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Working with families who experience parental mental health and/or drug and alcohol problems in the context of child protection concerns: recommendations for service improvement

Abstract

Child abuse and neglect often occurs within the context of multiple risk factors, in particular parental mental health and/or drug and alcohol problems. Interventions aimed at improving parental mental health and alcohol and drug issues can have a positive impact on children now, as well as in the future. However, implementing sustainable service models that facilitate positive change for families that experience multiple risk factors is challenging. The purpose of the present study was to gain feedback from key stakeholders on a service model targeted at families where there are parental drug and alcohol (D&A), mental health (MH) and child protection concerns to identify possible strengths and limitations of the model. In particular, the aim of this study was to identify possible strategies for service improvement from the perspective of discharged clients and clinical staff. Gaining feedback from key stakeholders on service models is increasingly recognised as central to mental health service evaluation and development. To do so, ten interviews were conducted

with clinical staff and twenty interviews with discharged clients of a pilot service that works with families where the child or children are at risk of significant harm in the context of parental MH and/or D&A issues. The interviews with clinicians highlight the difficulties of working with this complex client group and its impact on staff burnout. Clinicians put forward a range of ways the model could be changed to better support clinical staff from burnout. The interviews with discharged clients highlight the importance of the relationship with the worker in establishing client engagement and facilitating change. The way in which the service improvement recommendations have informed the design of the service model is discussed.

Key points

- Families that come into contact with child protection services commonly experience multiple risk factors, in particular parental mental health and/or drug and alcohol problems.
- Families with these risk factors benefit from interventions that include the whole family in treatment.
- While much of the evidence-base focusses on first order change, for many of these families more enduring change may come from a change in the family system.
- Interviews with clinicians who work with this complex client group highlight the difficulties of working with such complex and crisis prone families and its impact on staff burnout.
- Given the strong relationship between client outcomes and staff wellbeing, how to protect staff against burnout should be a key consideration in the design of service models.

Children who experience abuse and neglect are at risk now as well as in the future in terms of well documented second generation cycles of child abuse and neglect, mental illness and drug and alcohol abuse (Chang, Schwartz, Dodge, & McBride-Chang, 2003; Coates, 2010; Webster-Stratton, Reid, & Hammond, 2004). The devastating and long-term impact of child abuse and neglect on a child's development and life trajectory is well established (Briere, 2004; Briere & Scott, 2006; Coates, 2010; Draper et al., 2008; Spila, Makara, Kozak, & Urbanska, 2008). Studies that have investigated the characteristics of families that come into contact with child protection services have found that child abuse commonly occurs within the context of multiple risk factors, in particular parental mental health and/or drug and alcohol problems (Bromfield, Lamont, Parker, & Horsfall, 2010; Swenson & Chaffin, 2006; Wood, 2008).

Interventions aimed at improving parental mental health and alcohol and drug issues can have a positive impact on children now, as well as in the future. It is increasingly recognised that families with complex and multiple needs where there are child protection concerns benefit from interventions that include the whole family in treatment (Bickerton, Ward, Southgate, & Hense, 2014; Diamond, 2014; Ingram, Cash, Oats, Simpson, & Thompson, 2013; Ryan & Schuerman, 2004). However, implementing sustainable service models that facilitate positive change for such families is challenging (Ingram et al., 2013). Not only is it difficult to actively engage these families in treatment (Ingram et al., 2013), the work can be taxing on clinical staff and is associated with high rates of staff burnout and staff turnover (Coffey, Dugdill, & Tattersall, 2004; Dollard et al., 2012; Ghodse & Galea, 2006; Lloyd, King,

& Chenoweth, 2002; Mann, 2004; Montgomery, Panagopoulou, Kehoe, & Valkanos, 2011). The implementation of sustainable service models that improve the wellbeing of families where there are child protection concerns is highly complex, and fraught with challenges (Aarons & Palinkas, 2007; Ingram et al., 2013).

The purpose of the present study was to gain feedback from key stakeholders on a pilot service model targeted at families where there are parental drug and alcohol (D&A), mental health (MH) and child protection concerns to identify possible strengths and limitations of the model. In particular, the aim of this study was to identify possible strategies for service improvement following a three year pilot period from the perspective of discharged clients and clinical staff. Gaining feedback from key stakeholders on service models is increasingly recognised as central to mental health service evaluation and development (Aarons & Palinkas, 2007; Fernandez, 2007; Joseph et al., 2009; Simpson & House, 2002; Streiner, 2008).

