11	7	6	Feb-11
8	5	Jun-09	8	7	Jul-09	8	3	May-10	8	15	May-10	8	7	Feb-11	8	9	Mar-11

The analytical process

Ritchie and Spencer (1994) propose that Framework Analysis involves five distinct, yet highly interconnected stages:

1. ***Familiarisation***. Familiarisation with the data was achieved by reading the transcripts in their entirety several times. Combined with this, it was important to read any observational and summary notes that had been recorded during each meeting. This stage involved being immersed in the data to try to get a sense of each consultancy meeting as a whole, before breaking them down into parts. The initial themes for each meeting began to emerge during this process.
2. ***Identifying a thematic framework***. By writing memos and short phrases in the margin of the transcripts, the initial themes began to develop into categories.
3. ***Indexing***. Here the emerging categories were labeled by highlighting quotes and making comparisons across the transcripts.
4. ***Charting***. This was the first step in managing the data. Quotes were lifted from their original context and rearranged under thematic chart headings. One of the most important aspects of this step was comparing and contrasting data and cutting and pasting similar quotes together. Krueger & Casey (2000) advocated the use of either a long table or a computer-based approach for cutting, pasting, sorting, arranging and rearranging data. Although there is software available to aid the analysis, it was possible to analyse the transcripts using Microsoft Excel. During the charting process, it was important to include relevant information alongside the quotes, such as which team had provided the quote when (during consultancy meeting 1 – 8).
5. ***Mapping and interpretation***. Following the charting, the final stages of mapping and interpretation involved examining the relationships between the quotes and the links

between the data as a whole. By exploring the patterns and key issues grounded in the data, the major themes emerged and were summarised into five Excel worksheets.

These five matrices can be found in Appendix 14 (enclosed CD).

Following the five analytic stages, it was also possible to incorporate a method similar to directed content analysis (Graneheim & Lundman, 2004; Hsieh & Shannon, 2005) to examine the incidence and pattern of consensus of the themes. The frequency of the themes and sub-themes were counted to highlight the most common or ‘significant’ facilitators and barriers to the implementation of family-focused practice. Research has shown that enumerating qualitative data provides richer information than would be ordinarily obtained by using qualitative analysis alone (Sandelowski, 2001; Onwuegbuzie, Dickinson, Leech & Zoran, 2009).

RESULTS

Initial coding of the 48 transcripts led to 677 initial topics being identified. These initial topics were categorised into 54 sub-themes (see Table 17), which were further organised to fall under five salient themes:

- 1) **Staff commitment to family work**
(I see the value of family work and am being proactive to maximise involvement of family members);
- 2) **Culture shift**
(I have picked up on an attitude shift and family members are starting to be involved....the big change has come.....’ there’s been a fundamental psychological shift);
- 3) **Concern about family work**
(What do I physically do in a session when there are arguments in the room?....My general anxiety is am I skilled enough to work with DV, bereavement, conflict in the room?);

4) Priorities

(Our service level agreement isn't necessarily permissive of family work);

5) Expectations of family work

(I feel there is a tension about the way we work within these family sessions and what we are meant to be doing as a practitioner).

The results are presented under the five main headings, each heading corresponding to a salient theme within the discussions with the staff, with themes and sub-themes being discussed in order of significance. There is not room here to discuss all sub-themes emerging from the analysis; instead, for purposes of brevity, only the five most significant sub-themes within each main theme are discussed. Likewise, only a limited selection of the many exemplar quotes is provided.

Direct extracts provided by the staff are presented in italics. Additional words used to clarify the quotes are included within square brackets. To show where the quote was obtained from, the team and consultancy meeting month are provided alongside each quote (e.g. A:2 or C:5) as well as the job role of the member of staff.

Table 17. Themes and Sub-themes to Emerge from Consultancy Meeting Discussions

Theme 1	Superordinate theme	Subtheme
Staff commitment	1.1 Family focused practice improves outcomes for all	1.1.1 Seeing the benefit
		1.1.2 Influencing the substance user
		1.1.3 Appreciating family members need support in their own right
		1.1.4 Improved communication between FC and FM
	1.2 Importance of working creatively and flexibly	1.2.1 Importance of creating a family-focused environment
		1.2.2 Being pro-active to maximise family work
		1.2.3 Importance of advertising the work
		1.2.4 Need a thorough and consistent recording system
		1.2.5 Overcoming initial fears
		1.2.6 Creating family-focused language
		1.2.7 Importance of a whole-team training approach
		1.2.8 Importance of family-focused corporate literature
		1.2.10 Using imaginary social networks
		1.2.11 Managing confidentiality
		1.2.12 Normalising the situation
	1.3 Sustainability of family work	1.3.1 Hoping family-focused practice will continue to grow
Theme 2	Sub-theme	
Culture Shift	2.1 Appreciating the training package	
	2.2 Benefiting from on-going support	
	2.3 Positively influenced attitudes	
	2.4 Overcoming concerns	
	2.5 Positive changes in practice behaviour	
	2.6 Routine involvement of FMs	
	2.7 Outside services starting to recognise shift in focus within organisation	
	2.8 Great to have permission	
	2.9 Funding/ commissioning	
Theme 3	Sub-theme	
Concern	3.1 Anxiety / lack of skills	
	3.2 Issues with confidentiality	
	3.3 Inappropriate family / network member	
	3.4 Family members disrupt the session	
	3.5 Need tailored supervision	
	3.6 Suspicion of domestic violence	
	3.7 Cultural issues	
	3.8 Not fully grasping SBNT	
	3.9 Conflicts of interest	
Theme 4	Sub-theme	
Priorities	4.1 Funding / commissioning	
	4.2 Lack of time and resources	
	4.3 Recording	
	4.4 Family work not acknowledged or valued in outside organisations	
	4.5 Preference to work individually	
	4.6 Areas of the service with limited FM contact	
	4.7 Family-focused practice not yet automatic	
	4.8 Easier for staff when work kept separate	
	4.9 Takes time to change practices	
	4.10 New staff seeing family work as integral in their role	
Theme 5	Sub-theme	
Expectations	5.1 Meeting resistance	
	5.2 Conflicting expectations	
	5.3 Misconceptions of family work	
	5.4 FMs need educating	
	5.5 Organisational expectations	
	5.6 Feedback from FMs	
	5.7 Cultural issues	
	5.8 Home visits	
	5.9 Over-engagement of family members	
	5.10 Managing expectations	

Staff Commitment to Family Work

This theme was by far the most significant to emerge from the discussions across the six project teams. This theme appeared to depict the air of optimism to the new way of working having been given the permission to work inclusively with FMs. Most staff reported feeling hopeful that increases in the levels of family work would be maintained following the completion of the project, and that family work would continue to develop in the future.

Because Theme one was such a prominent and complex theme, it was further broken down into three sub-ordinate themes: family-focused practice improves outcomes for all; working creatively and flexibly; and sustainability of family work. Each sub-ordinate theme is discussed below.

Family-Focused Practice Improves Outcomes for All

Seeing the bigger picture

Prominent among the discussions was the appreciation of the benefit of *seeing the bigger picture* of which the focal client (FC) was a part. Appreciating there would be challenges in adjusting to a very new way of working, there was recognition that it was important to consider the FC's wider context and network. Rather than solely focusing on the individual substance user, working jointly with FCs and FMs in a treatment session had allowed staff to witness the benefits first hand:

*I had a session where a Mother and Daughter let some stuff out. At the end of it they got up and hugged each other, apparently for the first time in 5 years.
(A:3 - Manager).*

Positively influencing the substance user

A strong sub-theme concerned the positive influence of FMs in helping the substance user to modify their drinking, drug taking or gambling behaviour. Family member involvement was found to be particularly beneficial in helping the substance user to continue to remain engaged within the treatment process. A frequent term mentioned among the discussions was DNA (did not attend), with many FCs forgetting about scheduled appointments due to slips or lapses in their substance use. However, by allowing FMs to attend appointments, levels of non-attendance were not only reduced but family sessions brought *accuracy* into the sessions:

I was asking about the [focal] client's history as the client had forgotten most of it..... the assessment and the paperwork....she [the drinker's Wife] was just really useful in terms of helping him to remember his appointment and various things.
(E:1 – Alcohol Practitioner).

He was honest as you've got two perspectives in the room.
(B:1 – Alcohol Practitioner).

Family members need support in their own right

Being exposed to the philosophy and process of family work had allowed staff to see success in alleviating levels of stress within the family as a whole. There was also an appreciation of the importance of providing support to family members in their own right, irrespective of whether the FC was engaged in treatment:

I think any family member living with that complex individual needs support from us acknowledging that.
(A:6 – Alcohol Practitioner)

When the family member has read the [self-help] manual twice in the waiting room before the session, you know they're stressed and they need support in their own right
(B:3 – Family Alcohol Worker).

Improved communication between focal client and family member

Relationships between the FC and FM(s) had often broken down due to substance misuse. However, it was reported that ensuring the family member was involved in the on-going treatment process had allowed communication to be improved, particularly when working with couples. Sometimes FMs were satisfied having attended just one or two sessions, allowing FMs to realise the FC was attempting to change their substance use and were continuing to attend appointments. Joint sessions with a FC and family member had also allowed all parties to appreciate the 24/7 support FMs were able to provide to the substance user:

The wife now doesn't feel like she needs to come along as she trusts him. She's satisfied that he's seeing someone and she doesn't need to be involved any longer. (A:5 – Alcohol Practitioner).

It's not just an hour a week support from us, it's suddenly constant support at home for them.....in the back of your mind you feel, yeah they're going to give them that support and it really is encouraging when you get them on their own, or even when they're separate you sometimes get totally different stories, but at least if you've got them together they hear each other. (D:5 – Alcohol Practitioner).

Working Creatively and Flexibly

Having appreciated the need to improve outcomes for FCs and FMs, staff were working flexibly and creatively in an attempt to maximise the involvement of FMs. Working family-inclusively was a completely new approach for the majority of staff, e.g. working with more than one person in a room, or working with different FMs at different times during the treatment process. The extracts provided here capture a whole range of areas where staff were seen to be adapting their way of working, appreciating the need to be flexible.

Creating a family-focused environment

It was noted how the Organisational premises were predominantly set-up for one-to-one sessions with the FC, and that physical changes to the services would be needed in order for the reception, waiting room and treatment rooms to become more family-friendly. Ensuring that FMs felt welcome within the services was considered important, particularly those needing to bring their children along to appointments. There were various suggestions including having toys and books in the waiting room, a stack of self-help manuals available in the waiting area for FMs to read and take away with them, as well as the need for a family section on the Organisation's website and relevant family-focused corporate literature being produced. Such suggestions highlighted a solution-focused and creative attitude towards family work:

*The rooms are set up for individuals. If we could have mini-chairs or sofas they [FMs and FCs] could feel instantly relaxed.
(B:6 – Assistant Manager).*

*We need to have a room set up for families with children.
(C:2 – Social Work Trainee).*

Being pro-active to maximise family involvement

Considering that it might take a while for the new family-focused approach to be accepted as the norm, staff appeared to be proactive in promoting family work. This was seen to be particularly important early on in the treatment process, perhaps the very first time a FC was attending for their initial assessment. Staff were also reporting how they were opportunistic in terms of integrating family work into one-to-one sessions with a FC, and that FMs did not have to be physically present to be involved in the session:

*If your Mother were here now what would she say?
(B:1 - Manager).*

You're working with them, even if you don't see them.

(E:6 – Support Worker).

I ask them [focal clients] if your brother called me, could I talk to him? I'm proactive in searching around.

(A:4 – Alcohol Practitioner).

Finally, in order to see benefits of involving FMs, staff appreciated that the process may be lengthy, and that positive change might not happen immediately:

I'm hopefully going to work around the whole family until I get good outcomes for all.
(B:2 – Alcohol Practitioner).

