

## **Learning From Experience – Barriers to the Implementation of Evidence Based Practice**

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Mental health practitioners in Britain currently live and work in a Health Service environment dominated by the discourse of Evidence Based Practice. Indeed, mental health practitioners and researchers have themselves been actively involved in establishing what has now become a significant and extensive body of evidence on which mental health practice *could be* based. We say '*could be*' because in our experience, evidence based practice in many areas of mental health service provision in Britain remains the exception rather than the rule. Achieving the widespread adoption by clinicians of interventions shown, through research, to be effective has proven highly problematic.

For example, numerous studies by a variety of research teams around the world have consistently shown that educational, psychosocial and other forms of family focused interventions can significantly reduce relapse rates for clients experiencing severe and enduring mental health problems, (Leff et al, 1982, Hogarty et al, 1986, McFarlane et al 1995) . However, the use of such interventions by mainstream mental health practitioners is not as widespread as one would expect given the strength of the evidence available. There are a number of obvious possible explanations for this; first, a lack of awareness of the research evidence among practitioners; second, a lack of knowledge and skills on their part to deliver the recommended interventions. In response to the second point, a number of training courses for mental health workers were developed, (e.g. the Thorne Courses). Designed to provide course participants with the opportunity to acquire the requisite knowledge and skills to practice the tested interventions, such courses operated in the belief that course participants would then apply the tested interventions more widely in their everyday practice. However, based on our own experiences of running a training programme in family focused interventions, the authors are of the opinion that such a belief is ill founded. In the following paper we reflect on our experiences as members of a Family Project Team with service provision, consultation, educational and training remits, operating in an Inner London setting. As part of this reflection, we will identify and explore some additional factors to the two mentioned above that we believe act as significant barriers to the implementation of evidence based

practice. To place this reflection in context, a brief history of the project and its development will be given.

The Family Project was established nine years ago to serve the clients of an Inner London Mental Health Trust. Since its inception, it has systematically contributed family focused interventions to the routine package of care and services provided for individuals with severe and/or enduring mental health problems. Seven years ago, the Project acquired an in-service training remit by starting to run training courses in family focused interventions for mental health professionals working in associated mental health services. Initially validated by a local School of Nursing, and recognized by the professional body for Nurses and Midwives, the course was subsequently validated by a local university.

The historical development of this project is interesting for four reasons. First, because it illustrates the significance of Professional and Resource issues in attempts to change clinical practice in response to research findings and recommendations. Second, because it illustrates the necessity of close collaboration between service and education providers in the development of educational programmes designed to develop skills in a workforce required to meet locally identified need. Third, because it illustrates the necessity of close collaboration between members of different professional groups, and finally, because it illustrates the important, but problematic issue, of service evaluation in the quest for the continued funding of such initiatives.

### **Significance of Professional Issues**

Although exceptions certainly exist, the majority of current training programmes for psychiatrists still focus predominantly on developing diagnostic and 'prescribing' skills. Similarly, the majority of current training programmes for nurses still focus predominantly on developing the skills of 'connecting' and 'caring'. Both approaches to training are based on an 'individualized' approach to care; a model based on the idea of an individual "suffering" a mental health problem because of personal (i.e. 'inherent to them as an individual') 'deficits', dysfunctions or complications in their psychological development and/or biology. As a consequence, both psychiatrists and nurses focus their interventions and care on an approach centred on attempts to repair and/or attenuate such individual deficits.

By contrast, family focused work provides health professionals with a way of thinking about and giving attention to complementary aspects of behaviours between the client, their relatives or carers, and the mental health professionals they come into contact with when using services. It thus provides a conceptual framework for understanding the developmental processes in which potentially problematic or 'dysfunctional' patterns of interaction originated and the potentially positive 'survival value' of such patterns before attempts are made to modify them.

However, to work in a 'family focused' way calls not just for a development of new knowledge and skills, but also for a change in role. Family focused work redefines the

professional's role as a relative outsider, rather than that of the knowledgeable, unchallenged authority on treatment and management. For psychiatrists, recognition of their need to learn and develop new skills can unsettle their perception of themselves as the senior professional in the multidisciplinary team. In contrast, nurses may experience the anxiety associated with being in a much more responsible, and consequently exposed, position; one that their training has ill-prepared them for. Hence, both groups of professionals may be ill-disposed to the philosophical shift required to implement effectively a family focused approach to the delivery of mental health services.

Before moving on to look critically at the training programme that the Family Project has been running for the past five years, we will outline the characteristics of the Family Focused approach which has underpinned the work of the project.