The context of this inquiry is a Keep Them Safe-Whole Family Team (KTS-WFT) site in New South Wales (NSW). In 2010, the NSW Department of Premier and Cabinet allocated 'Keep Them Safe' funding to establish four Whole Family Team (WFT) pilots to fundamentally change the way children and families are supported and protected in NSW. A core concept of the KTS-WFT project is that MH and D&A teams and child protection services collaborate to make families safer places for children to be. As such, the KTS-WFTs work with families where the child or children are at risk of significant harm in the context of parental MH and/or D&A issues, taking referrals primarily from child protection services. The central aim of the KTS-

WFT pilot is to improve parenting capacity, child safety and family functioning to significantly reduce the level of risk of significant harm to the child/ren.

The current paper pertains to an evaluation of one of these sites, which is under the governance of the Central Coast Local Health District (CCLHD). This is a tertiary service that consists of a multidisciplinary team of MH and D&A clinicians who provide an assertive outreach service to the whole family, comprehensive assessment, and a range of individual and family interventions for a period of up to six months. Interventions include the building of resilience in children and the increase in parental competence through the application of parent skill training, mental health and drug and alcohol interventions. While the KTS-WFT site works with children aged 0-18, the vast majority of families referred by child protection have children/a child under the age of 13.

Over a three year period (since its outset in April 2011, until the 31st of March 2014), the KTS-WFT site has worked with 193 families, consisting of 700 individuals. As outlined elsewhere, the findings of an internal evaluation of the service conducted by the authors (i.e. the service research officer and manager) show positive outcomes for the participating families; in particular positive changes in family functioning and safety were demonstrated through the Revised North Carolina Family Assessment Scale (NCFAS-G) completed by clinicians at intake and discharge. To add meaning to these quantitative findings and gain feedback on the service model from the perspective of key stakeholders, as part of this evaluation, the service research officer also conducted interviews with discharged clients and KTS-WFT clinical staff at this site. The use of qualitative methods is increasingly recognised as critical to

service evaluation and development as they are most useful in elucidating the perspectives and experiences of stakeholders (Fernandez, 2007; Joseph et al., 2009; Streiner, 2008). The current paper outlines the findings of the interviews with clinical staff and discharged clients, and presents a range of service improvement suggestions as put forward by these key stakeholders.

Method

Ethics approval for this study was received by the Northern Sydney Local Health District (NSLHD) Human Research Ethics Committee and the Research Manager, Central Coast Local Health District (CCLHD).

Participants

Discharged clients

Twenty telephone interviews were conducted with discharged families in November and December 2013. All families who completed the KTS-WFT program at this site between April 2011 and November 2013 were posted an invitation to participate in a telephone interview. A total of 112 discharged families were posted an information statement and consent form. The information statement explained that the purpose of the telephone interviews was to gain an understanding of the experiences and perspectives of individual families in working with the KTS-WFT. As explained in the information statement, two weeks following the mail out, families were called to ask if they had received the information and if they were willing to participate. At this time it was again stressed that participation was anonymous and voluntary and that their decision to participate or not participate would not in any way impact on their current

or future relationship with the CCLHD. If they wished to participate a suitable time was arranged for the service research officer to call them.

It was hoped that by calling discharged families to invite them to participate, and conducting the interview at the time of first contact, diverse responses would be received. It is well recognised that those clients who complete service satisfaction surveys, or go through the trouble of completing consent forms agreeing to participate in an interview, are often those with either very negative or very positive service feedback. The current approach of directly calling discharged clients and taking consent over the phone helped to overcome this limitation.

All families the research officer managed to contact agreed to participate in an interview (n=24), and the majority were happy to discuss their experience with the KTS-WFT at the time of the initial follow up call (n=18). A suitable time was arranged for the interview with the remaining six parents, of which the service research officer managed to get hold of two. A total of 20 interviews were conducted with three fathers and 17 mothers. This relatively low response may be due to the high mobility of this population. Twenty five information statements and consent forms were returned to sender because the addresses were no longer accurate. Furthermore, many phone numbers on file were disconnected. This made it very challenging to get hold of many discharged families, especially those that had interventions in 2011 and 2012. Nonetheless, this is not regarded as a major limitation of this evaluation as after 20 interviews saturation was reached and no new themes emerged during the interviews.