Sustainability of Family Work

Hoping family-focused work would continue to grow

The final sub-theme related to staff commitment was sustainability of family work, with staff discussing the hope that family-focused practice would continue to develop. During the latter stages of the on-going supervision period, there were often discussions related to the formal input from the research team coming to an end, where staff were looking to the future, with some teams were looking to pilot a relatives' support group, and other teams were agreeing that family work should be a standing item on future team meeting agendas. There were also discussions related to changes within the Organisation and how treatment sessions would soon be delivered in outreach and community settings, where family work would be particularly important. Such suggestions highlighted that staff were aware of the importance of ensuring that family work became centrally integrated into the existing structures, policies and procedures within their services. Interestingly, suggestions for moving forward tended to come from the managers within the services:

We will be asked to engage in assertive outreach and families are the way through....I believe this is as so helped us to start to see it from the family's point of view, to be

*able to say yes I understand what this has been like for you and to be able to assess their needs. Everything we do will be mirrored with families.
(C:6 – Manager).*

*I am looking at almost a surface redesign and looking at structured groups and unstructured groups of activities and part of that is putting together a family group that family members can access within their own right so that people have their own space to talk about their own issues..... we're not going to separate things out but sometimes I think there's a need for specifics of what is it that families and carers need.....So we can certainly keep that on the agenda so it keeps the family focus.
(E:8 - Manager).*

Culture Shift

This second theme highlighted the beginnings of a culture shift, both in attitudes and practice behaviour, from solely thinking about and supporting the individual substance user towards a more family-oriented philosophy. Discussions during the early stages of the on-going supervision period showed how staff were reporting how family work was becoming much more 'the norm'. It was mentioned how involvement of FMs might have happened very rarely in the past, however, it was now much more immediate. Staff were also recognising that outside Organisations had started to acknowledge the value of family-inclusive addiction treatment.

Appreciating the training package and benefiting from on-going support

Staff reported how their work with FMs was now much more focused, and that the training had brought along some structure to the very limited and patchy family work that had previously taken place. It was discussed how training and supervision had helped to 'keep the family work alive' until family-focused practice was fully integrated into routine practice. Some staff commented on how family work was now much more in the 'front of their mind'. The importance of the continued support from the research team was also reported. It was felt

that simply attending a one or two-day training event or workshop would not have been sufficient to achieve such great changes in the beliefs and practice behaviour of the staff:

Nothing comes of a one-off model workshop. It needs a follow-up intervention.
(C:2 - Counsellor).

The meetings are a useful as a constant reminder. It's good having the contact. I need the contact.
(A:3 – Alcohol Practitioner).

Positively influenced attitudes to family work and overcoming concerns

Previous reservations about family work were discussed, with staff admitting that they had previously avoided working with FMs, and had instead stuck to what they knew best. However, having been provided with a substantial amount of training and supervision, including role-plays and case study exercises, staff commented on how they were now starting to overcome some of their initial fears, and that their perceptions of family work had been positively altered:

I was scared to begin with. Before I thought I won't get involved in this....I thought it might be damaging in a way, but later realised not.
(A:4 – Alcohol Practitioner).

Positive changes in practice behaviour

Routine family-focused practices were now being acknowledged and valued, and there was a recognition of the need to record the family work that was taking place. Very early on within the on-going supervision period it was also mentioned how the assessment documentation had been amended to consider FMs, including the recent addition of a network diagram at the back of the FC assessment pack:

All the informal phone calls to family members, we're recording all that. The whole assessment forms have changed. The triage pack now includes a form assessing the

client's network and an affected others form. We noticed that we hadn't recorded the phone calls, but going forward admin are aware of a need to record all the data.
(C:1 – Senior Counsellor).

Now the service is flexible enough that we can always offer our services to family members who may not ever come, but that's an intervention in its own right. A telephone call can sometimes be a lengthy intervention, that until now I didn't recognise it as being that important.
(E:3 – Senior Counsellor).

Concern and Difficulties Related to Family Work

The two preceding themes were made up of sub-themes describing factors facilitating family-focused practice, with staff recognising the importance of involving FMs and being flexible and proactive to ensure family work was taking place. However, this third theme highlighted factors likely to impede family-focused practice. This section reports the concerns and difficulties staff were facing related to family work. A lack of skills and a general anxiety towards family work was raised, with staff also feeling concerned about FC confidentiality and conflicts of interest for the practitioner when working with more than one member of family. Staff also described how they had experienced inappropriate family or network members being brought along to appointments, with suspected domestic violence between the FC and family member being discussed in some cases. Due to such concerns, some staff reported how their preference to working remained focused on the individual FC. Furthermore, some staff felt that the family-focused training package had focused too much on simple straightforward scenarios with families, rather than preparing them for worst-case scenarios. Even following the nine-month training and supervision period, some staff voiced concerns about the need for more training that was tailored to prepare staff to deal with 'complex' or 'dysfunctional' families.

Anxiety / lack of skills to work family-inclusively

Some staff reported feeling anxious and unsure of how to handle arguments and conflict in a session should the situation arise. Additionally, some staff felt confident to work with FMs in their own right, however, felt there were gaps in the training related to working jointly with a FC and FMs:

What do I physically do in a session when there are arguments in the room? My general anxiety is am I skilled enough to work with DV, bereavement, conflict in the room? Skills like how do you manage couple behaviour?
(B:6 –Manager).

The project has given us clear guidelines for individual client work or a family in their own right but it's the bit in the middle and the techniques in setting the ground rules we haven't quite got yet.
(C:8 - Manager).

Issues with confidentiality

There were also cases whereby a FC may have previously disclosed confidential information during a one-to-one with their practitioner, which staff felt later created issues with confidentiality if a family member were to attend subsequent sessions. Staff felt they were often left to hold or manage partial information, unsure of whether such information had been previously shared between the FC and family member. Such a feeling led staff to sometimes feel they were colluding with different members of the same family:

We've had it rammed down our throats, be careful of the confidentiality, careful not to give anything away.....it makes it frustrating and complicated if you can't disclose any information, especially if a FM gives you some information you didn't know before. You can't un-hear something.
(A:4 – Alcohol Practitioner).

Inappropriate family / network members

Finally, having encouraged a FC to bring along a family or network member, it was difficult for staff to manage a situation in which an inappropriate or chaotic network member had been brought along to the subsequent session. Staff worried about sending out mixed-messages to FCs by first encouraging them to bring along a friend of family member, and then having to explain that the family member was unlikely to be supportive of change. There were even concerns that family sessions might be unsafe, with FMs being involved in sessions without being screened first:

Her friend has some joint goals, but he is bipolar and a chaotic crack user. I'm not sure if these people should be coming into the sessions....he storms out of the session. He's not very supporting in the sessions.
(B:3 – Senior Alcohol Practitioner).

Without screening them or assessing them you might just find that you're plonked down and you're working with it. And if you don't handle it well it can feel quite unsafe.....potentially it is bordering on dangerous even, and I think we have to be very experienced to do the work to be honest.
(E:8 – Senior Alcohol Practitioner).

Family members disrupt the session with the focal client

Finally, there were concerns that sessions were more difficult when clients brought their FMs to the initial assessment session, and that FMs were almost considered an inconvenience by disrupting the session:

I took on your advice thinking I'll invite the client's Mum in, and it was a bit disastrous.....it just became, for her [family member] anyway, a real opportunity to rant and rave at the client..... now I've decided to see the client without the Mother as the session was a lot more productive when Mum was not present.
(F:1 – Primary Care Practitioner).

I have had situations where I've had to ask the client to come alone because there has just been arguments, and you actually see why this woman is drinking, because this bloke [family member] would drive me to drink.
(F:3 – Alcohol Practitioner).

Priorities

This theme highlights how often, despite the best efforts of the trained staff, the prevailing policies, procedures and structures that governed the Organisation often remained solely focused on the individual substance user, sometimes hampering their efforts to become more family-focused. For the most part, this theme highlights factors likely to impede family-focused practice due to the way the Organisation, its stakeholders and the wider health care system were driven by targets that prioritised the FC over affected FMs. Although the discussions highlighted some evidence of an encouraging shift in focus from some commissioners and outside Organisations, the five foremost sub-themes to emerge from the discussions demonstrated an uphill battle to achieving routine family-focused practice when training and supervising staff within one Organisation.

Funding / commissioning of family work

The key sub-theme within this theme was related to funding and commissioning of family work. The importance of ensuring the service commissioners acknowledged the value of family work was raised. It was felt family work needed to be included in the service level agreement (SLA) to allow more time and funding to be allocated to be able to legitimately work with families:

Our SLA isn't necessarily permissive of family work.
(C:4 - Manager).

It could have been a long history of angry family backgrounds. It doesn't fit into the cycle we're funded for.
(B:6 – Alcohol Practitioner).

Although part of the same Organisation, the six teams were commissioned separately. Encouragingly, one team reported that their commissioners were becoming much more open

and accepting of family work, which had actually enabled two family workers to be employed to specifically support affected FMs in their own right. Furthermore, another team reported being able to be more flexible when working with FMs due to the team's commissioners not specifically stipulating who should be receiving treatment and support:

I had some conversations with the commissioners over the last few months and one of the things that we discussed was the family work and that this is going to be included in our new service spec offering services to FMs, that will be part of our SLA.
(D:4 - Manager).

They [commissioners] want numbers, as in they want high numbers of people through the service.....they're not saying drinkers so I think it's for us to perhaps call that one because we could say it's equally relevant that we see relatives that we see drinkers.
(E:4 – Manager).

Lack of time and resources

Staff reported difficulties with family sessions due to constraints of space and time. Staff were used to having a set amount of time to work one-to-one with an individual FC during an assessment or follow-on appointment. Yet, the same amount of time was often allocated to work with two or more people, with each person expecting to tell their side of the story. Staff were concerned that having more than one person's perspective to hear and address meant issues were sometimes unresolved by the end of the session:

I did have a joint session with Mum and Son. I like the challenge but am struggling to fit it in.
(D:1 – Alcohol Practitioner).

You're at this point what do you do next?.....I don't want to go too far down this route because I've only got X amount of time to do it in.
(D:5 – Alcohol Practitioner).

Family work not valued outside of the Organisation

Although FMs were being viewed as clients in their own right within the trained teams, it was recognised that this view might not be shared outside of the Organisation. The nature of the staff's work often meant liaising with outside services including primary care, social services, residential services etc. Staff reported how involving FMs had led to clashes with outside Organisations due to their dominant individualistic focus. It was mentioned how there was a sense of 'competing' for FMs as clients, or that family work was coming to a standstill:

The work is coming undone due to other work taking place outside the service.....It's tough, my work with the family has involved more openness, more than what someone gets going to a drug service, more than just their script. But am I stepping on anyone's toes?..... the drug services are saying 'hang on, that's not your client'.
(B:4 – Drug Practitioner).

GPs don't pick up on the family members' own right.
(A:4 – Primary Care Practitioner).

Preference to work individually

There was evidence that some viewed individual work with a FC as their priority:

A one-to-one can be quite precious and that's my preference to working."
(B:4 – Manager)

That's how I work when I'm doing an assessment, I want to do the assessment with the person on their own, to give them that privacy and that space, and work with their agenda.
(D:3 – Senior Practitioner).

We are trying to be inclusive saying if you would like to bring a FM, we're suggesting that that is okay for them to come into the session and you can see at the end there are time boundaries.....they could sort of feel like they haven't had the space but it's not actually their appointment.
(D:6 – Senior Practitioner).

Recording family work

Throughout the course of the current project, staff reported how some of the centralised assessment documentation and procedures had been amended by the management team in an attempt to become more family-focused, including a family member assessment form and the aforementioned network diagram within the FC assessment triage. However, it was reported that the network diagram was the only part of the assessment that was voluntary, meaning staff would often leave it blank. Staff also mentioned that if it was completed, it would rarely be referred to in subsequent sessions. The centralised procedures for recording assessment and follow-up sessions were also predominantly set-up to record FC activity, rather than family sessions:

*There is no facility in the new Illy system [recording database] to record family work.....we need a facility to record family work.
(C:5 - Manager).*

*The social network diagram at the back, I mean I like that, but it's having the time to fit it in. The other problem being that if you're out at surgeries you don't have the paperwork with you because it remains here, so you haven't got that piece of paper with you.
(E:6 - Counsellor).*

Expectations of Family Work

The final theme related to expectations of family work, demonstrating how the staff often had to manage conflicting expectations regarding family work. There were often misconceptions about what constituted family work, with FCs, FMs, outside services and commissioners often holding opposing views. Staff often described how their efforts to work family-inclusively met resistance from FCs and/or FMs, who expected that the service would offer a one-to-one confidential treatment care plan. There was a sense that FMs often needed educating about alcohol or drug use in order to be able to support their substance using

relative. There was also confusion among the teams about the Organisation's policy regarding home-visits, and uncertainty regarding boundaries when working within a client's home. Finally, staff were unsure of the Organisation's expectations of family work. For example, they were often unsure about how many FMs should be on their caseload relative to FCs, how many sessions they were able to offer family members, and whether family sessions would 'count' in their statistics for the commissioners.

