

Training and disseminating family interventions for schizophrenia: developing family intervention skills with multi-disciplinary groups

Gráinne Fadden^a

Family interventions for psychosis are not routinely available, in spite of a robust evidence base, clear policies and guidelines, and requests from service recipients. The reasons for this are complex involving three key groups: service recipients, clinicians and organizations. This paper first of all identifies barriers to implementation in relation to each of these groups. It then outlines a range of strategies that may be employed at a number of levels to bring about change in each of these systems. The strategies are drawn from current research in the area, and from experiences over a seven-year period in the Meriden West Midlands Family Programme.

Introduction

The lack of the general availability of family interventions in spite of comprehensive policies and a staunch evidence base remains a topic of widespread discussion among mental health service providers, clinicians and families affected by mental health problems. The different arguments for the delivery of family work are summarized in Figure 1. At the simplest level, that of good practice, laypeople see it simply as common sense that family members are provided with some information and support when dealing with an unfamiliar and stressful situation given that mental health difficulties impact upon all members of a family. Our awareness from the literature on the needs of families in this situation and the coping difficulties they experience affords a moral imperative and argument for providing access to services that ease their difficulties, reduce stigma, and help them to develop

^a Consultant Clinical Psychologist, Birmingham and Solihull Mental Health Trust and Honorary Research Fellow, University of Birmingham.

The Meriden Programme, Northern Birmingham and Solihull Mental Health Trust, 71 Fentham Road, Erdington, Birmingham B23 6AL, UK. E-mail: grainne.fadden@bsmht.nhs.uk

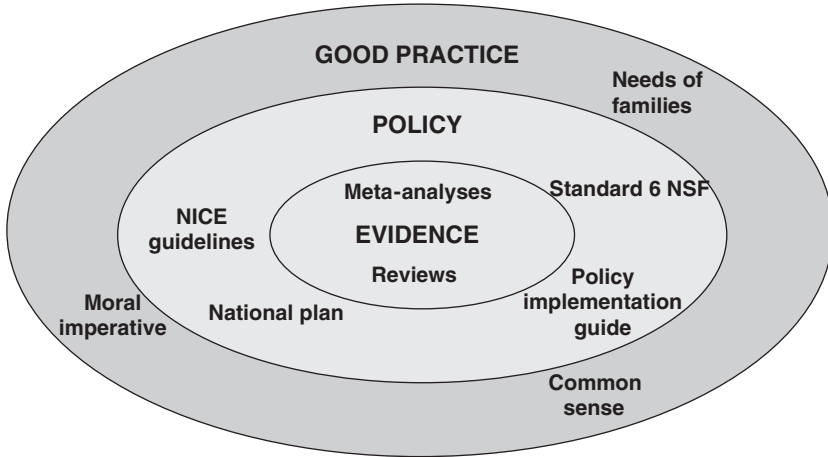


Figure 1. Factors supporting the availability of family work

effective strategies for dealing with the situation in which they find themselves.

However, in the area of family work, at least in the United Kingdom, we are not simply relying on ideas of good practice and common sense. In the past five years, a series of policies and guidelines have made it very clear to statutory services providing mental health care that comprehensive services to those with serious mental health difficulties must include services to families. The National Service Frameworks for Mental Health were significant in that one of the Standards, Standard 6, outlined the rights of those in key caring roles to receive an assessment of their needs and a care plan that is implemented and reviewed annually (Department of Health, 2000). A policy implementation guide specifically relating to this was later published (Department of Health, 2002), and a number of the other policy implementation guides such as those relating to assertive outreach teams and early psychosis services also stipulated that services to families be provided on these newly developed teams. The guidelines on the management of psychosis published in 2002 (NICE, 2002) could not be clearer in their recommendations around services to families, stipulating that family interventions should be offered to all those with schizophrenia who are in contact with their families, and that interventions offered should last for a period of at least six months.