KTS-WFT clinicians

KTS-WFT clinicians were invited to participate in a face-to-face interview. All KTS-WFT workers at this site (n=10) accepted this invitation and the service research officer conducted interviews with seven clinicians, the Family Support Worker, the (now former) team leader and the (now former) KTS-WFT psychiatrist.

Interviews were between 40 minutes and 1.5 hours in duration. Pseudonyms have been used to protect the anonymity of all participants.

Data collection and analysis

The data collection and analysis was informed by a general inductive approach, so that the research findings emerged naturally from frequent themes not predetermined by the research team (Jain & Ogden, 1999; Marshall, 1999; Thomas, 2006). The interviews were semi structured and took the form of 'guided conversations' (Charmaz, 2006). As is common in qualitative research (Charmaz, 2006; Creswell, 1994, 1998), the interviews commenced with a broad open ended question followed by a series of follow up prompts. The interviews with discharged clients commenced with a general question into their experience with the service, such as "*How was your experience with the KTS-WFT service?*" Interviews with KTS-WFT clinical staff commenced with a broad question such as "*What do you think about this service?*" or "*Tell me about your experiences with the team?*" The use of broad open-ended questions allowed for themes to naturally emerge during the interview, and topics that were important to the interviewees to be raised (Bryant & Charmaz, 2007). While some probing was used, care was taken to remain open to

what the interviewees had to say and maintain a balance between the research agenda and whichever meaning emerged during the interviews (Ezzy, 2010, p. 164).

With the consent of the participants, all interviews were audio recorded. Interviews were transcribed verbatim and thematic analysis was conducted. The transcripts were read several times to identify themes and categories (Braun & Charles, 2006). From this a coding frame was developed using NVivo 10, a computer based data analysis package designed for qualitative research. If new codes emerged, the coding frame was changed and the transcripts were reread according to the new structure (Braun & Charles, 2006).

Findings and Discussion

Service model improvement recommendations from the perspective of clinical staff

Analysis of the interviews with KTS-WFT clinicians identified two broad themes. One key theme regards the difficulties of working with this complex client group, its impact on staff burnout, and the way in which the model could be improved to better support clinical staff from burnout. This theme is the focus of the current paper. The other key theme that emerged in these interviews pertains the challenges of working with child protection services, and how collaboration could be improved; this theme is outlined elsewhere (Coates, 2015).

All interviewees described the client group as “*incredibly complex and crisis prone*”, “*the most complex and challenging client group I have ever worked with*”, and “*affected by many generations of poor parenting and alcohol abuse, mental illness*”.

As described by Samantha:

None of my families have employment, and they all have children with needs and behaviours that need to be addressed, and they themselves have mental health problems often combined with alcohol and drug problem... It's a lifelong cycle... Many of my mums are doing exactly what their mothers did and exactly what their grandmothers did... The way they live is the way their family members live and their neighbours. Whatever coping strategies they have they've put in place after years and years of hardship and trauma, and it's a big ask to ask people to turn around and think about things differently and do things differently when everyone around them is doing the exact same thing they've done for years.

Clinicians explain that working with such complex and crisis prone clients, and in particular the child protection concerns, impact negatively on staff wellbeing and leads to emotional exhaustion and burnout. Even though clinicians attribute their emotional exhaustion and sense of burnout primarily to the complexity of the client group, they argue that changes could be made to the service model to better support staff wellbeing and protect staff against burnout. As such, clinicians put forward a range of service improvement recommendations that they perceive would better support staff. In particular, analysis identified that the recommendations put forward address a range of key ‘clinician needs’ that, if met, can be conceptualised as

protective factors against burnout. The 'clinician need' identified are: consistency and direction from management, a sense of achievement, to use professional skills and strengths and more success stories/"wins". Clinicians argue that a model that better addresses these staff needs will impact positively on staff wellbeing as well as client outcomes. It is well established that protecting staff against burnout, or enhancing staff wellbeing, impacts positively on staff as well as clients (Farhenkopf et al., 2008; Montgomery et al., 2011; Walsh & Walsh, 2001; Williams, Manwell, Konrad, Konrad, & Mark, 2007). The service improvement recommendations put forward by clinicians, and the way in which the service model has changed in response, are outlined below.