Meeting resistance

By attempting to involve FMs, staff sometimes experienced resistance from FCs who were not keen on a member of their family or network being involved in their treatment or care plan as they were worried about disclosing the actual levels of substances that they were consuming. Conversely, resistance also came from FMs who did not feel the need to be involved as they didn't have a problem:

*I think it's the problem with confidentiality that people don't want their friends telling the rest of the people.
(B:6 – Alcohol Practitioner).*

*I did a follow-up call and she [family member] was adamant she wasn't the one with the problem.
(A:2 – Senior Practitioner).*

Conflicting expectations

It was also described how FMs did not expect to be involved in the sessions and so were sometimes caught off guard when asked to participate in a session. Family members who had been offered support had sometimes disengaged from the service for fear of disclosing information that might be later used against them:

*There was a client that came in yesterday and said her partner was out in the car park and I said well do you want him to be involved and she said yes, so I went and asked him..... and he was almost horrified.
(F:3 – Alcohol Practitioner).*

*I had to get a lot of factual information and the body language from the Mother was very protective and out of nowhere she said “you’re not going to tell the bank about this are you?”
(A:7 – Manager).*

Misconceptions of family work

Although the training and supervision sessions had emphasised the importance of ‘quick-wins’ related to family work (e.g. simply offering information and support to a family member on the telephone, or sending a self-help manual to an affected family member), there was often a misperception from staff that family work involved intense on-going family therapy:

*I think that it can become very complex very quickly, but it’s hard as it becomes very muddy. It’s sometimes not just the drinking, but the breakdown of the relationships can start coming into the pot.....It feels like you’re doing serious family work.
(B:6 – Family Alcohol Practitioner).*

A need to educate family members

A substantial amount of discussion took place relating to the need to educate FMs about substance use and addiction problems. Staff found that sometimes FMs had unrealistic expectations of the amount of time it might take for their relative to be able to stop drinking, or were perhaps unaware of the likelihood of relapse following a period of abstinence. One example provided below also highlighted the importance of educating and supporting the FC and their FMs following a detoxification to avoid ‘undoing’ the positives that had taken place:

His condition is prone to relapse and I said that’s always a possibility.....I felt awkward saying that because she obviously wanted me to say that he would be great,

its been two years. That's always a risk you can't sugar coat it for people because you have to be realistic.
(C:2 – Senior Counsellor)

I've been out after detoxes and the Wife has walked past with a six pack of lager, 'oh are you nearly finished dear, I'll put these in the fridge for you later', and this was post-detox.
(F:3 – Manager).

Unsure of Organisational expectations

Finally, the discussions highlighted that staff were often unsure of Organisational expectations regarding family work, with a lack of policies and procedures in place to guide their practice. Some staff felt that they were using their experience and common sense to ensure family-inclusive practice rather than having clearly defined contracts and policies in place for family work. There were also discussions about sessions being carried out in a FC's / family member's home, and although it was useful to see the real situation that the family were living in, staff were often unsure of boundaries and ways of working outside of the Organisational premises:

But I do feel sometimes that a lot of what I do is because of the experience I've got, and whether I should be doing it in the remit of what the Organisation now does.
(D:7 – Alcohol Practitioner).

I am sort of finding it strange working in people's homes.....Personally I feel it's not been perhaps explored enough and how much of a difference that environment makes, whole different territory, different rules and different customs and things..... perhaps she's [focal client] popping out to have a drink, how do you tackle that?it's far more difficult to apply boundaries in somebody's house.
(D:3 - Alcohol Practitioner).

There was also uncertainty about statistics for commissioners regarding the number of clients who had received information and support from the services. Staff were unsure whether a family session would be 'counted' as a statistic, and whether a change in recording the session

on the Organisation's database as a family session rather than a 'drinking session' would appear as a decrease in the number of FCs receiving advice and treatment:

*There is a question about whether family members should have the whole assessment paperwork.....because I guess we're losing a stat there aren't we? We're gaining a family stat, but are we losing a drinker's, because the drinker's stat has now gone.....It depends what we're counting, if we're counting sessions, or people.
(E:5 – Alcohol Practitioner).*

SUMMARY OF BARRIERS AND ENABLERS OF FAMILY WORK

The results presented thus far have discussed the main themes and sub-themes to emerge during discussions with the staff during the on-going supervision period, highlighting the barriers and facilitators of family work. Enumeration of the emerging topics allowed the five most prominent facilitators and barriers to family-focused practice to be examined (see Table 18). On the whole, results showed that just over 60% (443 / 667) of the initial codes were related to factors likely to facilitate family-focused practice, with less than 40% being factors likely to impede family-focused practice. The results here also highlighted that there are factors likely to enhance or impede family work both within the Organisation's control, as well as those outside of the Organisation.

Table 18. Five most prominent facilitators and barriers to family-focused practice

Five most prominent <u>facilitators</u> of family-focused practice <i>(in order of significance)</i>	Five most prominent <u>barriers</u> to family-focused practice <i>(in order of significance)</i>
1) Seeing the benefit of involving family members.	1) Family work not being acknowledged or funded by commissioners.
2) Working creatively and flexibly to encourage family-focused practice.	2) Staff feeling anxious and concerned about a lack of skills to work with family members.
3) Organisational practices becoming family-oriented.	3) Concerns regarding confidentiality
4) Appreciating that family involvement positively influences the substance user.	4) Family work not acknowledged by outside services.
5) The efficacious impact of the package of training and supervision.	5) Preference to work individually.

Figure 16 presents an overview of the primary facilitators and enablers of family work at the internal level (factors under the control of the participating Organisation) and external level (factors beyond the control of the Organisation). The green shaded area presents the facilitators of family work; whereas the red shaded areas present the barriers to family work.



Figure 16. Principal Barriers and Enablers of Family Work

DISCUSSION

The experiences of staff in relation to a greater involvement of FMs in their daily practice have been presented here. The findings reported here were strengthened by combining accounts from all staff involved in the two phases of the project. The broad range of findings identified highlighted the usefulness of the group discussion approach in identifying barriers and facilitators to family-focused practice.

Drawing on evidence from all six project teams highlighted that staff were committed and enthusiastic towards learning new skills to be able to work effectively with FMs. The finding that staff commitment was the most significant theme to emerge from the data is promising in terms moving the Organisation towards becoming more family-focused, with previous research highlighting the importance of commitment of staff as a critical success factor for large-scale Organisational change programs (e.g. Lau & Herbert, 2001; May & Kettelhut, 1996). Commitment to a particular intervention has the potential to influence both behavioural and attitudinal change and to have a long lasting effect (Bartram, 2009). Employee commitment has been found to be crucial for behaviour change initiatives since employees actually execute the activities during the implementation of a new program (Hansson, Backlund & Lycke, 2003), and employees with a strong commitment have been found to ‘go the extra mile’ to ensure the success of a change initiative (Meyer & Herscovitch, 2001).

Being committed and enthusiastic towards family work, staff recognised the need for a shift away from an individual focus towards a more family-focused philosophy. Research has shown that although enthusiasm and commitment is the first step required in moving a

programme from ‘paper to practice’, there is a need to also change the behaviour of the providers for successful implementation to take place (Wilson, 1994). The findings reported here supported this finding in that staff appreciated that their participation within the project had led them to value the importance of family work and that family work was now becoming more automatic within their daily routines.

The findings revealed the beginnings of an Organisational shift in culture towards a more family-focused philosophy. Such findings are particularly significant as Organisational culture has been found to be a key factor that inhibits or allows the success of such an intervention change program, with programs being more likely to succeed if the prevailing system of norms, shared values, concerns and common beliefs are compatible with the values and assumptions proposed by the intervention (Kujala & Lillrank, 2004). Interestingly, new members of the team (who might not have attended the initial training event and had only attended very few consultancy meetings) appeared to accept family work as being the norm, showing how the culture of the Organisation was being transmitted to new arrivals by established staff.

In contrast, barriers to family-focused implementation included concerns and anxieties related to family work, lack of skills to work within a family inclusive framework, confidentiality issues, and some staff maintaining that their preference was to work individually. Furthermore, results highlighted that following the nine-month period of on-going supervision with the research team, staff felt the need for more training, specifically tailored to deal with the aforementioned issues. Such findings suggest that a successful shift towards a more family-focused Organisation requires more than a change in attitudes, skills and self-efficacy of

individual practitioners and managers. Instead, the results highlighted how important the Organisational climate is. That is, many of the barriers were related to Organisational policies and procedures, from less complex factors such as daily recording of family work, or having necessary assessment forms, to the more complex, such as having the time, resources and funding to legitimately involve FMs.

The findings showed that the majority of barriers to family work were internal to the Organisation, and appeared to be factors that could be tackled through continued family-focused training and support further development of Organisational policies and procedures to support family-focused practice. For example, staff ‘preferring’ to work individually with a FC, feeling anxious with regards to family work and feeling concerned about confidentiality. The findings suggested that nine-months of family-focused training and supervision was perhaps too short a time span to fully alleviate some of these concerns and anxieties, or for the Organisation to amend policies and procedures, e.g. to produce a centralised confidentiality document to advise staff on confidentiality when working with FMs. Such centralised procedures would aim to ensure that staff were fully aware of the Organisation’s expectations regarding family work.

Two major barriers encountered by staff during this project, however, were related to outside factors beyond the control of the frontline service providers, their managers and senior executives within the Organisation. That is, family work was not acknowledged or funded by commissioners, and family work was not recognised by outside services and Organisations (including those services likely to refer FCs/FMs for treatment). It appeared that such barriers cannot be addressed purely through an Organisational approach of family-focused training

and supervision. Instead, future efforts to implement family work within addiction treatment services need to ensure support is obtained from outside Organisations, to raise the awareness of the importance of family intervention with all relevant stakeholders, particularly those commissioning the services. The findings here showed how the culture and climate outside the Organisation can impact the extent to which such a training programme can achieve, and the difficulties of changing Organisational practice when such practice behaviour depends on many layers of policy and funding bodies. The findings clearly supported Fadden (1997; pg 609) who contended that, “unless there is change at a systems level, staff who have been trained in family interventions, however motivated, cannot effectively implement those interventions when the system in which they work remains unchanged.”

Limitations

It is important to consider the limitations of the findings from this analysis. Firstly, the responses of the participating staff are unlikely to be representative of all professionals working in similar services. However, the findings do allow an understanding of the kinds of issues involved in the implementation of a new program within an Organisation. Secondly, group discussions may have the tendency for certain types of socially acceptable opinions to emerge, or for certain participants to dominate the discussion (Smithson, 2000); nevertheless, the group discussions here did permit the opportunity for participants to discuss their ideas collectively and to present their own case examples and priorities.

LESSONS LEARNED FROM THE PROJECT

INTRODUCTION

This section brings together the experiences of the project Steering Group Committee to examine the main lessons learned when attempting to promote a more family-focused philosophy with an addiction treatment Organisation. It was felt that family-focused practice across the Organisation was unlikely to be achieved unless there was careful attention given to the quality of the training and supervision, as well as continuous identification of any problems arising for the staff associated with family work.

Steering Group Committee meetings had taken place approximately every three months during the project, and detailed minutes from each meeting were taken by the author. Additionally, the author arranged and facilitated two meetings at the halfway-stage of the research, which took the format of focus groups. The focus groups were conducted in order to specifically discuss the lessons learned from the project. The author generated the focus group questions and facilitated the discussions. Some examples of the kinds of questions asked were: “As members of the Project Steering Committee, what have been your experiences of the process of development and implementation of the project?”; “What in your view have been the important lessons learnt from this project so far?”; and “In your experience, have there been any important milestones reached so far?” The full list of focus group questions can be found in Appendix 15. The focus group discussions were recorded, transcribed and qualitatively analysed in order to examine the main lessons learned when attempting to promote a shift towards a family-oriented addiction treatment Organisation.

METHOD

Participants

As mentioned in Chapter two, the Steering Group Committee was a collaborative group made up of five members: the author, two researchers from the University of Birmingham (one of whom delivered the nine-month training and supervision package), one Senior Counsellor working for the Organisation (also responsible for delivering the training), and the Practice Development Manager (sponsor) within the Organisation, who reported to the Chief Executive of the Organisation.

Data analysis

The minutes from the Steering Group Committee meetings and the two focus group transcripts were triangulated and analysed using Thematic Analysis. Braun and Clarke's (2006) guidelines to conducting thematic analysis were used to steer the analysis by becoming familiar with the data, generating initial codes, searching for themes, reviewing the emergent themes, and finally defining and naming the themes.