In terms of an evidence base, family interventions in psychosis and other serious mental health problems have one of the most robust and long established in mental health. It is an area where numerous randomized controlled trials have been conducted, all testifying to the efficacy of family interventions in reducing relapse rates and hospitalizations. Meta-analyses conclude that the evidence supports the provision of family interventions in psychotic disorders (Pilling *et al.*, 2002). There have been a number of reviews of this area recently and all come to the same conclusion that family work is essential in the management of schizophrenia, and that family interventions be offered to the majority of families (Bustilla *et al.*, 2001; Dixon *et al.*, 2000; Pitschel-Walz *et al.*, 2001). It is also clear that family interventions can be adapted to different cultures, and that the results are sustained over time.

Current situation regarding the availability of family work

Given the strong evidence base, the existence of clear policy, and the acceptability of family interventions to those who need them, it is indeed difficult to understand why there would be any problem with their widespread availability. The strong evidence base has had a number of positive effects in terms of raising the profile of family work. It has resulted in many professionals being interested in family work, and has made it difficult for those resistant to family interventions to continue to argue against their availability. The evidence base has had a strong influence on the development of policy, and the message about the value and impact of family work has certainly gone out to carers. On the other hand however, the impact of such a strong research base has been slow to improve services in practice, given that the efficacy of family interventions was first described some twenty-five years ago. It is clear that evidence is a necessary but not sufficient condition for bringing about changes in clinical practice.

Similarly, the existence of clear policies and guidelines has been beneficial in the development of family services. They have certainly highlighted family issues, and once again have made it difficult for anyone to oppose openly the development of family services. They have provided powerful tools for those managers and clinicians who are committed to bringing about a change in services. However, while they are a starting point, the existence of policies has not resulted in rapid change. To date, the returns on Standard 6 assessments have not been good, reflecting the difficulty services have in changing

existing practice and introducing change. In relation to the NICE guidelines, the energy invested in their development was not matched by similar attention to their implementation, and it does not appear initially that those who monitor services are asking the right questions in relation to the availability of services to families. The whole area of performance management has not been addressed, and the delivery or lack of delivery of family services often does not count towards the ratings that matter to those charged with the provision of mental health services. Some initiatives, while positive in themselves, are not always thought through with due care. One such example is the provision of funding for carer support workers. While this is positive, it is becoming apparent that the roles they will fulfil, or how they will integrate with existing services, has not been planned in detail, resulting in a wide variability in the impact of these new posts on carers' needs across the country.

Influences on the delivery and receipt of family work

Given that family work is not routinely available in spite of policy, research evidence and the fact that it is good clinical practice, it is obvious that its delivery is determined by a number of complex factors. Three overarching factors may be identified as the recipients of services (both service users and carers), the clinicians and other staff who deliver services, and the context in which this interaction happens (i.e. the organizations and systems responsible for the delivery of services). While it may seem simple to have only three key factors, each of these contains a complexity which, when taken together, helps to explain why the routine availability of family work is so hard to achieve (see Figure 2).

Families and services users

As recipients of services, those who experience mental health difficulties and their families often feel disempowered in the mental health system. While much progress has been made over the past number of years in terms of developing user involvement in services, there is still a power imbalance, and the whole area of family involvement is much less developed. It can be difficult therefore for service users and family members to quote research and policy to service providers, and to be assertive in asking for evidence-based interventions, or assessments and care plans to which they are entitled. Many carers talk