"I need consistency and direction from management"

Clinicians expressed frustration around the "fluidity" of the way in which the program is implemented. They explained that given the KTS-WFT is a pilot project, there has been some confusion and uncertainty around the model, and how it can best be implemented. They explain that a lack of clarity of the service model and the specific aims of the intervention has left them feeling uncertain and unclear of their role as clinicians. This, they argue, is a source of stress that could be prevented by developing a clear model of care that is consistently applied.

While they recognise that the model needs to be flexible and adaptive while it is being implemented, in particular as it is a pilot project, they stress that a service model cannot continue to be in this state of ambiguity or uncertainty for very long as it becomes too stressful for clinical staff. Clinicians need a framework that guides

their work and clarity of what is expected of them, perhaps particularly so given the complexity of the client group. As explained by Suzanne:

Every time you change something there's uncertainty, a bit of a loss of confidence... Things can't just keep changing, at some point you have to agree on what the service model is and you stick with it for a while... Because of this lack of direction my ability to do the type of work I want to do is a bit stifled. It's like having a parachute on your back, you can't quite move forward.

It is well established that role ambiguity and a lack of job clarity is a common source of stress for mental health workers, and it is important that this is avoided (Lewandowski, 2003; Lloyd et al., 2002). Even though it is critical that clinicians are given some autonomy and the freedom to take initiatives (Dollard, Dormann, Boyd, Winefield, & Winefield, 2003; Morrison & Payne, 2003; Noblet, 2003) job clarity and clear direction are also key to staff wellbeing (Dollard et al., 2003; Fearon & Nicol, 2011; Lewandowski, 2003; Lloyd et al., 2002).

To help address clinicians' need for role clarity, as an outcome of this evaluation, the service research officer and service manager reviewed and strengthened the KTS-WFT model of care for this site, clearly stipulating all processes and procedures, clinical duties and expectations at all stages of care. Having a written document that describes the service model in great detail has been helpful in supporting and guiding staff. This has increased program fidelity and given staff a tangible resource to guide their work.

Nonetheless, while increased clarity around the service model and greater consistency in how it is implemented addresses some of the need for direction expressed by staff, it is important to recognise that a certain level of uncertainty and ambiguity is inherent in this work and cannot be addressed or 'resolved' through carefully articulated policies and procedures. While all therapeutic work is complex, working with whole families is particularly challenging as interventions seek to facilitate change at both an individual as well as a system level. While interventions that focus on individual level change, or first order change, are informed by well-established evidence-based practice, the way in which change at a system level is best achieved is less understood (Davey, Davey, Tubbs, Savla, & Anderson, 2012). To this extent, while the KTS-WFT interventions that seek to address presenting issues such as parental mental illness and/or drug and alcohol abuse are guided by significant evidence based practice and can be relatively easily operationalised, how to transform a family system, or facilitate second order change, is less clear (Davey et al., 2012). While critical to facilitating sustainable change in these families, there is a paucity of literature into the way in which second order change can be operationalised or measured (Davey et al., 2012). Because of the complexity and uniqueness of each system, there is no single or best way of facilitating second order change (Davey et al., 2012), and no clear and unambiguous guidelines can be provided to support clinicians.

In addition to the complexities around facilitating second order change, clinicians who work with multiple family members are faced with the challenge of forming a therapeutic alliance with multiple family members. When working with multiple

members in a family the position the clinician takes in relation to competing and contradictory lived experiences of various family members must be carefully considered if the working alliance is to be sustained (Brimhall & Butler, 2011). The clinician must develop an alliance with each family members while remaining 'neutral' (Brimhall & Butler, 2011). When working with multiple family members, the complexity and importance of neutrality is heightened because of the necessity of creating and sustaining multiple alliances (Butler, Harper, & Brimhall, 2011). Even though both a strong therapeutic alliance and neutrality of one form or another are considered core component of successful therapies, in practice the therapeutic alliance and clinical neutrality co-exist in a dialectic tension (Butler et al., 2011). While these tensions are not easily resolved, regular clinical supervision is paramount in supporting staff identify and overcome these challenges.