RESULTS

Eight key themes (lessons learned) emerged from the data and are presented below under eight separate headings. For purposes of brevity, only a limited number of exemplar quotes under each heading are presented. Additionally, the member of the Steering Group who provided the quote is presented in brackets.

1. The Organisation often felt frustrated that staff were not up to speed with family work, however, appreciated that the design of the project enabled the impact of the project to be assessed.

A first lesson arising from the project was that integrating a research component into the overall structure of the project had been integral. The research and evaluation determined the impact the project was having on the implementation of family-focused practice across the teams. It was appreciated that the quasi-experimental design had allowed the six separate teams to be assessed as single cases to directly compare outcomes during the different phases of the project. Furthermore, the on-going or process evaluation had allowed the reliability and quality of the training package to be assessed throughout the project. This approach had, however, created some frustration and tension within the Organisation. Although the sponsors of the project working within the Organisation appreciated the benefits of the research, they would have liked to have had all teams ‘up to speed’ at an earlier stage. It was, however, agreed that this tension was inevitable and that the design was the best way of providing evidence of the impact of the project:

It's the Organisational context that is sometimes quite frustrating, people struggling in ways they might not need to struggle if only they got some training. If I didn't have the research I'd be saying this is for the whole Organisation to use but I won't because we've got the other teams who aren't in place yet.
(Sponsor).

The findings emphasised the importance of balancing methodological issues and implementation efforts. It has been argued elsewhere that researchers can become ‘obsessed’ with potential research issues to the point where they actually create problems for the successful implementation of an intervention (Dennis, Perl, Huebner & McLellan, 2000).

The design of the family-focused training package was also discussed, and how the training had aimed to influence the Organisation via frontline staff using a ‘bottom-up’ approach. It was mentioned how an alternative approach might have been to train higher-level staff, with training then being cascaded down to the teams. However, the Steering Committee reported feeling glad the training approach had been conducted in this way.

2. A collaborative approach ensured research met the real world

It was felt that the successes so far within the project had been largely achieved due to the on-going collaboration and communication between the Steering Committee Group and the research group. Being made up of members from the ‘two sides’ of the project (i.e. the researchers and the sponsors from within the Organisation), was seen as being vital to the success of the project. Maintaining regular contact between the two groups had allowed the two different worlds to come together and touch base. This ensured that the higher level management within the Organisation (whom had not received the training and supervision) understood what stage the project was at, whether the project had hit any snags and were able to quickly resolve any problems:

*The Steering Group has provided a really valuable function for us to identify the barriers that maybe coming up for practitioners...we can come back and review where we are in terms of the Organisational support, policies, procedures and structures that support this change.
(Research team).*

The research team responsible for delivering the training and supervision package was also a collaborative group made up of an external researcher with a long history of involvement in promoting family-inclusive and the Family Services Manager working within the Organisation. This collaboration was seen as a real benefit:

We've got a double-headed approach where we can look at what we know works from other research, but also, when people raise difficulties of the application within the Organisation then I'm able to respond and say well I know about the assessment processes...screening processes...delivery of interventions.
(Research team).

It was discussed how meeting regularly and discussing successes and barriers to family-work had allowed the Steering Committee Group to maximise family work across the Organisation, and to ensure that family work was integrated into the existing Organisational structure before the project came to an end.

3. Ensure a Whole-Team Approach to Family Work

Following the completion of phase one, the importance of training administrative staff, as well as those staff working with FCs and FMs in a therapeutic manner, had been recognised. Phase one of the project had only minimally involved administrative staff. This was because the research team had assumed that a substantial amount of the training package would not be relevant to administrative staff. The importance of a whole-team approach to family work, however, was discussed with a need to train administrative staff in phase two:

The involvement of the administrators is a change in our way of working, and initially this was on the insistence of one of the team's managers.....It works better and that's the model we'll be looking at now each time.....because they're fundamental to this work, because they're the first port of call for family members.
(Research team).

Additionally, ensuring a whole-team approach to family work meant taking into account the newly created Support Worker role. The Support Worker role had been created within the Organisation during the early stages of Phase two. Although Support Workers might not be delivering SBNT or 5-Step, they were likely to come into contact with FCs and FMs with

regards to accommodation, employment, child care etc. Therefore, in addition to training practitioners and managers, it was important for the Research team to adapt elements of the training package to ensure it was relevant for support workers and administrative staff, so that they understood how and why family work was being implemented within the Organisation:

One of the things we need to be thinking about is the support worker role and that support workers won't necessarily be doing the interventions but they'll be picking up elements of family and we need them to know why that's important. (Sponsor).

4. The Need to Adopt a 'Direct' Approach to Training and Supervision

The fourth lesson learned was the need for the Research team to be more directive in their training approach. It was discussed how the Research team had adopted a non-directive and receptive stance in the Pilot phase of the project. As opposed to telling staff what, when and how to make changes to their practices, the Research team had instead suggested to staff 'you can do this, you probably are already, you can build on this'. The Research team quickly realised however, that making suggestions was not necessarily leading to increases in family work. To give an example, early on within the project, the Research team discussed the importance of creating a family-focused environment. The research team suggested that teams could make their waiting room more family-friendly. Although staff agreed that this would be a good idea at the time, no changes in the waiting rooms in either Team A or B had taken place at the end of the Pilot phase. It was suggested that the staff thought 'someone else was going to do it'. Examples such as this led the Research team to recognise a need to adopt a more direct approach in order to maximise levels of family-focused practice within the teams. This was echoed by the Practice Development Manager:

You don't have to let them guide you. Be the guiding force.

The Research team discussed how they often felt unsure about ‘how far to go’ in terms of telling staff what to do versus trying to get them to engage in family-work through their own motivation:

*Does it create resistance if we’re being too instructive?
(Research team).*

However, during phase two of the project, it was agreed that the Research team needed to move up the continuum from the non-directive pole, to the more directive pole:

*Now we’re saying where are we in the process?We’re not waiting for them to come forward; we very much go with a flexible structure but now we’re actually saying these are certain milestones we feel are helpful in making this process happen.
(Research team).*

5. Work closely with resistant staff to ensure key staff are ‘on-board’

The Research team discussed how, during Phase one, they had experienced resistance to family work from some senior and managerial staff. During the on-going supervision sessions, such staff had been extremely vocal about their preference to work individually with a FC. It was also felt that the attitudes of senior staff may have ‘swayed’ less experienced members of the team:

*If there are reservations and counterarguments coming from managers and seniors in the team then you’ve got an uphill battle.
(Researcher).*

It was agreed that to move forward, it is imperative to more fully understand the resistance from these staff in order to understand their position in an attempt to ensure that the key staff in authority were on board with family work. It was felt that the momentum for family work would increase if powerful staff were committed to driving family work forward. Furthermore, it was suggested that ‘family champions’ could be used as advocates within the Organisation

to promote family work. Staff who were particularly positive about family-focused practice could be utilised to work with resistant staff and provide advice and support to new staff, particularly once the project had come to an end.

6. Training content should incorporate worst-case scenarios as well as basic solutions

The Research group appreciated that staff receiving the family-focused training package were likely to be at differing levels of experience in their role. The content and delivery of the training package focused, therefore, on family work being ‘simple’, not requiring extensive family therapy training, and that all staff (regardless of their role or level of expertise) would easily be able to involve FMs in their daily routine. However, it was discussed that staff who had received training during phase one had felt that it was too basic. Instead, the staff felt they needed the training content to cover heavy end family work, as their work often involved working with complex families:

We were talking about the continuum of family work from the quick wins which we wanted to focus on, but staff were saying, no we need the more intensive training to deal with the can of worms scenarios, you’re making this too simplistic, it’s more complicated than that.
(Research team).

The Research team discussed how they had focused on the basics of family work so that staff would be more likely to take the examples and use them, rather than focusing on complex issues where staff might have left the sessions feeling anxious or negative towards involving FMs. Due to the feedback from the staff, however, the sixth lesson learned was the need to adapt the training package to incorporate more complex or worst-case scenarios:

I think the shift in the follow-up training was to say, okay, let's just deal with these, let's get into the complexity and see how you can still get some gain, even in awful case. You can still do some good work within a complex family.
(Research team).

Having taken these comments into consideration, staff's subsequent feedback was more positive and that the training *now hit the right buttons*:

I heard it was great in terms of really grappling the complexity of issues and showing that's do-able and within their competency and repertoire.
(Sponsor).

7. Nine months of family-focused training and supervision may not be adequate to successfully change behaviour

Having considered the results from the previous IFM project (Orford *et al.*, 2009), whereby teams had been trained and supervised for almost two years, the research team had initially felt that it should be possible to see and achieve positive results in a shorter period of time. However, through their experiences with the current six teams, the Research team had concerns as to whether the nine-month training package was sufficient to produce significant behaviour changes:

There is a nagging question that remains for me as to whether the package of nine-months, an hour and a half a month is sufficient, because when you've got very large teams and finite resources...
(Research team).

A Stages of Change analogy was used when considering the successes of the training. Depending on where the staff were 'starting' from appeared to determine where they were following the nine-month training package:

So if there's one team that's been really hard work all the way through, they're basically at precontemplation all the way through...but you've pushed them from where they were, to start the process.....and there's others that are really in action and are actually being directive with us and want to get onto the next level.

(Researcher).

Furthermore, the Research team wondered whether positive changes were due to the *presence* of the research team, who were constantly reminding and pushing the teams to make changes. Once the project had finished, there was a concern that practices may revert back to how they were before the project:

When you're there and you're kind of working, pushing it, but I never get the sense that things are going to grow from this.
(Research team).

There was again some frustration expressed by the Organisation sponsor having heard these concerns, with the Practice Development Manager expressing that she wanted to provide further support to the teams immediately, however, didn't want to *scupper* the research design by doing so:

I'd like to implement things during the project but I can't put any of that into action until we've trained the last two teams, but I've already started to think about how to keep the momentum going after the research project has finished.
(Sponsor).

8. A family-oriented culture and climate is crucial for family-focused practice to take place and be sustained

The final, yet crucial, lesson learned that underpins all of the lessons learned so far was the need for an 'Organisational push' to further encourage a family-focused culture and climate. It was felt that continuing to create policies, procedures and structures to support family-focused practice would allow family-work to 'flourish.'

Lesson one discussed how a bottom-up approach to training working with frontline staff had been beneficial and had allowed staff to develop necessary skills for family work. It was also felt that it had been crucial to 'back up the training from the top':

It starts from having a Chief Exec who is really wanting to take this forward and actually planning this. I think that underpins everything really.

(Researcher).

Although family-focused changes may not yet have been adopted whole-heartedly by all staff, the clear vision that the Organisation was sending out to staff was that they should be working with FMs. Rather than perceiving family work as a project that would come to an end, staff were able to witness changes in systems and procedures:

*Since the redrafting of the assessment paperwork there is actually some equity for FMs, they do have a care plan and a risk assessment and that wasn't there before.
(Research team).*

*It's almost like they can see that changes are happening, the systems and structures are there.....so what's the point of kicking and screaming; this is the world we're in now.
(Research team).*

It was also suggested that without the Organisational 'push', the most successful training programme may not have had such successful outcomes:

*You could get those people to have the vision at the coal face, but if you don't have the Organisation ratifying that, then it doesn't go anywhere.
(Researcher).*

DISCUSSION

This section has presented a summary of the key challenges and lessons learned during the project. Important issues and insights with practical implications have been highlighted, which were taken into account by the research team during phase two. The findings here demonstrate the importance of on-going communication between Steering Group members when attempting a complex Organisational change program. Gray *et al.*, (2001) supported the importance of clear communication between researchers and sponsors in order to monitor outcomes and increase the credibility of an intervention, and that findings from the evaluation should not 'come as a shock' to the sponsors.

The findings also highlighted the advantages of using a ‘bottom-up’ training approach to family work, allowing the research team to communicate the goals of the project at each step, to encourage staff to reach certain milestones on their own so that they felt empowered in the implementation efforts, and that their initiatives were acknowledged. A bottom-up approach is supported elsewhere, that companies employing top down programs often meet serious barriers when trying to implement change purely professed from top level management (Beer *et al.*, 1990).

It was found to be beneficial that the research team responsible for delivering the training was made up of external researchers as well as a member of staff from within the Organisation. This finding is consistent with previous research suggesting that change introduced by an external change agent can lead to resistance from frontline staff, in that an ‘outsider’ cannot possibly know what is best for the Organisation (Hedge & Pulakos, 2002).