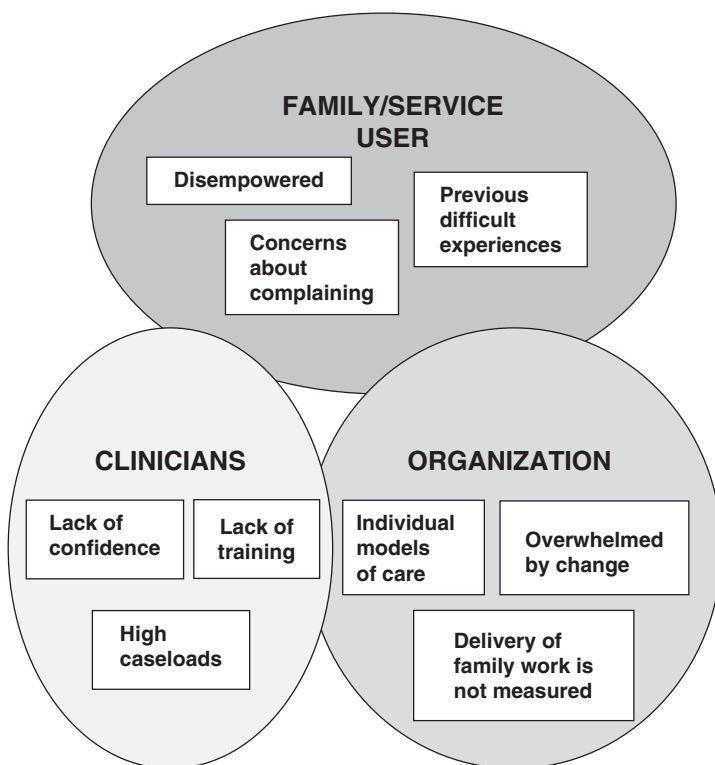


Figure 2. Influences on the delivery and receipt of family services

about their concern that if they complain, there will be implications for their relative who is in receipt of services. While this concern may be unfounded, it is difficult to risk this when you are feeling vulnerable, and when your relative is relying on the only services available in the area. Those of us who work in services know how easy it is for families to be labelled as difficult or complaining, often simply because they are well informed and questioning of why they are not receiving services. Some families may have had difficult experiences of services in the past, sometimes where they feel blamed in some way for their relative's condition. They are therefore reluctant to engage with services lest the experience is repeated. For some, the issue is that they are new to the whole experience of mental health problems, are not aware that they have a role to play, and that they would benefit

from more information. It can be difficult therefore for family members to be assertive about their right to services.

Mental health professionals

For professionals charged with delivering services to families, the move from individual therapies to more family-based care is a difficult transition. For many, their training was almost exclusively in individual therapeutic models, and a majority of clinicians report receiving no training in family work in their professional training courses. In the large-scale Meriden Family Programme in the West Midlands in the UK where almost 2000 therapists have been trained in family work over a seven-year period, 72% of those who entered the programme of training reported that they had not previously received any skills-based training in working with families (Fadden *et al.*, 2004). It is not surprising therefore that they are lacking in confidence and reluctant to engage with families.

In the Meriden Programme, those undergoing training have to submit therapy tapes as part of their assessment. It is clear from evaluation of these assignments that clinicians struggle with a number of areas that are necessary for the delivery of family work. Many find the whole area of planning sessions, setting agendas and keeping a focus within the session difficult. These clinicians appear in the past to have worked in a totally unstructured way, arriving at a session with no clear sense of what they want to achieve, and being unfamiliar with the concept of discussing with a family what they would like to talk about or achieve in the time spent together. Some clinicians lack what might be referred to as general counselling skills, and appear either to lack empathy or to be unable to express it to family members. For many, there is a struggle with the idea of being responsive, yet at the same time having some structure, and some seem to be able to be either one or the other, too structured and therefore unresponsive, or totally unstructured and therefore lacking any direction or focus.

The basic training of clinicians therefore fails to equip them with the broad range of skills they require for working in modern mental health services where they are expected to provide services no longer to the user alone, but also to those who are significant in that person's social network. Working with families requires a range of skills and attitudes listed in Table 1. This list is not comprehensive, but goes some way towards explaining why clinicians without adequate train-

TABLE 1 Skills, knowledge and attitudes needed for family work

■	Positive, understanding attitude towards families
■	Ability to use Rogerian principles (e.g. empathy, positive regard, listening and reflecting skills)
■	Ability to engage with families
■	Awareness of transference/countertransference issues
■	Good communication skills
■	Experience of group work
■	Ability to involve all family members equally in sessions
■	Confidence in handling conflict
■	Dealing with complex issues such as conflicts around confidentiality
■	Understanding of normal family development
■	Knowledge of family systems and how they function
■	Familiarity with the evidence base for family work
■	Awareness of biological theories of mental health difficulties
■	Knowledge of the key components of psychoeducational family interventions
■	Skills in applying components of family work
■	Behavioural and cognitive skills
■	Familiarity with policies relating to families
■	Openness to reflecting on own practice
■	Willingness to use supervision

ing or supervision in family work may struggle with moving away from delivering services to individuals rather than family-based care.