### **Family focused approach to care delivery**

Insights derived from Expressed Emotion research and from Family Intervention studies suggest that if the needs of individuals with severe and enduring mental health problems are going to be met by mental health services, there needs to be a radical shift in paradigm. Away from the 'individualized' model outlined above to a model based on the idea that the identified individual with a 'mental health problem' is part of a relationship network, or *System*, in an environmental context. Such a systemic theoretical framework, [derived from General Systems Theory, (Von Bertalanffy 1968)], when combined with the stress/vulnerability model of mental illness, enables mental health *problems* to be conceptualized as the product of interactions between a vulnerable individual and their 'surroundings' or environment, including, especially, "significant others" ( e.g. other family members, close friends etc.).

Because research suggests that this interactional context can have a major impact on the ability of an individual experiencing mental health problems to regain and sustain mental health, treatment/care regimes should involve interventions aimed not just at the individual with a diagnosis, but at the level of their relationships with significant others; at the level of habitual interactions, and their patterning, over time. Such an approach might involve a consideration or examination of any or all of the following:

- patterns of interaction
- beliefs and value systems
- ways of thinking about the individuals involved, and
- the influence of culture and the impact of other groups that the various individuals involved might belong to or be influenced by.

For this to take place effectively, significant others must be included, if at all possible, in the treatment/care regime.

So practitioners who include their clients' relationship systems in their thinking about their clients' mental health consider the kinds of interactions that characterise those relationships:

- How supportive they are from a practical and emotional point of view
- How stressful
- The balance of power in those relationships
- The extent to which the relationships are characterised by criticism or over-involvement
- The ways in which characteristic interactions/discourses generate meanings that relate to how clients experience themselves, and their relationship to their mental health difficulties
  - for example, do the interactions/discourses construct an idea of the client as ill or not ill, as symptomatic or as morally deficient (e.g. lazy), as handicapped, as compromised as a person, as essentially incompetent, etc?
- How are these meanings related to other and previous beliefs/patterns of behaviour and interaction?
- Finally, how do these constructions, and the relationships that support them, affect the client's ability to regain and maintain mental health, and to maximise quality of life?

If mental health professionals are going to attempt to influence their clients' relationship contexts in ways that reduce stress, then they will need to acquire not only a knowledge and understanding of systemic thinking but also the thinking and practical skills required to work in this "family" or relationship focused way. For example, the ability to make psycho-educational interventions, to explore family members' previous experiences, related beliefs and patterns of behaviour, and to support relatives in their role as "carers".

### **Characteristics of the Family Project training programme**

The training programme at the Family Project differs in three main ways from the more exclusively "psycho-educational/psychosocial" principles adopted by other training programmes, e.g. Thorne courses:

- First, the course has been, and remains, restricted and dedicated to a specific mental health care provider. The primary goal of the training remit has been to bring about a change in practice in the services offered by that provider to one more closely aligned with the evidence base available; i.e. a shift away from an individualized approach to care towards a family focused approach.
- Second, most of the families are initially seen at the Project's base in a Mental Health Outpatient department where facilities exist for the 'live' supervision of course participants. While this may be the usual base for some course participants, and where some clients normally attend, for many it is not.
- Third, the approach attempts to incorporate the "family management" and "problem solving" approaches within an overall systemic framework.

## **Model of intervention**

The philosophy of the project is based on the belief that major mental illness cannot be managed successfully if it is treated as a discreet entity, independent of the social context or culture in which it occurs. This has conceptual as well as practical advantages:

- It offers a model of the family that is optimistic and doesn't focus on pathology or search for causes.
- It offers clear guidelines to the therapist for intervention.
- It respects the natural hierarchy and structure of the family, seeking to support the family in the development of new solutions, rather than undermining the structure by implying the therapist knows better.
- It provides a clear model for the resolution of day to day practical problems associated with mental health difficulties through attention to detail.

## **Methods used in the training programme**

The teaching strategies adopted by the project include didactic instruction, recommended reading, lectures, workshops and discussion groups. However, the most important component of the training programme includes the 'modelling' of interviewing, assessment, and intervention skills by qualified team members, followed by the rehearsal of these skills by course participants in role plays, receiving feedback and coaching on their performance. This is followed by live supervision of the practice of course participants as they work with families in small clinical supervision teams. There are also fortnightly discussions of clinical work based on presentations of videotaped family sessions by course participants.

## **Impact of family project training initiative**

Despite the implementation of this training initiative over a number of years, it became clear to the Family Project Team members that the original aims and objectives of the programme were not being fully realised. The impact on service delivery hoped for, namely the wider adoption of evidenced based family focused interventions, had not occurred. In many areas of the service, care was still being delivered on an "individualistic" model, and the incorporation of the families, relatives and other social networks of those experiencing mental health problems was not taking place as a matter of course in everyday care delivery. A number of factors were implicated in explaining why this might be the case.