Another key lesson to emerge was the need to ensure a whole-team approach to family work. The findings presented here emphasised the importance of providing training to administrative and support staff, irrespective of whether they are working therapeutically with FCs and their FMs. Observations during phase one meant that all staff were more fully utilised and valued in phase two. Specific training was tailored for administrative and support staff in an attempt to ensure they were aware of the importance of routinely communicating the family-inclusive message to new and existing service users and their families. Providing these staff with tailored training and support in phase two attempted to ensure that all staff within the Organisation were provided with clear and comprehensible concepts regarding family work, and that they felt a part of the behaviour change initiatives.

The research team had also learned that routine behaviour related to family work required a more direct training approach. This finding supported Hersey, Blanchard and Johnson (2000) who suggested that leaders should adapt their style based on how ready and willing the follower is to perform required tasks. Furthermore, a directive leadership may be required when staff are 'precontemplators' (Witchel, 2003).

One of the major challenges highlighted for the research team was the resistance to family work from some staff, particularly experienced senior members of staff. Interestingly, the staff most resistant were those who had been working within the Organisation for a number of years and were extremely experienced with one-to-one treatment with a FC. Research examining Organisational change suggests that possible reasons for such resistance to change can include incompatibility, fear of uncertainty and inconvenience, amongst many others (King, 1990; Hultman, 1998). Furthermore, a major issue in achieving successful implementation of a new initiative is a lack of support and commitment from senior members of staff (Hedge & Pulokos, 2002).

To encourage family-focused practice, it was important to understand how this would be best achieved, which meant understanding the perspective of the staff themselves. Based on the feedback from the staff receiving the training package, a further lesson learned was the need to amend the content of the training. Rather than focusing on simpler aspects of family work, it had been necessary to provide staff with training around more complex scenarios involving families. The importance of tailoring training to the needs and requests of staff was consistent with previous findings (Grover & Walker, 2003). The alterations to the training materials

based on the staff's feedback during the early stages of the project were found to be positive in subsequent training during phase two.

The Steering Group members suggested that nine-months of family-focused training and supervision may not be adequate in order to successfully implement routine family-focused practice. Previous efforts to change provider behaviour elsewhere have also been successful during the course of an intervention, however, practice has been found to revert back to the starting point on completion of the intervention (Halm, Atlas, Borowsky, Benzer, & Singer, 1999). It may be that utilizing positive staff as family advocates or 'champions' would allow family work to be further enhanced following the completion of the formal training stages. A train-the-trainer approach could be used to provide family champions with the skills to be able to continue to provide 'in-house' family-focused training sessions to new staff, or to provide booster training sessions to existing staff. Fadden (2006) suggested that the role of the family champion could also be to write policies related to family work and liaise with middle and senior managers to help ensure that all staff are comfortable and capable of working effectively with FMs.

Finally, it was felt that a family-focused culture and climate is crucial for routine family-focused practice to take place and be sustained, with a responsibility for managers and executives to continue to develop family-focused procedures, structures and policies. The findings appear to suggest that a balance between a bottom-up and top-down approach is required. The importance of an 'Organisational push' is also supported by Greenhalgh *et al.*, (2004) who made an important distinction between 'letting it happen' and 'making it happen'.

The lessons learned here have emphasised the importance of an Organisation which ‘makes it happen,’ even if the desired changes meet resistance at first.

Conclusion

In conclusion, the results and analysis presented within this chapter demonstrated how the research design was integral to evaluate the impact of the project, and that successful implementation of evidence-based interventions involving controlled research design methods requires careful development, flexibility, and collaborative communication between all stakeholders to ensure maximum effectiveness. Oakley, Strange, Bonell, Allen and Stephenson (2006) support process evaluation being ‘nested inside a trial’ in order to clarify causal mechanisms and identify contextual factors associated with the variation in outcomes.

The current findings also highlighted that qualitative research methods are a valuable component in the evaluation of interventions and are able to provide depth of detail not found in the quantitative analysis. These findings are more fully reported in the General Discussion in Chapter eight. The qualitative results provided a collection of barriers and facilitators to involvement of FMs in treatment for substance use problems. Findings highlighted the importance of identifying such barriers early on within the training and supervision process, to help ensure maximum implementation of family work.

CHAPTER EIGHT

DISCUSSION, IMPLICATIONS AND CONCLUSIONS

This final chapter will discuss the main findings and implications from the research reported within this thesis. Some recommendations for clinical practice and future investigation are presented, followed by a discussion of the strengths and limitations of the research undertaken. The overall conclusions from the research close the chapter.

SUMMARY OF FINDINGS

The literature review (Chapter one) first examined the efficacy of family intervention for substance use problems. A ‘tertiary review’ was conducted to examine the collective evidence for the efficacy of family-based intervention for substance misuse problems from fourteen reviews, spanning a 17 year period. The overall conclusion drawn was that there was robust evidence, from high-quality reviews, of the benefits of family-intervention; by and large family-based treatment approaches were considered superior compared to individual addiction treatment.

The tertiary review also highlighted that, despite their effectiveness, there is limited implementation of family interventions into routine addiction treatment practice, and treatment providers often do not have access to training in family work. Therefore, a second aim of Chapter one was to examine the extent to which family-focused practice is implemented following training. Due to the limited number of studies identified within addiction treatment

settings (six studies), the review was broadened to include the wider healthcare system (e.g. mental health services, primary care and hospital settings) allowing 26 studies to be systematically identified and reviewed. A number of conclusions were drawn with regards to the implementation of family work, however, the two principal conclusions were the need for methodologically sound research evaluating the implementation of family work within addiction treatment services; and the importance of a whole Organisation training approach to family work to attempt to tackle the many layers of obstacles to the implementation of family work.

The research reported within this thesis, therefore was an attempt to address these gaps by evaluating the impact of a package of evidence-based family-focused training and supervision on the promotion and implementation of family-focused practice across a whole addiction treatment Organisation. The quasi-experimental research design (described in Chapter two) integrated action research and randomisation to training and supervision in order to assess the impact of the programme of work on a whole-Organisation shift towards becoming more family-oriented. Following the package of training and support, this research investigated whether staff felt they now possessed the necessary skills and tools to work effectively with family members (FMs) in their daily routine, and whether the amount of FMs receiving support from the Organisation had increased as a result of the whole-organisation training approach. Facilitators and barriers to increased involvement of FMs were also examined.

The quantitative results from the Pilot study (Chapter three) provided valuable findings during the early stages of the research, demonstrating that the training and supervision had led to improvements in staff attitudes and practice behaviour towards a greater involvement of

family-focused practice. Furthermore, important lessons learned led to the refinement of the evaluation outcome measures to be used within the larger main quasi-experiment in phase two. The Pilot study results were also important in terms of identifying the need for a more sensitive family-specific attitude scale as previous standardized measures used for measuring addiction treatment staff's attitudes towards family-focused addiction treatment were found to be lacking significant components.

The major strengths of the author-developed AIFMTQ (Chapter four) were thought to be due to the addition of the recognised components lacking in existing measures, as well as being developed specifically for the context in which the staff were working. It is thought that the AIFMTQ is the first scale to be developed and contextualized specifically to assess staff attitudes to involvement of FMs within addiction treatment services.

Consistent with the findings from the Pilot phase and previous Involving Family Member (IFM) project, the quantitative results from the main quasi-experiment (Chapters five & six) revealed that, overall, attitudes towards family work, and the levels of family-focused practice taking place across the teams, were significantly greater following receipt of the package of training and supervision, compared to baseline. Measuring outcomes during a wait-listed baseline period was important in highlighting that increases in attitudes were not confined to the training period alone; instead, significant improvements in the Delayed teams' attitudes prior to receiving training were also revealed. Furthermore, attitudes continued to rise following the conclusion of the training period, with total attitude scores being at their highest at nine-month follow-up. An optimistic explanation for these findings was proposed whereby

the training and support provided at the level of individual teams had led to a wider systems-level permeation of a family-focused culture.

The newly-developed AIFMTQ showed similar results to the standardized AAFPQ in relation to increases in positive attitudes throughout the duration of Phase two, however, also detected differences between the Immediate and Delayed groups at the mid-point and end-point of the project (differences not found using the AAFPQ). Such findings perhaps implied that the AIFMTQ is indeed more sensitive, being specifically developed within the context in which staff were working.

Despite positive attitudes towards family-focused practice, the proportion of family-focused practice taking place within the Delayed teams was, on the whole, significantly less compared to the immediately trained team, being relatively constant both before and during the training period. The proportion of family work taking place within the Immediate team was found to be approximately 15% at baseline, rising to around 30% during and post-training, and again increasing to 46% at follow-up. Whereas the proportion of family-focused practice within the Delayed group tended to be below 25% throughout phase two, and rising slightly to 27% post-training. The regression model examining whether attitudes predict practice behavior suggested a weak relationship, with attitudes accounting for approximately 12% of the variance in the proportion of family-focused practice.

The findings from the qualitative analysis (Chapter seven) were particularly useful in terms of more fully understanding the other factors at play that were either enhancing or hindering levels of family work. Analysis of the collective experiences of the staff working across all

six teams highlighted how family work can be positively or negatively influenced at the level of the individual, Organisation and wider environment in which the Organisation is situated. It was suggested that, although sufficient to achieve positive increases in attitudes, a period of nine-months training and supervision is perhaps too short a time for necessary Organisational structures and policies to become family-oriented to maximize the amount of family-focused practice taking place within the teams. Yet, findings did suggest that a large proportion of the barriers to family work could be alleviated through continued training and support, coupled with amendments to organizational structures and procedures.

Consistent with previous research, the results highlighted that changing the behaviour of staff is not easy, especially for those staff who are comfortable and fond of a familiar program (irrespective of whether that program works well) (Cabana et al., 1999; Kotter et al., 1995). Thus, creating family-oriented organizational structures, strategies and policies are essential to enable staff to feel adequately supported and to ensure that family intervention becomes integrated into their core duties (Prinz & Sanders, 2007).

The lessons learned within the Steering Committee Group also recognized the importance of tackling ‘in-house’ barriers, e.g. a prevailing preference for individualistic practice voiced by some of the senior / experienced members of staff. Such resistance has also been experienced elsewhere following attempts to implement family work into community psychiatric services, concluding that the transitional period from ‘individualistic’ to family-oriented practice presents a difficult shift for staff, requiring close supervision to help staff adapt to a new way of working (Jones & Scannell, 2002).

The qualitative findings were useful in emphasizing the ‘external’ barriers experienced by staff related to family work. Such factors were beyond the control of the staff and beyond the remit of the training and supervision package. The first being that family-oriented addiction treatment is not recognized or sufficiently funded by commissioners, and second being that the benefits of family-involvement in addiction treatment are not always acknowledged by outside Organisations (e.g. primary care, social services and other addiction treatment services).

Before discussing the implications of the main findings to emerge from this research, there were some noteworthy results to briefly mention here. Firstly, throughout the course of this research (nearly three years) the number of specialist family workers employed by the Organisation increased from 9 to 14. Secondly, the audit of proportion of family-focused practice taking place among the four teams during phase two, taken together, had increased from on average, 19% at baseline to 34% following training (including data immediately post-training and during the nine-month follow-up period). These findings are possible signs that family work within the Organisation grew despite the Organisation tackling with a multitude of other pressures and commitments including short-term funding, turnover of staff, and competitive tendering of service delivery contracts.

IMPLICATIONS OF THE FINDINGS

The results reported within the present thesis presented several important findings. The results advocated that a whole-organization family-focused training approach has potential to promote the implementation of family-focused addiction treatment practice. Consistent with the studies reviewed in Chapter one whereby attitudes to family work were examined

following a period of training in family intervention, (e.g. Brooker *et al.*, 2003; Copello *et al.*, 2000b; Liddle *et al.*, 2006; Magliano *et al.*, 2006; Orford *et al.*, 2009; Redhead *et al.*, 2011; Schweitzer *et al.*, 2007; Slade *et al.*, 2003; Turner *et al.*, 2011; Wills *et al.*, 2007; Zazzali *et al.*, 2008), the findings from this research also revealed that providing staff with training and supervision in family intervention can positively influence their attitudes towards family work, and provide them with the necessary tools to work effectively with affected FMs. It was evident that a considerably greater amount of FMs affected by their relative's substance use and related issues (child protection, domestic violence, crime etc.) received support from the Organisation as a result of the project; supporting the findings of studies reviewed in chapter one (e.g. Bailey *et al.*, 2003; McFarlane *et al.*, 2001; Mottaghipour *et al.*, 2010; Redhead *et al.*, 2011). However, family-oriented practices needed to evolve over a sizeable amount of time, and staff needed to be pro-active and flexible. Despite positive shifts in attitudes and practice behavior, some staff continued to perceive family work as complicated and multifaceted due to a variety of impeding factors beyond their control (e.g. limitations of time, funding and resources, priorities of outside agencies, neglect of affected FMs in primary care), again lending support to the studies reviewed in Chapter one (e.g. Bailey *et al.*, 2003; Brooker *et al.*, 2003; Cohen *et al.*, 2010; Mottaghipour *et al.*, 2010; Ritchie *et al.*, 2009; Slade *et al.*, 2003).