Organizational factors

The delivery and receipt of family work occurs in an organizational context, and factors in mental health services influence their delivery. At this stage there have been a number of studies highlighting difficulties in implementing family work in services, all of which come up with similar results (Brooker *et al.*, 2003; Fadden, 1997; Fadden and Birchwood, 2002). These describe the results of training large groups of staff as distinct from training small groups of highly motivated staff. In the Brooker *et al.* (2003) follow-up study of Thorn trainees, 37% of the sample had not worked with a family following training, 30% had seen one family, 22% had worked with between three and nine families, and 11% had seen ten or more families. It is clear that only small groups of motivated staff work consistently with families which is parallel to the findings of the previous Fadden (1997) study. What is also clear, however, is that organizations facilitate staff in receiving training, but afterwards do not create the conditions or the expectation that the training received will be put into practice. In the initial results from the Meriden Programme, those trained reported

TABLE 2 *Top ten difficulties experienced by therapists in implementing family work two years following training*

1	Integration of family work with the other demands of my caseload
2	Allowance of time by the service to carry out family work
3	Integration of family work with my own personal commitments (e.g. my own family)
4	Availability of 'suitable' or 'appropriate' families to work with
5	Availability of time in lieu for evening work spent seeing families
6	Keeping family discussions on track
7	Engagement of families
8	Long-term commitment to the family
9	Crisis with other clients which took priority over family work
10	Clash of family work with the other clinical needs of the client

working with between one to two families in the first year following training (Fadden and Birchwood, 2002).

An analysis of the implementation difficulties described by staff trained within the Meriden Programme indicates that apart from some issues relating to clinicians' skills, the majority of the key difficulties listed relate to service or organisational issues. For example, at two years post-training, clinicians list the factors described in Table 2 as the top ten difficulties experienced in implementing family work.

It is obvious that family work is not given priority in many mental health services, that time is not made available for clinicians to work with families, and that unhelpful attitudes, such as the idea that only certain families are suitable for family work, are not challenged. There is a history in mental health services of individual models of care, whether these are biological, psychodynamic or cognitive-behavioural. Although many services have moved from hospital-based care to community services, many of the ideas relating to the family that held sway in institutions carry into community settings. Many of the ideas drawn from biological models such as who has expertise relating to the difficulties experienced, and the emphasis on the confidentiality of the doctor-patient relationship, continue to have an impact on the fact that many families do not receive services. Recovery models which emphasize the importance of an individual's social network in helping them to cope with their mental health difficulties do not carry the same weight. The long-established history of mental health services therefore works against families receiving help, and long-established practices are difficult to change.

Apart from historical factors, modern mental health services and their management are currently overwhelmed with change. The

emphasis on targets, budgets, mergers, restructuring, and the development of new services often means that clinical priorities do not receive due attention. There is still a focus on structures such as the composition of teams, rather than attention being paid to what therapeutic approaches clinicians should be delivering, in spite of clear evidence and guidelines. Sometimes those who champion family work do not have power in the system to bring about change, and change is frequently resisted at any rate.

In relation to family work in particular, this is still not prioritized and tends to be perceived as an 'optional extra'. Time and facilities are not provided, and as mentioned above, staff can receive training without the expectation of putting that training into practice. Often, data on family work are not collected in a systematic way, and in some services, staff report that there is no system of auditing numbers of families either in contact with services or receiving help. Others report that even in terms of note-keeping, there is no space for recording contact with families. It is clear that until such time as these organizational factors are addressed, there will not be a notable change in relation to the delivery of services to families.