Consistent with the literature, regular supervision was identified by clinicians as of utmost importance. Clinicians explain that both individual and group supervision is critical in terms of enhancing objectivity and assisting them tolerate the uncertainty and complexity of the work. As noted by Suzanne: "*Supervision is crucial as it is hard to remain objective when working with families where children might need to be removed. It touches a core*" (Suzanne). Regular supervision is essential to equipping clinicians with self-awareness needed to recognise the push and pull of opposing family members and avoid possible emotional alliances (Senediak, 2014). It is well established that regular clinical supervision, in particular supervision that promotes self-reflective practice, enhances therapeutic outcomes and supports staff wellbeing (Blomberg & Sahlberg-Blom, 2007; Fearon & Nicol, 2011; Jack & Miller, 2007; Mandell, Stalker, de Zeeuw Wright, Frensch, & Harvey, 2013; Senediak, 2014).

“I need a sense of achievement”

Analysis identified the importance of a sense of achievement as key to staff wellbeing, at least from the perspective of clinicians. Clinicians commented that given the complexity and multiple needs of these families, and the “*somewhat unrealistic*” aim of the program “*to be everything to everyone*” there are not many clear measurable outcomes. As explained by Annalies:

The model is too big for what it can achieve. I don't think we can make the changes that we say we can make because these families have many many generations of abuse and trauma behind them... For us to come in and think that we're going to make a massive change within six to twelve months is not actually doable... Our inclusion criteria is everyone's exclusion criteria and we promise to be and do everything. It's not realistic and we need to be clear on what we can and can't do, and in what timeframes. Realistically you're only hoping for one small bit of difference that will have a positive impact on the child.

Clinicians argued that because this population is very crisis prone, the work becomes directed by the crisis, “*going from managing crisis to crisis*” rather than “*offering a goal focussed intervention*”. While clinicians recognise that a lack of clear focus and constant crisis intervention can be expected when working with highly complex families, they argue that they need the sense of satisfaction that comes from achieving clear goals. As explained by Bonnie:

I like to know what I'm supposed to do, so I can achieve that and move to the next thing. That's difficult when working with families who go from crisis to crisis... By trying to help all the members in this family with all their complicated and multiple needs and I'm left feeling I've achieved nothing. That's not good for staff morale... How do you measure positive outcomes if it's crisis after crisis? And how do you not get exhausted?"

Clinicians put forward a number of service improvement strategies that may assist in developing a service model that is not driven by crisis but is goal focused, with achievable outcomes. In particular, they argue that processes need to be put in place to assist clinicians identify the key priorities so appropriate and realistic treatment goals can be identified and focussed on. As noted by clinicians:

It is important that we, together with the family, and through consultation with child protection, decide what the priority concerns are and focus on those. We can't do a-z. We can only do a, b and c (Annalies).

There are always multiple problems and we need to learn to prioritise better. We need to identify which problems we can realistically address and take a more targeted approach. If we worked like this it wouldn't be so frustrating (Samantha).

It's important that we set realistic goals. You have to work with people where they are at. Too often we set the bar far too high ... Setting everyone up to fail

... We need to work together with child protection and families to set acceptable goals and outcomes... By working with child protection and the family to identify goals, we're all on the same page and we have a shared direction.

To help identify what the treatment priorities and goals should be, participants put forward the following recommendations: a) a comprehensive whole family assessment to be conducted in a time-limited way by a multidisciplinary team with the aim of identifying priorities, b) the family as well as the referring agency (mostly child protection services) to be openly and transparently involved in this process, c) in conjunction with the referring agency and the family the identified priorities to be translated into achievable goals, clearly stipulating what achieving this goals means or looks like for each individual in the family, and d) each individuals in the family to be allocated a clinician that is best placed to provide an intervention that will meet the identified goal/priority for this individual.

Prior to this evaluation, a family accepted into the service was allocated to one clinician who worked with the entire family. This clinician would conduct a comprehensive assessment over a period of six weeks and then provide an intervention to the entire family. While supported by the team and the psychiatrist through case consultations and psychiatric assessments if required, this clinician was the primary worker for each family member. As a result of the recommendations put forward from this evaluation, changes have been made to the model, in particular around the assessment process, the way in which families and individuals within the family are allocated to workers, and the way in which clinicians collaborate with child

protection services. The interviews generated a lot of in-depth data pertaining to collaboration with child protection services, so these findings have been outlined elsewhere (Coates, 2015).