Results also revealed that despite having support from the senior management team and Chief Executive within the Organisation, practice was generally dictated by contractual service level agreements, confined due to political priorities and competitive contracts to fund service delivery. Such contractual requirements stated the teams' obligations to treatment, and what interventions or practices should be delivered within the available resources, being by and

large focused on the individual drinker, drug user or gambler. It seems the ‘micro-environment’ (those ‘in-house’ elements of which the Organisation had control) was able to be influenced by the training and supervision, for example, the competence, skills, knowledge and motivation of the staff in relation to family work. However, training efforts were beyond the realms of influencing the Organisation’s ‘macro-environment’, that is, forces external to the Organisation e.g. commissioners, outside Organisations, primary care, social services and aspects of the social-political milieu. We have seen how such external forces are important for the success of such a project.

Interestingly, the process of implementing family-focused practice within addiction treatment interestingly appeared analogous with the popular model used to explain the process by which people overcome addiction problems – the Transtheoretical Model (TTM) or ‘Stages of Change Model’ (Prochaska & DiClemente, 1984). Supporting the work of Rogers (2003) and Sherman and Carothers (2005), the findings here lend further support that staging the processes of implementation provides a useful framework to understand the complexities and the varying levels of change.

First, prior to receiving the training package, staff working within the Organisation were, generally, thought to be in *precontemplation*, having little knowledge or experience of working with FMs due to working within a dominant individualistic framework. Such a well-established dominant paradigm has had many years in which to establish and hone its assumptions, language and processes (Adams, 2007).

Yet, there was evidence that the training and on-going supervision had been successful in providing the staff with the fundamental knowledge of the benefits and importance of family work, and ‘persuading’ staff to develop a positive attitude towards family work. During this *contemplation* stage, staff were starting to appreciate the positive outcomes of family work, yet, levels of family-focused practice remained relatively low, seemingly due to various obstacles related to a lack of family-oriented policies and procedures (e.g. recording processes, assessment paperwork, service environment etc.). It was apparent that such procedures needed time to develop and adapt, sometimes thwarting family work and contributing to concerns and fears of the practices being suggested by the Research team.

Next, staff were *planning* to try out sessions involving a family (*preparation*). The process evaluation of staff’s experiences during the consultancy meetings, coupled with the frequent collection of diary activity, was particularly useful to understand the family-oriented developments taking place within this early stage. Results indicated that levels of family work, albeit slow at first, gradually started to increase over time. Conversely, no such increases in levels of family work were observed in the Delayed comparison group’s baseline period, suggesting the importance of the package of training and supervision in aiding the greater involvement of FMs. Sherman and Carothers (2005) argued that many questions arise for professionals preparing to implement a family intervention program, such as who to provide the intervention to, for how long, and how to assess the FC/family member’s satisfaction with the intervention. It appeared that the on-going supervision helped to endorse family-focused practice and provide a forum for questions to be answered and lessons learned to be shared.

Once staff's concerns regarding family work had been lessened through assistance from the Research team, coupled with the development of Organisational family-oriented processes, behaviour change followed (*action*) (evident from on-going involvement of families among the trained teams). The nine-month follow-up period later revealed increases in family work in the absence of on-going training and support, suggesting that family work was becoming integrated into routine practice (maintenance) and that new members of staff were being encouraged by previously trained staff. 'Seeing the benefit' of family-involvement also helped to confirm the new approach.

Overall, the findings highlighted that to successfully implement family-focused practice into routine addiction services, efforts need to extend beyond a 'bottom-up' approach of training the professionals who are responsible for delivering the day-to-day family work. There is also a need for a working dialogue between all stakeholders, to focus on adapting wider systemic processes (Rollnick, Kinnerly & Butler, 2002; Stirman *et al.*, 2004). Consistent with previous research (e.g. Cohen *et al.*, 2010; Ritchie *et al.*, 2000; Slade *et al.*, 2003), the findings from this research further underlined the importance of obtaining support from policy makers and commissioners to ensure that family-oriented practice is included in the priorities within the funding and delivery arrangements of the Organisation. Since commissioners have a considerable influence on frontline staffs' time and resources, it is important to acquire their commitment, as family involvement may be viewed as waning the costly resources needed for the treatment of the substance user (Sherman & Carothers, 2005).

Recommendations for clinical practice

Based on the current findings, a number of recommendations for clinical practice are suggested for future efforts to implement family-focused practice within addiction treatment services.

Firstly, there is a need to identify individuals or groups of professionals whose acceptance and commitment is crucial for the success of the intervention. We saw the importance of working with key staff within the Organisation to ensure they are committed to family work and to attempt to resolve family-related concerns. Open sharing of implementation strategies could minimise the feelings of threat that come with change. Consistent with Fadden (2006), one solution to supporting staff who feel anxious or resistant to change, or to support new staff who may not have received training in family work, is to utilise ‘family champions’. A champion in family work could help to ensure all staff are comfortable and competent with family work through performance appraisals, overseeing required training and supervision in family work, liaising with management to communicate issues and ensure policies and procedures are family-oriented. It may also be helpful if the family champion is readily available to provide staff with positive feedback for improving skills in family work until the behaviour becomes well-established. Miller *et al.*, (2006) argued that “attending a workshop, studying a manual or trying to master a new treatment without feedback or coaching is like reading about and attending a lecture on golf, then practicing swings blindfolded.....you will hit one now and then albeit probably not very well.” (pg. 36). Furthermore, previous research has also proposed utilizing a family work support group as a useful way of helping resistant colleagues to work through their difficulties or conflicts, being led by those members of staff who are positive influences for change (Barrowclough & Tarrier, 1997).

The findings suggest that support and active involvement from staff at all levels will help to ensure that family work is effectively implemented and sustained. Although based only on the perspective of the Organisation's management, it is perhaps important to more fully appreciate the role of administrative and support staff in helping to change the 'culture' of the teams. Campion and Thayer (1985) suggested using incentives to encourage staff to develop skills, with those able to develop and excel in the desired skills being rewarded appropriately in order to make the job more satisfying, rewarding and motivating.

Efforts to implement family work through training should employ a combination of bottom-up and top-down approaches. We have seen here the importance of projects being planned and co-ordinated from the top to attempt to 'make it happen', however, this needs to be coupled with training and supervision that is specifically tailored to frontline staff's needs and requests to maximise interest and implementation at the 'coal-face.'

Finally, above all, to allow routine family-focused practice to develop within addiction treatment services, beyond what could be considered as modest changes achieved within one Organisation, it is clear there is a need for a strong and shared vision of the importance of family work so that key stakeholders have a shared understanding of the importance of family-focused addiction treatment. It is important that the senior management within this Organisation target commissioners and policy makers through quarterly and annual reports to demonstrate the benefits of family-focused practice and to demonstrate that they are 'ahead of the game'. Policy makers then need to promote the wider awareness of the benefits of family-intervention and to guarantee that services give equal priority to substance users and affected FMs on a daily basis. Furthermore, it is vital to promote family intervention at the level of the

commissioner. Commissioners oversee funding for non-statutory addiction services, and need to consider that the potential of family support is unlikely to be achieved without additional investment in funding and resources. Commissioners also make decisions regarding contracts and service level agreements, which directly impact on what happens each day within such an Organisation. As a legally binding document, a contract including family intervention offers a practical, enforceable approach to family intervention implementation (Rieckman, Kovas, Cassidy & McCarty, 2011). One specific example, as highlighted by experiences of the staff, is the need for a clear policy or ‘contract’ for staff to consult when working with FMs, including: guidance on managing confidentiality; working within FC/FMs’ homes; and what to do when there is suspected domestic violence etc.

Suggestions for future research

The findings from the literature review revealed that research related to training in family intervention for substance misuse has tended to focus on professionals’ knowledge and confidence development, rather than strategies to prepare Organisations to accept and adopt the knowledge gained. The current status of the literature on guiding implementation of family-focused practice could be described as being in an embryonic state. Future research efforts could, therefore, examine the best ways to prepare Organisations for change towards becoming family-oriented.

The results highlighted the benefits of providing staff with nine-months of training and supervision in family intervention; the comparison with the previously trained IFM team also showed how a period of two and a half years of training and supervision can lead to sustainability of family-focused practice. Future research could clarify the frequency, amount

and type of contact that favours the acquisition and maintenance of family-focused attitudes and practice, considering that the findings revealed positive increases in attitudes in teams ‘waiting’ to receive training. The cost of such family-focused services must also be considered.

The findings here also identified limitations of the content and format of the training and supervision package, and have given pointers for future projects, ensuring that training is tailored to staff’s requirements.

The results have highlighted the significance of improving communication channels between front-line staff, managers, outside Organisations, commissioners, policy makers in order to link service provision. Future research should examine how to ensure all stakeholders can successfully make their contribution to the future development of family-focused addiction practice. It remains unclear the extent to which contract language would influence whether family intervention would be translated into routine practice. Future research could examine the impact of including family-intervention in treatment providers’ contractual agreements. On-going process evaluation should then be carried out to assess the impact of having family work written into the contractual agreement.

Disseminating the results of this research (and those studies that follow) in a toolkit is perhaps a critical next step. The results from this research and the lessons learned from the Steering Committee have furthered the understanding within the field in terms of the kind of information and training (content and format) that addiction treatment providers find most useful and accessible. These findings could be used to put together a ‘train-the-trainer’ portfolio that could be used to further promote the benefits of family work. The portfolio

could present examples of best practices for developing family-oriented addiction treatment services, including the challenges they are likely to face and how best to overcome them.

STRENGTHS AND LIMITATIONS

It is important to consider the limitations of the research reported within this thesis. Firstly, the results were based on one non-statutory addiction treatment Organisation, meaning the responses of these staff were unlikely to be representative of all professionals working in UK addiction treatment services. It is possible that the findings here were influenced by the characteristics of the clients (substance users / family members), professionals, and / or environment and locality of the Organisation. As noted earlier, it is also possible that staff members from one setting have more similar attitudes than members at different facilities. Moreover, the diary-snapshot only measured the proportion of family-focused practice (counts of encounters), rather than the fidelity of the sessions involving FMs. Ultimately the aim of implementing family-focused practice is to improve FC and FM outcomes, which were not assessed here, however, as the literature reviewed emphasised there is already a large body of evidence for the efficacy of family intervention for substance use problems.

Secondly, the limitations inherent with self-report data means that the attitude and diary-based data can only provide rudimentary evidence as to the effectiveness of the training package. Similarly, the effect of the training package was examined among the groups as a whole, rather than examining sub-groups of professionals (e.g. management vs. support workers, or full training vs. limited training). Instead, the results attempted to examine the impact of the training overall within the Organisation across the multiple time-points. It is, however, important to consider that such an analytic strategy may have diluted the overall results and

impact of the result training and supervision. For example, the statistical analyses examined differences between whole groups as independent samples, meaning that staff were included in the analysis regardless of the amount of training they had received, or their job role. A repeated measures analysis which compared those staff who had taken part in training with those who had not experienced training may have helped to give a more detailed analysis that might have shown higher impact on the former group of staff.

It is also possible that there were different impacts of the training on staff with different job roles which the analysis did not elucidate. It would also have been possible to conduct many more statistical tests, e.g. using repeated measures to examine the data from those staff who had provided data at multiple stages of the research (e.g. baseline, immediately following training, follow-up), or examine differences in data according to staff's job role. Furthermore, additional analyses could have been conducted comparing those who had been fully trained with those staff who were new to the Organisation, and who had perceived received very limited, or no training at all. Such analyses were not included within the thesis for purposes of brevity, however, there is the possibility to explore these areas in future and would be useful to consider within potential publications.