First, the model or strategy of change adopted when the training initiative began was based on the assumption that once a 'critical mass' of mental health personnel had been trained, and were suitably skilled in family focused interventions, then the required shift

in 'paradigm' would take place. This would be followed by family focused interventions becoming an "institutionalized" mode of intervention among mental health professionals providing mental health services. Over a five year period the project trained almost forty of the Trust's mental health practitioners [the programme had a restricted intake (a maximum of 9 participants) because of the need to provide live clinical supervision], including nurses, occupational therapists, psychiatrists, and social workers. However, the vast majority of course participants were nurses.

There are obvious problems with such a strategy for change. First, there is the problem of attrition rates. Some programme participants moved on to jobs outside the locality, either during the programme or after completing it. Some moved jobs within the locality, sometimes into management and away from practice. Also, evidence began to emerge that if practitioners are provided with opportunities to develop their knowledge and clinical skills in family work but are subsequently deprived of opportunities to practice them, then they are highly likely to search for, and move to, posts or settings where family focused work is the dominant paradigm. For example, two programme participants, after completing the programme, left the Trust to work with the family intervention projects run by the National Schizophrenia Fellowship. Hence, any training initiative that fails to address the organizational frameworks that course participants may come from, and return to, are unlikely to have the desired impact.

Second, the "critical mass" approach to change facilitation does not necessarily deal with the issue of whether, and to what extent, programme participants are interested in, or suited to, acting as "change agents" in their normal work setting. How well placed such individuals might be to carry out such a role is undoubtedly affected by the power differentials that exist within a multidisciplinary team. For example, the power base of an 'E' grade staff nurse is not the same as that of a senior nurse manager or consultant psychiatrist. Therefore, such nurses are ill placed in terms of power and authority to bring about the significant paradigm shift that the implementation of family focused interventions requires. If they constitute a significant proportion of the 'critical mass' trained, then such a critical mass is unlikely to be able to bring about the changes in practice sought even if supported by a strong body of evidence.

### **Other factors affecting impact of training**

Over the years that the programme has been running, service managers within the Trust have been faced with increasing pressures to contain their continuing professional development budgets. What was possible four years ago is no longer the case. Recent participants, particularly nurses, have had to invest larger proportions of their own time to attend the programme, even though they are acquiring knowledge and skills which will enable them to more effectively and efficiently meet the needs of their clients, their clients relatives and/or carers.

Changes in the philosophy of care delivery can lead to changes in professional roles. In turn, this may necessitate changes in the organization and management of services. Administrators and managers are loathe to commit themselves to the uncertainty such

changes might promote. Especially when faced with the ambivalence, or outright resistance, from some staff and professional groups that sees the proposed change in practice as a threat to their present position or clinical role. The present climate of service configuration and provision, characterized as it is by relentless change, often leads to management being 'crisis driven' rather than 'philosophy' or 'evidence driven'. Such approaches to management are not conducive to strategic workforce planning and service development. In addition, the debate about how best to provide community care, and its relationship to inpatient care, continues unabated.

Because of the way the Family Project programme is organized, the majority of course participants have to leave their normal work settings for supervised clinical skills acquisition. Although they see clients from within their own catchment areas, they nevertheless see them as members of a clinical team in a tertiary setting. While this is an excellent way to facilitate skill and knowledge acquisition, it does not fit comfortably with the everyday need to provide a clinical service. Nor does it facilitate an examination of the problems involved in the application of these skills in other settings, such as the client's home, or the inpatient setting, or how such work might be facilitated and supported. The programme has undoubtedly neglected these important areas by focusing particularly on clinical skill acquisition.

The experience of the project team also suggests that significant obstacles to skill application can emerge from existing "policies and procedures", established working cultures and practices, and existing facilities/resources. For example, existing methods of auditing the amount of time community mental health workers spend in direct clinical contact with clients, compared to other activities (e.g. administration), do not allow the recognition of time spent with relatives/carers in the absence of the designated mental health client. Consequently, under this auditing procedure, facilitating a relative's Support Group would not count as 'client contact' time, even though such interventions may have an important impact on the client's 'context' or environment. Similarly, the design and allocation of space in in-patient facilities often makes it difficult to accommodate other family members. This applies both in terms of them spending time with their ill relative on the ward, or there being suitable and convenient private space in which a primary nurse, for example, might meet with a patient and their family. Also, in community mental health settings interview areas are often designed for individual interviewing.