Encouraging change – influencing the three key groups of players in the system

Having identified the three key groups that influence the delivery and receipt of services, the next logical step is to address how each of these three groups can be encouraged to change in order to improve the delivery of family services. As with any system, it is important that attempts to bring about change address all three groups, otherwise it is unlikely to be effective. Many of the strategies that will be described are drawn from experiences in the Meriden West Midlands Family Programme over the past seven years. The programme will be described briefly in the last section of this paper. These strategies are also confirmed by those who work in other geographical areas that are similarly trying to introduce sustainable family services, such as those described by Smith and Velleman (2002), and Burbach and Stanbridge in the current issue of this journal.

Service recipients

Describing strategies relating to service users and carers first of all, it is obvious that they need to be valued in the system, and to be

empowered to work with professionals and managers to bring about improvements in services. Two-way supportive relationships between professionals and recipients of services need to be developed. Service users and carers need a forum where they can advocate safely in order to have their needs met. It is useful to have a group that family members can link with so that issues can be raised in a neutral manner without identifying individual families, and in order to reduce isolation. An excellent example of this is the West Midlands Carers in Partnership group that covers the whole of the Midlands and participates actively in services, on committees, writing position papers and a host of other activities. Similar groups such as Making Space operate in other parts of the UK, and some operate under the auspices of *rethink* (formerly the National Schizophrenia Fellowship). The National Institute for Mental Health in England (NIMHE) has also been supportive across the country in establishing service user and carer leads in the eight regional development centres. At a local level, many mental health service providers have policies encouraging the involvement of those who receive services in planning and audit. All of these developments have been very positive in facilitating the true involvement of carers and service users in services.

One of the key ways in which the recipients of services can influence change is through involvement in training. In the Meriden Programme, we have found that the most powerful way to influence attitudes is to have training delivered by those who receive services and their families. We now include input from family members on all our courses. It is very difficult for clinicians who are not keen to shift to a model of family-based care to argue with the actual experiences of those who have been at the receiving end of services. Having carers and service users as trainers helps to increase the awareness of professionals of the needs of families, and enables providers and recipients of services to work together to bring about change. The power of this type of involvement is being recognized by professional bodies such as the Royal College of Psychiatrists. In June 2005, it became mandatory for psychiatry trainees to receive training directly from service users and carers. A series of training days have been held for tutors to prepare them for this involvement, and further guidance has been prepared (Fadden *et al.*, 2005). This initiative will be closely monitored, and accreditation will be withheld from psychiatry training schemes that cannot provide evidence of this kind of involvement. There is growing evidence therefore that the unequal power balance between professionals and recipients is beginning to be redressed.

Clinicians

With regard to clinicians and the delivery of family work, it is obvious from the discussion of the issues identified above that training and supervision are two key areas to be addressed. Because of the lack of confidence of clinicians, we have found in the Meriden Programme that a system of ongoing supervision where those trained can bring their issues over time as they develop their work with families is effective, although problems with attendance and the prioritization of supervision can continue. Other strategies that help workers to develop confidence are co-working with a more experienced family worker, or with a family member trained in the approach. Those who begin to work with families soon after they have completed training tend to continue to do so, and having an initial positive experience of family work also encourages workers to continue. Being able to link up with other clinicians who are trying to implement family work is crucial in reducing isolation and encouraging workers to persist in the face of difficulties or opposition. It is very important that those who deliver family work are acknowledged, valued and rewarded for doing so. This does not necessarily mean financial reward. Most clinicians value more the acknowledgement of their managers and the fact that they feel valued in the organizations they work in. Positive feedback from families is also very rewarding.

Some of the strategies relating to clinicians overlap with organizational issues, and these will be described below. The issue of protected time to do this work is crucial however, or that time is facilitated within existing workloads to carry out family work. A final, very effective strategy is the identification of clinicians who are nominated as 'champions' of family work. This has been identified by Smith and Velleman (2002) as one of the ways of developing and sustaining family work in services. Within the Meriden Programme which operates on a cascade training system, the trainers and supervisors in each service play a crucial role as 'product champions' for family work, and the programme would not function without their tireless promotion of the needs of families.