It is hoped that random 'snapshots' of routine practice behaviour, collected over a substantial number of time-points, coupled with the process evaluation from the qualitative data helped to strengthen the overall validity of the outcomes. As Gorman (1993) suggested, the evaluation approach employed here ensured that the nature of the intervention being assessed and the context in which it was implemented was examined.

The research reported has a number of other strengths. That the author came from outside the Organisation was a strength, being regarded by the staff working within the Organisation as someone whom they could speak to freely, being were assured discretion and confidentiality. Another strength was the action research methodology employed, allowing the bringing together of research and practice by sharing decisions within the Steering Committee to generate knowledge through action. Being practical and collaborative helped the staff to become ‘better’ at being able to respond to, and effectively work with families, and at the same time able to provide scientific evidence using robust methodological techniques to evaluate the outcomes of project. Such a design was able to investigate and explain discrepancies between expected and observed outcomes and provided insights to aid further implementation of family-focused practice. The mixed-methods approach also allowed the complex and sometimes hidden feelings from the staff to be illustrated, helping to support and aid the interpretation of the statistical findings.

It is important to consider the potential influence of the author’s dual role throughout the research, i.e. by taking on responsibilities for change, being an ‘inside’ implementer, as well as attempting to maintain an objective stance as a scientific researcher. Such an approach breaks the traditional distance between research and objective and is a common double-bind within action research where there is interdependence between the researcher and the Organisation (Checkland & Holwell, 1998).

With regards to the author’s aforementioned dual role, there are both advantages and disadvantages. Firstly, an advantage is that the approach perhaps prevented the author from being perceived as a disinterested observer, instead able to clarify and discuss her own

viewpoints and values with the participating staff. Additionally, the research process was demystified for the participating staff, allowing them to appreciate the pertinence of the collaboration between the Organisation and researcher. Furthermore, the author was able to establish a stronger rapport with the staff, which helped to capture their interest in family work. However, a disadvantage of the author's dual role is that it was difficult to stand back from the research and explore issues in a neutral and dispassionate manner. This notion is very different to traditional research, whereby the researcher remains 'outside', detached and removed from the research context. One of the disadvantages of traditional research, however, is that an external researcher may not be aware of the subtleties of the research environment in which they are investigating. It was important for the author to be mindful of the advantages and disadvantages of the approach taken within this research, and the possibility of a distorting influence on the research process. These were issues often reflected upon within academic supervision.

A strength of the package of family-focused training and supervision package was that it was evidence-based, being supplemented with detailed manuals and interactive learning principles using role-play and visual aids (DVD). Furthermore, the Research team responsible for the delivery of the nine-month training and supervision package were experienced in providing staff with training in family intervention, ensuring that on-going supervision and advice was offered using the staff's real-life casework.

Finally, it is believed that the results from the training and supervision are still being achieved today in day-to-day practice, with the creation of new family-oriented contracts and negotiations with commissioners. The results and evaluation will continue to ensure the

positive development and implementation of evidence-based family-focused approaches and to continue to give a voice to affected FMs.

CONCLUSIONS

The research reported in this thesis has investigated and evaluated the impact of a programme of evidence-based training and on-going support on the implementation of family-focused practice within one non-statutory addiction treatment Organisation. Although this thesis has provided some answers to the questions it set out to, the findings have also raised many additional questions. The findings support the use of an Organisational platform to understand how to successfully implement family-focused practice within addiction treatment services. It appears that a carefully planned family-focused training program can help to promote some shifts in attitudes and practice behavior, and alleviate a large proportion of the barriers that exist at the level of the individual treatment provider and Organisation. However, established practices were not easy to change, and strategies related to family work are complicated, multifaceted, and intertwined with outside Organisations and related to financial restraints.

Future efforts to implement family-focused addiction treatment practice requires intervention at the individual level, the Organisational level, and the wider environment of which the Organisation is a part. Fully examining the environment in which the Organisation was situated was beyond the scope of this thesis, however, will be important to consider going forward, bearing in mind the relatively diffident changes that a training programme can achieve within one Organisation.

It can be concluded that addiction treatment services have the capacity to implement family-focused practice, however, the success of this implementation depends very much on the system in which the service/Organisation exists, and that researchers alone cannot guarantee that family intervention for substance misuse problems finds its way into routine practice. Instead, key stakeholders need to work together to shape future addiction treatment services and to respond to the barriers to family-focused practice reported here, ensuring that family work is a central component of their philosophy and routine treatment delivery.

APPENDICES

Appendix 1: Attitudes to Addiction Related Family Problems Questionnaire (AAFPQ)

1. I am interested in working with, and responding to, the problems of relatives of alcohol or drug misusers
2. Specialist drug and alcohol services are an ideal environment in which to work with relatives of alcohol or drug misusers
3. I know enough about the relationship between alcohol or drug misuse and family problems to work with relatives of misusers
4. I feel that I am a failure when working with relatives of alcohol or drug misusers
5. Working with relatives of alcohol or drug misusers can impact on the behaviour of the misusers
6. I could find someone outside my service who would be able to help me with any problems I might be having with relatives of alcohol or drug misusers
7. I feel my clients believe I have the right to ask them if they need any help dealing with alcohol or drug misusers in their family.
8. I feel confident when working with relatives of alcohol or drug misusers
9. I have a clear idea of my responsibilities when working with relatives of alcohol or drug misusers
10. I feel adequately supported within my service to work with relatives of alcohol or drug misusers
11. Helping the relatives of alcohol or drug misusers is just as important as helping the misusers
12. I want to work with relatives of alcohol or drug misusers
13. I feel able to work with relatives of alcohol or drug misusers as well as I can with other groups of clients
14. There is little I can do to help relatives of alcohol or drug misusers
15. I have a good knowledge of the effects problem alcohol or drug misuse can have on the relatives of misusers
16. The knowledge I have enables me to work well with relatives of alcohol or drug misusers
17. It is rewarding to work with relatives of alcohol or drug misusers

18. I could find someone within my service who would be able to help me with any problems I might be having with relatives of alcohol or drug misusers
19. I have the right to ask alcohol or drug misusers about how their relatives may be coping
20. I sometimes feel uncomfortable working with relatives of alcohol or drug misusers
21. I can adequately assess the state of relatives of alcohol or drug misusers
22. Teaching relatives of alcohol or drug misusers new ways of coping with the problem is an effective way of helping the misusers
23. The best solution I can offer relatives of alcohol or drug misusers is referral to someone else
24. Helping alcohol or drug misusers and their relatives to communicate better is an effective way of helping the misuser
25. I feel adequately supported outside my service to work with relatives of alcohol or drug misusers
26. I feel I have the right to ask relatives of alcohol or drug misusers about the effects the problem may be having on them and whether they need any help coping
27. I can understand relatives of alcohol or drug misusers and the problems they may be having
28. Helping relatives of alcohol or drug misusers is a legitimate and important part of my work

AAFPQ SCORING INSTRUCTIONS

Questions are answered on a seven-point Likert scale:

7=Strongly agree

6=Quite strongly agree

5=Agree

4=Neither agree nor disagree

3=Disagree

2=Quite strongly disagree

1=Strongly disagree

Negatively worded questions need to be recoded so that the higher the score, the more positive the respondent. Therefore, responses for questions 4, 14, 20, 23 need to be recoded – for these questions 1=Strongly agree, 2=Quite strongly agree and so on.

The sub-scales:

Knowledge (questions 3, 15, 16) (total score achievable is 21)

Confidence (questions 8, 9, 21) (total score achievable is 21)

Support (questions 6, 10, 18, 25) (total score achievable is 28)

Legitimacy (7, 19, 26) (total score achievable is 21)

Motivation (1, 2, 11, 12) (total score achievable is 28)

Self-belief (4, 14, 20, 23) (total score achievable is 28)

Impact on the user (5, 22, 24) (total score achievable is 21)

Total score achievable = 168

Government	Percentage
Current government	85%
Previous government	15%

Appendix 3: Participant Information Sheet

Involving Family Members in Addiction Treatment Services **Participant Information Sheet**

The University of Birmingham are working on a research project taking place at your workplace over the next two years. We would like you to understand why the research is being done and what it involves. Please take time to read the information carefully and discuss it with others if you wish. Please contact Claire Hampson or Alex Copello (University of Birmingham) if there is anything that is unclear to you or if you would like further information.

What is the study and how have I been chosen?

Aquarius will be involved in a programme of project development and research responding to family members. As part of this programme four teams have been picked to attend a two-day family-focused training event at Head Office (dates to be provided by your manager). You have been chosen to participate in the research project as you work within one of the teams attending the training event. The training event will be delivered by Richard McVey and Alex Copello.

What will I have to do if I take part?

The project is part of an Organisational initiative with a research element. Claire Hampson (PhD researcher from the University) will be recording and measuring various outcomes over the two years.

After the initial training event you will be asked to attend 8 consultancy meetings with the research team (Richard McVey, Alex Copello and Claire Hampson – PhD student). These meetings will take place each month. After the 8 consultancy meetings you will be asked to attend a follow-up one-day event at Head Office.

The research element of the project will involve you:

- Completing two standardised questionnaires asking about your views on family members affected by addiction problems. You will be asked to complete these at the beginning of the project and at 9 and 18 month intervals.
- Attending 8 consultancy meetings at your team base with the research team. Minutes from each meeting will be typed up for research purposes.
- Occasionally being selected at random to provide brief details on your treatment activity for one week by completing a brief form.

Do I have to take part?

All staff will be required to attend the training event as part of the Organisational development. The research element involves completing the questionnaires and providing brief details on treatment activity

occasionally. The measurement evaluations mentioned above here voluntary, however it would be very helpful for the research if you were to take part in these.

What are the benefits of taking part?

You will be helping to continue to ensure the positive development of research-based training and interventions for specialist addiction treatment services.

Will my taking part in the study be kept confidential?

All information collected from you during the course of this research will be kept strictly confidential. You do not have to provide your name when completing the questionnaires. The minutes taken from the monthly consultancy meetings will be typed up for research purposes, however all names of clients and staff will be removed for confidentiality reasons.

What will happen to the results of the research study?

The results will eventually be published in a scientific journal so others can learn from them, as well as being part of Claire Hampson's Ph.D project. You should contact the research team if you wish to request feedback on the results of the project.

What happens next?

You will be asked to sign a consent form showing you are willing to participate in the project collaborating with the University of Birmingham. You will then be asked to complete the two questionnaires. Your manager will advise you when you will be attending the training event.



Thank you very much for your time.

Appendix 4: Instructions for completion of the diary-snapshot

Weekly Monitoring Form Instructions

Every so often you will be asked to participate in a weekly monitoring task. This task will ask you to record who you have seen or spoken to during that particular week. This is to enable a consistent method of recording the amount of family work being carried out across the team during a particular period of time.

Please note, it is purely explorative and is not at all intended as a method to monitor staff performance or progress. All responses will be anonymous.

The research team will, at random, assign the diary snapshot to your team. Claire Hampson from the research team will contact you by telephone on the Thursday or Friday the week before to advise you that you have been chosen that week. If for any reason you are unable to complete the 'diary-snapshot', please let Claire know then. Claire will also arrange a mutually suitable time to call again after the week to make a note of your contact.

When recording the family work it is entirely up to you how you do so. The research team have put together a form which you may choose to use, however you may prefer to record the contact in your own diary. The form provided lists categories which you may find quicker to use. Please do not provide any names of focal clients or family members. The comments section is there for you to fill in details which you feel may be relevant e.g. 'Mother of drinker, initial assessment.'

Claire will call you the following week to record the contact. If you prefer you can email the form to her at

[REDACTED]

It is not anticipated that the diary snapshot will cause you any additional work, and hopefully will fit into your existing day-to-day duties. If however you have any queries please don't hesitate to contact the research team on the contact details below:

[REDACTED]

[REDACTED]

Appendix 5: Consent Form

Involving Family Members in Addiction Treatment Services

Consent Form

Please initial box

The research has been explained to me. I understand that I will be asked to complete two questionnaires about my views on family members affected by addiction problems.

I understand that minutes from the consultancy meetings will be typed up for qualitative research purposes and that any quotes used for analysis will have names removed.

I understand that any information that I give in this research project will be kept strictly confidential.

I understand I may be occasionally selected at random to provide brief details on my treatment activity for one week by completing a brief form. I also understand that all data I provide will be kept strictly confidential and anonymous.

I know that I can ask questions about the research now or at any stage. I understand I should contact my manager should I wish my responses to be removed from the project.