The assessment process has changed in that a comprehensive assessment is now conducted by multiple clinicians conjointly as well as the psychiatrist, and key priorities are identified as a team. A systemic approach to family assessment is employed, recognising that problems are unlikely to solely located in an identified client, but involve other, if not all, members of a family (Nichols & Tafuri, 2013). Based on the outcomes of the assessment, the best placed clinicians to work with this family are allocated to individuals in that family. While the family still has a primary worker allocated to oversee the work with the family as a whole, each family member is allocated an individual clinician. The importance of allocating clinicians to individual family members based on skills and experience is discussed in the next section.

“I need to use my skills and strengths”

A key ‘clinician need’ that emerged in the interviews was the opportunity to draw on specific skills and strengths in their work, rather than having to be “*everything to everyone*”. As noted, prior to this evaluation, families were allocated a clinician to work with the family as a whole. During the interviews, clinicians argued that the practice of allocating entire families to single clinicians is problematic as they do not have the skills and confidence to work with each member of the family across a wide range of different concerns. They argued that a number of clinicians should be

allocated to each family based on skills and experience, and that this is paramount to staff wellbeing. As explained by Kim:

I think it's important that a number of clinicians are allocated to a family so it doesn't all fall on the one person... The clinicians working with the family come together and support each other. They can work collectively when possible, and work at the same time, going into a home together... I need to be side by side with someone going into this work.... I can't be responsible for everything, some of the issues I have no experience with. I need to be used for my strengths, and not expected to do everything.

While it is not uncommon for mental health services to employ workers under generic positions expecting each worker, regardless of discipline or strengths, to perform the same duties, this practice can impact negatively on clinicians' sense of professional identity (Mental Health Commission, 2006, p. 46). Allocating based on clinicians strengths and skills supports clinicians' professional identity and, as outlined above, enhances clinicians' capacity to work with the family to meet identified priorities and goals.

In addition to strengthening clinicians' professional identity, a shift towards multiple clinicians being allocated to one family enhances clinicians' capacity to support each other to maintain a balance between the alliance and neutrality as discussed before (Butler et al., 2011). By working together, a number of clinicians are present to

observe and challenge the family system, increasing capacity for second order change.

“I need more success stories”

Another common theme across the interviews regards the importance of success stories as a protective factor against burnout. Clinicians comment that while they understand that it is difficult to measure “success” in this context, and that the positives ways in which the intervention has impacted on families is often not clear until many years later, the lack of “*tangible wins*” can be demoralising. While some clinicians remain motivated despite limited positive feedback, others need more obvious wins or success stories to protect against burnout.

Identifying priorities and working in a more goal-directed way, as outlined above, is one strategy that may help clinicians achieve a greater sense of “*having made a win*”. Other strategies put forward by clinicians include a) not continuing to chase clients who are not engaged, b) getting referrals from child protection services earlier, and not at the point where the risk is so high that statutory intervention appears unavoidable.

Chasing clients who are not engaging is not good for staff morale, and clinicians argue that those clients/families who do not engage should be discharged more readily to “*free up*” more time for families who do engage. While perhaps those individuals who are hard to engage in services are most vulnerable and perhaps

most in need of support, clinicians argue that “*chasing*” clients is not therapeutically beneficial. As argued by Bonnie:

I don't think chasing people is helpful, not for the client and not for the clinician either. Sometimes we persist with families when we're not getting anywhere, and we're not good at recognising when it's not going anywhere and letting it go... There's people who just aren't prepared to do the work... If you haven't got a customer, you haven't got a customer. Sometimes you get a window shopper, but you need a customer.... I think we should offer a longer service for clients who engage if required, and stop chasing those who don't engage.

This observation is supported by comments from discharged clients as outlined below.

While clinicians continue to provide an assertive outreach service and do home visits, as a result of this evaluation there has been an increased emphasis on active participation and clients are expected, if at all possible, to attend some appointments at the KTS-WFT service. This encourages clients to actively participate in their own recovery rather than to be passive recipients of care. The importance of active participation of clients in their own care and recovery is well established and has been associated with increased motivation and better treatment outcomes (Larsson, Sahlsten, Segesten, & Plos, 2011; Nordgren & Fridlund, 2001; Omeni, Barnes, MacDonald, Crawford, & Rose, 2014; Tambuyzer, Pieters, & Van Audenhove, 2014; Wahrenberger, Murtaugh, & Ross, 2013).