Organizations

Given that organizational factors play a key role in terms of whether or not family services are delivered, it is obvious that interventions with management and organizations are crucial if implementation of

family work is to be successful. It is clear that training clinicians on courses that are not integrated with services is not effective. This lesson has been learned from follow-up studies of those initially trained on the Thorn training courses (Brooker *et al.*, 2003), and people attending these courses still report difficulties in implementing family work in services that have not been involved in the process. It is clear from our own work in the Meriden Programme, and from others involved in similar initiatives, that as much if not more attention should be paid to preparing the Organizations in which the clinicians who are trained work (Repper and Brooker, 2002).

The first important point in relation to this kind of work with organizations is that it takes time and persistence. Organizations such as the National Health Service and those who work in it are used to innovations coming and going, and are effective at resisting change on the assumption that it is the latest fad that will pass if they hold out for long enough. It is notable that the services which are currently beginning to impact upon the delivery of family work in the UK are those where committed individuals championing the cause of families have continued to work in the same area and have had an impact upon services over time. Examples are the services in Somerset (Burbach *et al.*, 2002; Smith and Velleman, 2002), the services in Bournemouth (Kelly and Newstead, 2004), and the Meriden Programme in the West Midlands which has been established since 1998 (Fadden *et al.*, 2002). The area of introducing family work into services is therefore no place for the 'hero innovator' to arrive, hoping for quick successes and rapid change!

In terms of impacting upon organizations, a range of strategies must be employed. First, a solid relationship must be established with senior management, and those charged with implementing family work must be at a sufficiently senior level to be able to relate to management at this level. Having backing at the most senior level, for example, at Board level in an organization, is a necessary but not sufficient condition for implementation. One thing that becomes evident is that the personnel in organizations change frequently, so it is important to be attentive to these changes and to develop relationships with each new relevant senior manager as soon as they take up post. At Board level, policies around family work can be endorsed and ratified, and it is important that the provision of family work is clearly listed in the organization's plans and priorities. It also needs to feature clearly in discussions with purchasers and those who commission services. There needs to be a mechanism for monitoring

the delivery of family work; therefore it is essential that audit departments are involved. Clinical governance structures are useful routes through which to channel reports of activity. Family work should also link in with monitoring of the care programme approach.

It is helpful to have a steering committee to oversee the implementation of family work in a service. This group need not be very large, but should have representation from senior management, and also from operational management as well as service user and family member representatives. A detailed implementation plan should be drawn up based upon the family work policy. This plan should outline clearly the responsibilities of those at different levels in the organization in relation to the delivery of family work, and should have targets with dates when they will be reviewed. Given the history of individual therapy in organizations, we have found it useful to write into clinicians' job descriptions and annual performance reviews that they have a role in relation to families as well as individuals, and also to include presentations on family work in trust induction programmes such as nurse perceptorship programmes, and other systems where new staff are joining organizations.

Given the implementation difficulties described by clinicians, it is important to address issues such as team priorities, out-of-hours working, and caseload size and management. For all of these, the role of middle managers is crucial. These are the people who determine whether family work is prioritized on teams, whether staff are released for training, and whether or not they attend ongoing supervision. Because of this, within the Meriden Programme we now spend a lot of time working with managers at this level, and provide training that is especially directed at middle managers. This covers basic information about family work in terms of what it consists of, the evidence base and policy. Crucially, much time is spent in helping managers to clarify their role in terms of leadership, and creating an ethos and culture that supports the delivery of services to families.

Meriden: the West Midlands Family Programme

The Meriden Programme has been described elsewhere (Fadden and Birchwood, 2002; Fadden *et al.*, 2004), but a brief description will be provided for those who are unfamiliar with it. The programme was established in 1998 with the aims of ensuring that services sensitive to the needs of families were delivered, and that evidence-based family approaches were available to families in the West Midlands region of

the UK. This area has a population of 5.5 million, with both urban and rural areas and a diverse cultural mix, particularly in Birmingham and the surrounding cities.