I have been given the names and telephone numbers of those responsible for this research, including the name of the researcher to whom I should address any complaint or grievance I might have.

I understand I should contact the research team if I wish to request feedback on the results of the project.

I hereby give my consent to take part in the research project with the University of Birmingham exploring views on family members affected by addiction problems.

Signature..... Name

Researcher's Name: Claire Hampson

Date.....

Appendix 6: Formulae used to calculate differences in diary-snapshot data (two-proportion z test)

A worked example of how the differences in diary-snapshot data were examined is provided using example data below.

Time-point	Total work	Sessions involving FMs	FC & FM	FM(s) alone	Other family work	FC alone
1	272	85	9	14	62	187
2	299	96	14	29	53	203

p is a weighted average of the p_1 (proportion of family-focused practice at T1) and p_2 (proportion of family-focused practice at T2), n_1 was the total number of sessions taking place at T1, and n_2 was the total number of sessions taking place at T2.

The first step was to compute the difference between the sample proportions: $p_1 - p_2 = 85/272 - 96/299 = 0.3125 - 0.3211 = -0.0086$. The next step was to compute p , the probability of obtaining a difference between the proportions larger than the difference observed in the experiment using the formula

$$z = \frac{p_1 - p_2}{s_{p_1 - p_2}}$$

$s_{p_1 - p_2}$ is the estimated standard error of the difference between proportions.

$$s_{p_1 - p_2} = \sqrt{\frac{p(1-p)}{n_1} + \frac{p(1-p)}{n_2}}$$

The formula for the estimated standard error was

Therefore, $p(1-p)/n_1 = 0.3125*0.6875/272 = 0.000790$

$p(1-p)/n_2 = 0.3211*0.6789/299 = 0.000729$

$0.000790 + 0.000729 = 0.001519$

$\sqrt{0.001519} = 0.038973 = s_{p_1 - p_2}$

$Z = -0.0086/0.038973$

$Z = -0.2199$

If $Z < 1.96$, the probability that the two proportions are the same is less than 5% (p value is less than 0.05). Hence, $Z = 0.22$ SE's away from zero, and $0.22 < 1.96$, the null hypothesis is accepted, meaning there is no difference in levels of family-focused practice between T1 and T2.

Appendix 7: NHS Ethical Approval Correspondence







Appendix 8: NHS Research and Innovation (R&I) approval



Appendix 9: Attitudes to Involving Family Members in Treatment Questionnaire (AIFMTQ) - Questions and Coding Instructions

1. I believe that involving family members should be the norm.
2. I have concerns about confidentiality issues if family members are included in treatment.
3. I don't feel confident about handling open conflicts between the user and his/her family members.
4. I feel that family members can be too dominating in sessions.
5. I find I get a clearer picture of the addiction problem when I involve the family members.
6. Suspicion of domestic violence is always a contrary indication for involving family members.
7. Conflicts of interest usually arise for the counsellor/practitioner when family members are involved in sessions.
8. I feel that involving a family member makes the user feel resentful.
9. I feel out of my depth when working with more than one person in the room.
10. I find that involving a family member helps to identify positive coping strategies for the family as a whole.
11. I would never attempt to involve family members if there was a hint of a child protection issue.
12. I find it difficult to remain neutral when working with the user and his/her family members.
13. It is inappropriate to ask users about involving their family members.
14. Family members think it is the user's problem and don't wish to be involved themselves.
15. I find there are too many logistical difficulties in involving family members in sessions.
16. Working with family members is as important as working with the user.
17. Involving family members is very helpful even in complex cases.
18. Family members take over sessions, nagging and point scoring.
19. Making sure that family members are well informed about the users' problems is an essential part of good treatment.
20. Family members just want to have the user's addiction problem fixed and think anything else would be unhelpful.
21. The needs of users and their family members are very often incompatible.
22. It creates a more coherent approach towards tackling the problem if a family member is involved.

AIFMTQ SCORING INSTRUCTIONS

Questions are answered on a seven-point Likert scale:

7=Strongly agree

6=Quite strongly agree

5=Agree

4=Neither agree nor disagree

3=Disagree

2=Quite strongly disagree

1=Strongly disagree

Negatively worded questions need to be recoded so that the higher the score, the more positive the respondent. Therefore, responses for questions 2, 3, 4, 6, 7, 8, 9, 11, 12, 13, 14, 15, 18, 20, 21 need to be recoded – for these questions 1=Strongly agree, 2=Quite strongly agree and so on.

The sub-scales:

General Orientation (questions 1, 5, 10, 16, 17, 19, 22) (total score achievable is 49)

Confidence managing interpersonal issues (questions 3, 9, 11, 12, 13, 15) (total score achievable is 42)

Lack of concern involving family members (questions 2, 4, 6, 7, 18) (total score achievable is 35)

Perceived compatibility of needs (questions 8, 14, 20, 21) (total score achievable is 28)

Total score achievable = 154

Appendix 10: Log-transformed mean AAFPQ sub-scale and total score (phase two)

AAFPQ sub-scale	Immediate group			Delayed group		
	T1 (<i>n</i> =23)	T2 (<i>n</i> =25)	T3 (<i>n</i> =24)	T1 (<i>n</i> =12)	T2 (<i>n</i> =14)	T3 (<i>n</i> =20)
	Baseline	Post-intervention	Follow-up	Baseline	Baseline	Post-intervention
Knowledge	2.67 (0.25)	2.78 (0.18)*	2.86 (0.15)**	2.72 (0.23)	2.80 (0.15)	2.84 (0.15)
Confidence	2.59 (0.20)	2.77 (0.14)**	2.80 (0.15)***	2.65 (0.26)	2.76 (0.19)	2.78 (0.17)
Support	2.83 (0.13)	2.99 (0.19)**	3.01 (0.17)***	2.82 (0.16)	2.99 (0.22)*	3.06 (0.21)
Legitimacy	2.71 (0.18)	2.76 (0.11)	2.81 (0.15)	2.76 (0.16)	2.78 (0.17)	2.77 (0.17)
Motivation	3.13 (0.18)	3.12 (0.16)	3.16 (0.15)	3.12 (0.17)	3.23 (0.11)	3.18 (0.16)
Self-belief	2.97 (0.20)	3.03 (0.21)	3.08 (0.13)*	2.93 (0.22)	3.09 (0.18)*	3.06 (0.16)
Impact on the user	2.81 (0.13)	2.83 (0.12)	2.84 (0.13)	2.83 (0.11)	2.89 (0.14)	2.88 (0.13)
Total AAFPQ score	4.79 (0.13)	4.86 (0.11)*	4.90 (0.12)**	4.80 (0.13)	4.90 (0.13)*	4.90 (0.14)*

Notes: *Significantly greater than baseline ($p < .05$). **Significantly greater than baseline ($p < .01$). ***Significantly greater than baseline ($p < .001$).

Appendix 11: Log-transformed mean AIFMTQ sub-scale and total score (phase two)

AIFMTQ sub-scale	Immediate group			Delayed group		
	T1 (<i>n</i> =22) Baseline	T2 (<i>n</i> =25) Post-intervention	T3 (<i>n</i> =22) Follow-up	T1 (<i>n</i> =12) Baseline	T2 (<i>n</i> =14) Baseline	T3 (<i>n</i> =20) Post-intervention
General orientation	3.59 (0.16)	3.62 (0.12)	3.66 (0.13)*	3.63 (0.16)	3.68 (0.13)	3.76 (0.13)** ^ #
Confidence managing interpersonal issues	3.32 (0.18)	3.34 (0.20)	3.39 (0.16)	3.33 (0.13)	3.44 (0.19)	3.46 (0.20)
Lack of concern involving family members	2.90 (0.17)	2.90 (0.29)	2.91 (0.24)	2.95 (0.18)	3.09 (0.20)*#	3.13 (0.15)##
Perceived compatibility of needs	2.80 (0.17)	2.82 (0.27)	2.88 (0.16)	2.85 (0.17)	2.94 (0.17)	3.00 (0.15)** ##
Total AIFMTQ score	4.60 (0.12)	4.62 (0.13)	4.66 (0.12)*	4.63 (0.12)	4.72 (0.11)*##	4.77 (0.13)** ##

Notes: *Significantly greater than baseline ($p < .05$). **Significantly greater than baseline ($p < .01$).

^Significantly greater than T2 ($p < .05$).

#Significantly greater than Immediate group at equivalent time-point ($p < .05$). ##Significantly greater than Delayed group at equivalent time-point ($p < .01$).

Appendix 12: Log-transformed AAFPQ sub-scale means (and standard deviations) for the Immediate, Delayed and Comparison Groups

	Quasi-experiment teams		Previously trained team G
	Immediate group	Delayed group	Comparison group
AAFPQ sub-scale	(<i>n</i> = 25)	(<i>n</i> = 14)	(<i>n</i> = 9)
Knowledge	2.78 (0.18)	2.80 (0.15)	2.87 (0.18)
Confidence	2.77 (0.14)	2.76 (0.19)	2.87 (0.18)
Support	2.99 (0.19)	2.99 (0.22)	3.14 (0.15)
Legitimacy	2.76 (0.11)	2.78 (0.17)	2.88 (0.20)
Motivation	3.12 (0.16)	3.23 (0.11)	3.24 (0.13)*
Self-belief	3.03 (0.21)	3.09 (0.18)	3.20 (0.14)*
Impact on the user	2.83 (0.12)	2.89 (0.14)	2.87 (0.18)
Total AAFPQ score	4.86 (0.11)	4.90 (0.13)	4.97 (0.14)*

Notes: *Significantly greater than the immediately trained group ($p < .05$).

Appendix 13: Log-transformed AIFMTQ sub-scale means (and standard deviations) for the Immediate, Delayed and Comparison Groups

AIFMTQ sub-scale	Quasi-experiment teams		Previously trained team G
	Immediate group (<i>n</i> =25)	Delayed group (<i>n</i> =14)	Comparison group (<i>n</i> =9)
General orientation	3.62 (0.12)	3.68 (0.13)	3.74 (0.13)*
Confidence managing interpersonal issues	3.34 (0.20)	3.44 (0.19)	(3.44) (0.21)
Lack of concern involving family members	2.90 (0.29)	3.09 (0.20)	3.10 (0.20)*
Perceived compatibility of needs	2.82 (0.27)	2.94 (0.17)	2.87 (0.24)
Total AIFMTQ score	4.62 (0.13)	4.72 (0.11)	4.73 (0.16)*

Notes: *Significantly greater than the immediately trained group ($p < .05$).

Appendix 14: Framework Analysis Matrices (Qualitative Themes and Sub-themes) (see enclosed CD)

Appendix 15: Focus Group Questions - Steering Committee Group Lessons Learned

As members of the Steering Committee for the project, we are responsible for driving the project. Our role is to understand important project issues, provide necessary guidance to the Organisation and make appropriate decisions regarding the vision and strategic direction of the project. The purpose of this focus group is, therefore, to explore and understand lessons learned by the committee, from the beginning stages of the project, through to current training and supervision within the teams.

1. As members of the Steering Committee, what have been your experiences of the process of development and implementation of the project? What in your view have been the important lessons learned from this project so far?
2. Do we feel the training and supervision package has led to increased involvement of family members in the trained teams? Are these changes thought to be sufficient?
3. Have there been differences in the level of success of the implementation of family-focused practice within teams? Can we attribute this success to the training/supervision package?
4. Has the culture shifted regarding involving family members? Do the trained teams ensure that family members are offered services in their own right?
5. Do we feel the changes will be maintained within the teams after the project? I.e. will the family-work permeate to new members of staff within the teams?
6. Is there anything the research team can do to ensure family-focused practice continues after the project?
7. Are there any important milestones that have been reached so far?
8. What new family-focused practices have been put in place, both within individual teams and organisationally? (E.g. family member/concerned other assessment forms including asking about the focal client's social network in the assessment triage pack).
9. What has been the experience of involving 'key' managers across different levels of the Organisation? Are they crucial to actively support the project?
10. Is there anything we would have done differently during the 9 month supervision package during Phase I? Are we intending to make these changes going forward?
11. What have been the barriers to implementation of family work? Can we help the teams/Organisation to overcome these barriers?
12. Has the feedback about the training and delivery so far been satisfactory? What changes are needed going forward?

13. Does a more direct approach during supervision meetings improve family-focused practice? E.g. allowing the teams to raise items for the agenda vs. the research team setting the agenda for the meetings.

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