While not “*continuing to chase*” clients who are not engaged in the service may protect clinicians against burnout as working with families who are actively engaged is more likely to lead to “*success stories*”, clinicians stress that the key to getting more “*wins*” is getting referrals earlier from child protection. A number of clinicians commented that by the time child protection refers some of these families, the likelihood that they will successfully achieve the goals set by child protection is “*very small*” if not “*nearly non-existent*”. As observed by Alex “*On many occasions some children are at such a high risk that statutory intervention is inevitable*”.

The majority of clinicians comment that families should be referred “*much earlier, not when it’s at the pointy end*” (Alex). Clinicians argue that working with families earlier, before they have reached such high levels of risk, will impact positively on client outcomes as well as staff wellbeing. As argued by Bonnie:

I need to have more success stories; otherwise it’s all doom and gloom... I think it’s families that are at lower risk, more early intervention, that are more likely to be success stories... The time’s I’ve been happiest in this job is when the families are stable, and you have that ability to do some good work, when they’re listening and taking things on. The crisis stuff is when I just want to get out of here.

While clinicians would like to work with more families that are “*more stable*” and “*better able to engage and do the therapeutic work*”, they recognise that the KTS-WFT service specifically targets those families that are at high risk and experience child protection concerns in the context of parental MH and/or D&A issues. They

recognise that this service model is specifically designed to “*see clients other services won’t*”, and not using the resources to work with those clients at greatest risk “*could not be justified*”. Nonetheless, in terms of service design it should be noted that as to protect clinical staff against burnout, clinicians may need to have a mix of client groups to ensure that the stress of failing to facilitate positive change for some clients is balanced against “*success stories*”.

The KTS-WFT site from the perspective of discharged clients

The interviews with discharged clients primarily generated positive feedback on the service. The vast majority of discharged clients (n=16) were very complimentary of the service, commenting that they “*felt listened to*”, “*felt supported*”, and were taught parenting skills and strategies to better manage their mental health problems and/or drug and alcohol problems. Even though most discharged clients described their experience as positive, four presented mixed reports and two were negative. Of the two discharged clients who were very negative, one appeared quite unwell during the interview and was chaotic and inconsistent in her responses. The other person had had her child removed by child protection services since the KTS-WFT intervention, so in a sense, for this family the intervention was not successful in keeping the family together. From a child safety perspective, ‘keeping the family’ together would not have been in the best interest of the child.

In addition to feedback on their experience working with the team, discharged clients were asked for specific feedback on what worked well and what didn't, and how the service could be improved. The main theme that emerged during these discussions regarded the "*relationship with the worker*" and its critical role in establishing engagement and facilitating change.

Many of the discharged clients who were very positive about the service referred to their relationship with the worker as critical in this (n=12). Comments such as "*I felt very negative until I met [the worker]. He was so lovely and I just kept going with it*" were common. Six discharged clients commented that their worker was not only critical in engaging them in the service, but also provided them with the insight and skills needed to build more meaningful and supportive relationships in the community. As explained by Sophie: "*I had negative friends and now, thanks to [the worker] I look for friendship in a positive way and I chose my friends more carefully*".

Those clients who were less positive or had shared mixed experiences (n=5) also referred to the relationship with the clinician as critical in this. As noted by Suzanne: "*If it's a good fit between you and your worker, it's great, but if it's not, it's really hard and you don't make progress*". A number of participants (n=4) commented that while they liked one worker and could do "*good work with her*", they didn't like a different worker. As noted by Ali "*It's all about that relationship; I liked one of the caseworkers and worked well with her, but not the other one, we didn't click and we couldn't do any work*". Christine made a very similar observation: "*The first one was great but she left and then I got someone I couldn't work with. I tried to go with it, but it wasn't*

working for me. I should have said something but I didn't; I didn't want to appear rude".

The importance of the therapeutic relationship from the perspective of discharged clients is consistent with a rich body of literature that shows that the therapeutic alliance is foundational to successful client engagement and mental health outcomes (Hubble, Duncan, & Miller, 1999; Shaw & Murray, 2014). Of note here is that some clients may not communicate difficulties in the relationship with the worker, and perhaps disengage instead or 'soldier on' with limited therapeutic gains. As noted previously, the model was changed to allocate a number of clinicians to each family based on skills and experience and this strategy recognises that the importance of a good fit between the worker and the client.