The programme has employed two main strategies – a detailed programme of staff training and ongoing supervision, and an extensive range of organizational strategies, many of which have been described in this paper. The programme was funded initially through regional training funds for the first six years, after which funding has been provided by the participating organizations. The cost of the first six years of the programme was just over half a million pounds sterling, so it has been very cost-effective, given its scale.

The programme operates a cascade training system whereby therapists are trained and then go on to train and supervise others within their services. There are currently 123 trainers/supervisors within the programme within the thirteen participating organizations, and just over 2000 people have been trained to deliver family work over the seven years the programme has been running (see Figures 3 and 4). Those trained are drawn from both statutory and voluntary agencies, and also include service users and carers.

The programme is funded up until April 2007, and the commitment to the implementation of family work is clear, in particular since April 2004 when the participating organizations made a three-year

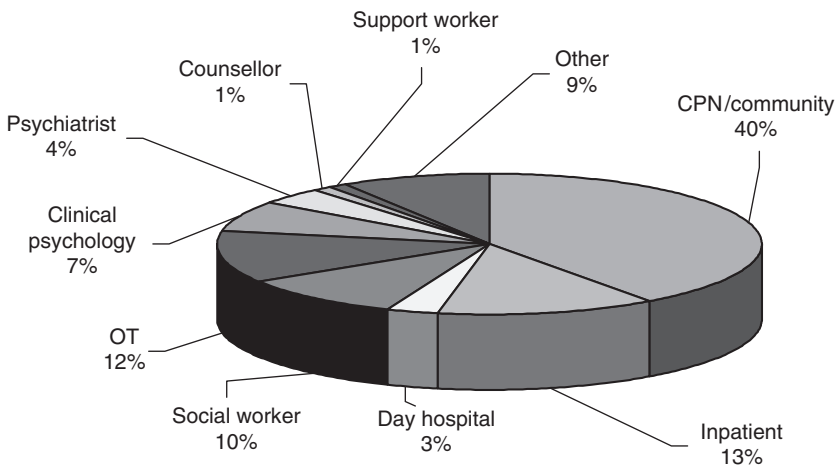


Figure 3. Profession of trainers/supervisors in Meriden Programme (N = 123)

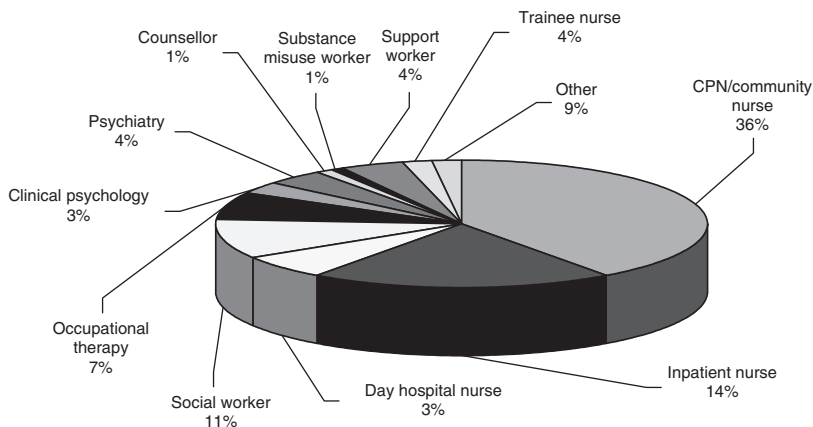


Figure 4. Profession of therapists trained in the Meriden Programme (N = 1819)

commitment to funding. The impact of the programme reaches beyond its own activities. The networks that have developed provide an excellent infrastructure for other activities relating to family services, as is evidenced by the active participation of services in the West Midlands in the recent Royal College of Psychiatrists 'Partners in Care' Campaign (www.partnersincare.co.uk). It is interesting that in the 2003 survey of carers carried out by *rethink*, the West Midlands was the area of the UK where services to carers were reported as having improved, and where the highest proportion of carers reported that they had received sufficient information on their relative's difficulties (Pinfold and Corry, 2003). It is hardly a coincidence that these results were reported in the only region of the country that has a comprehensive programme aimed at implementing family work. Further information may be found on www.meridenfamilyprogramme.com.

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