The opportunity to include other family members in CPA meetings, or other treatment reviews and decision-making forums, often seems to be missed. This could be for a number of reasons:

- administrative convenience; for example, when such meetings are scheduled to fit in with ward-rounds, the timing and format of which may make it difficult for family members to attend

- the unconscious, or even conscious, desire of mental health professionals to avoid participating in the exploration and examination of the assumptions inherent in established practices
- concerns over the issues of confidentiality between the client, the professional team and carers or other family members.

Also, to achieve a fundamental shift in working practices, the fragmentation of service provision, with each discipline tending to embrace a different model of care/treatment, has to be addressed. A unified, family focused approach is very difficult to achieve in the context of what still remains a very hierarchical structure, where the occupational groups within it have different levels of power and spheres of influence. Any attempt at change that fails to take these elements into account is doomed, at best, to partial success, at worst, to failure. In our experience, as outlined above, using staff nurses as potential change agents in some areas is totally unrealistic.

### **Targeting training initiatives**

We conclude the paper by looking at some of the implications of these issues for the targeting of training initiatives. First, if such training initiatives are intended to facilitate a more fundamental change in service philosophy as well as service delivery, then our experiences suggest that training should be targeted carefully. Instead of focusing at the level of the individual and his/her conceptualisations and skills, initial training initiatives should be targeted at key players, or teams, involved in the planning and management of mental health service delivery. This model of change is more likely to bring about congruence between the overall service philosophy or paradigm being promoted, and the philosophies of care adopted by particular professionals or professional groups. That is, training should be targeted at practitioners in their professional relationship contexts. To achieve this, several possible approaches have occurred to us.

One is to adapt the current training programme in ways that involve the Family Project team members relating in much more significant ways to the colleagues and managers of the practitioners in training. This might involve promoting the course in a different way. Rather than presenting the course as a post-qualifying forum for the continuing professional development of individual practitioners, it could be presented as a resource for mental health teams. The team would nominate a team member as a course participant with the expectation that they would be assisted in planning and introducing family focused approaches within the team. Such an approach would encourage an on-going “three-way” discussion between the course facilitators, course participants and their colleagues and service managers, thereby actively engaging them in the process of developing and operationlizing a family focused approach to care provision.

Also, such an approach could facilitate the development of training and assessment strategies that would allow trainees to work with clients from their own case lists, under supervision, in their normal work roles. Course assignments could then be focused on the implementation of new practice and service delivery models that incorporate the relationship/contextual approach; for example, the introduction of relatives' or multi-family groups (MacFarlane 1990).

While many middle managers have supported the work of the Family Project Team, and welcomed its attempt to bring about a family focused approach to service provision, it is our perception that to be successful, such a major paradigm shift must:

- be clearly articulated as part of an over-arching service development strategy, and
- have the support of management at the highest level.

This paper has focused exclusively on the role of continuing professional development for qualified practitioners in bringing about the implementation of evidence based practice. It has suggested that part of the problem lies in a clash or conflict of paradigms; between the 'individualized' approach underpinning past and current programmes of initial preparation for nursing and medical practice and the 'contextualized' model underpinning a family focused approach. In pursuing this argument, the very real issue of its implications for the initial preparation of the nursing and medical practitioners of the future has been ignored. However, there have been 'murmurings' recently in both the nursing and medical literatures in Britain that suggest current initial programmes of preparation for nursing and medical practitioners do not equip participants with the requisite knowledge and skills for safe and effective practice in the contemporary health service. If this were the case, it would suggest the need to think very carefully about the contents of these programmes. The design of medical and nursing curricula has become increasingly complex. There are constant demands from different quarters to include as part of these programmes an ever-increasing array of skills training. Perhaps the time has come for a radical reassessment of the skills, competencies or capabilities, and the paradigms that underpin them, that we think newly qualified mental health practitioners need to possess to meet the increasingly complex needs of clients receiving care in a community orientated health service. However, our experience suggests that we also need to give careful thought to the wider context in which the teaching and learning strategies we employ are situated.

Many of the difficulties experienced in the implementation of Care in the Community, both nationally and locally, serve only to reinforce the argument for the shift in paradigm outlined above. A number of the reports produced by inquiries into untoward incidents in the community, some involving the deaths of members of the public or relatives, have highlighted the dangers inherent in mental health professionals working with the client in isolation. It is our belief that the 'contextualized' way of thinking about clients and their mental health problems, and the interventions that emanate from it, is essential for the safe and successful implementation and delivery of a 'Care in the Community' orientated mental health service.

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