While it is clear that a positive relationship between the worker and the client is critical for engagement, a number of discharged clients (n=4) comment that "*even the best worker*" couldn't have engaged them because they were "*not ready to do the work*". Consistent with observations made by clinicians, these discharged clients argued that chasing clients who are not ready to engage is unhelpful. This idea is reflected in the following comments:

I don't have any complaints about how the service was run. You either seize the opportunity or you don't. It is what you make of it. I could have used it better. I look back and I think I did the best I could at the time. Nothing to do with the service; I was just not in a good place back then. We weren't in a good place last year and we didn't make the most of things... They couldn't

have done anything differently. You can't force people to do things, you can only guide them and make suggestions. It was up to us to put in the effort and meet them half way, and we didn't (Steven).

We just weren't in the right place to use the support. I wasn't engaging myself last year but this year I am. Things might have been different if I did my bit to engage and put in a bit more effort... If I was to go into this year it would be a lot more beneficial as my head's a lot clearer and things are getting on track... There's nothing they could have done differently to engage me more, so in some ways, perhaps chasing me was a waste of time really (Matthew).

While it is clear from the literature that clinicians' behaviour impacts on family engagement (Dawson & Berry, 2002; Ingram et al., 2013), and that the relationship between the worker and the family member is critical to engagement (Shaw & Murray, 2014) these comments suggest that some clients may not be ready or willing to engage and even the best designed services and most skilled clinicians may not be able to facilitate engagement.

Conclusion

The purpose of the present study was to gain feedback from key stakeholders on a service model targeted at families where there are parental D&A, MH and child protection concerns to identify possible strengths and limitations of the model and generate a range of service improvement strategies from the perspective of discharged clients and clinical staff.

The interviews with clinicians highlight the difficulties of working with this complex client group and its impact on staff burnout. Clinicians put forward a range of ways the model could be changed to better support clinical staff from burnout. Workplace stress and burnout in mental health services is a significant issue that needs urgent attention (Coffey et al., 2004; Dollard et al., 2012; Ghodse & Galea, 2006; Montgomery et al., 2011). Mental health workers consistently report poorer mental health and job satisfaction and higher levels of work-related stress, anxiety, burnout and job turnover than employees in general (Coffey et al., 2004; Dollard et al., 2012; Ghodse & Galea, 2006; Lloyd et al., 2002; Mann, 2004; Montgomery et al., 2011; Walsh & Walsh, 2001). The negative impacts of staff burnout not only impact negatively on the organisation and the individual, but extend to client care and, in turn, client satisfaction (Farhenkopf et al., 2008; Montgomery et al., 2011; Walsh & Walsh, 2001; Williams et al., 2007). The high staff turnover associated with job burnout leads to understaffing and this affects the quality and continuity of client care (Bakker, Schaufeli, Sixma, Bosveld, & Dierendonck, 2000; Shanafelt, Bradley, Wipf, & Back, 2002).

While, as recognised by the clinicians, experiences of burnout can, at least in part, be attributed to the nature of the work, perhaps in particular to the high complexity of this client group, service design plays a critical role in protecting staff against burnout. The findings suggest that, for these participants, the service model could be “improved” to better meet key “clinicians’ needs”, in particular consistency and direction from management, a sense of achievement, to use professional skills and strengths and more success stories/“wins”.

The KTS-WFT service model is flexible and adaptive and has evolved since its inception in response to feedback from clinicians and clients. For example, the service has become more goal-focussed and has evolved to a co-case management model. As outlined previously, as the result of this evaluation now multiple clinicians are allocated to each family based on experience, skills and discipline. It is hoped that as the result of this strategy clinicians will be better utilised for their strengths and skills, will be more likely to achieve goals, better support each other, and have more success stories as a result. Furthermore, this strategy also supports the key observation made by discharged clients, namely, that the relationship with the worker is critical in establishing client engagement and facilitating change. By allocating clinicians based on skills and experience, *“a good fit”* between worker and client is more likely to ensue. Furthermore, as multiple workers are allocated to one family, family members are much more likely to “get to know” more than one worker, which makes it much easier to re-allocate family members to a different worker if this is desired or becomes necessary.

The current study has informed the ongoing development and improvement of the KTS-WFT service model at one site, and anecdotal evidence from clinicians suggest that the service improvement strategies implemented thus far have been positive in terms of protecting them against burnout.

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