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Implementing a family-inclusive practice model in youth mental health services in Australia

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Abstract

Aim: A brief family inclusive practice model, Single Session Family Consultation (SSFC), was introduced at four youth mental health service sites to determine the extent to which the model could be implemented in this context and its acceptability as a means of engaging families of young people.

Methods: Within an action research paradigm, both quantitative and qualitative measures were used for this implementation project with the former reported here. There were two components: 1) evaluation of the experiences of young people and their families and 2) evaluation of the extent of implementation of SSFC. Quantitative data were analysed descriptively (item scores, range and any changes over time).

Results: Twenty practitioners who were trained and supported in the use of SSFC participated in the 6-month implementation evaluation. In six months, 131 SSFC sessions were conducted across the four sites and the young people and their families were very satisfied with sessions (overall mean=5.2, range=0-6). Six months post-training, there were statistically significant improvements in the practitioners' confidence in providing family interventions (mean improvement= -0.47 (95%CI = -0.91, -0.04), *p*=0.035) and familiarity with approaches to working with families (mean

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improvement= -0.61 (95%CI = -1.13, -0.10, *P*=0.023). Practitioners perceived significant improvement in organisational support for working with families.

Conclusions: SSFC was acceptable to clients and their families, was adopted by practitioners and was successfully implemented in the participating sites. This suggests that SSFC, when appropriately implemented, is useful to engage families in the treatment of young people facing mental health issues.

Keywords

Caregivers, Mental health, Family program, Action research, Adolescent

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Introduction

Family members of young people with mental illness experience psychological distress[1-3] and report mixed experiences regarding recognition of, and support for, their caregiving role by services.[4-6] This is despite their critical role in young people's pathways to care[7-9] and wanting to be involved in care and treatment of their relatives.[1] However, there is limited knowledge about how to best involve family members in the care of young people with emerging mental health problems or at risk of developing mental illness.

There are several ways to include families in the mental health treatment of their relative.[10, 11] Family psycho-education has been shown to improve outcomes for individuals experiencing first episodes of psychosis and for their families[11-13] but has proven difficult to implement in routine mental health care, in part, due to its length.[10, 14-16] This points to a need to provide briefer interventions to families.[17, 18]

Brief practice models have the advantage that they can be more easily incorporated in routine care and therefore reach and enable assessment of the needs of many more families than lengthier interventions. In addition, they offer a service to those families who may not want or need more lengthy interventions, and allow other available interventions to be matched to family needs and preferences. Family consultation is a model developed in the USA for identifying and responding to the needs of families where a member has a mental illness.[19, 20] An early study of family consultation revealed improvements in family member self-efficacy when compared with a wait list

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control.[21] More recently, Consumer Centred Family Consultation (CCFC) was implemented in the USA with evidence for its value as a way of including family members in the treatment process.[22, 23]

The Bouverie Centre, a specialist family mental health service, has integrated family consultation[22] with concepts and techniques from single session therapy to create Single Session Family Consultation (SSFC).[24] SSFC values brief therapeutic encounters and uses techniques that seek to maximise the benefit of each session.[25] Trials of single session therapy in Australian child and adolescent mental health and family services show that the majority of clients experienced improvements in psychopathology, suggesting that single session therapy is promising for young people with mental health problems.[26-29]

The current research was part of a SSFC implementation project conducted as a partnership between The Bouverie Centre and headspace. headspace is a multi-centred, national youth mental health service that aims to build the capacity of young people and their families for early detection and intervention in emerging mental and substance use disorders.[30, 31] The project aimed to introduce SSFC to four headspace centres as a way of improving the extent and quality of family involvement within the service based on our previous promising experience in which perceived barriers to family inclusive work were reduced, and family inclusive practice by practitioners was enhanced.[32, 33] In addition, a recent study conducted within one headspace centre using a model similar to SSFC found high levels of satisfaction with sessions and significant improvements in clients' functioning at five week follow-up.[34]

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The research questions are:

1. How acceptable is SSFC to clients and their families in a youth mental health context?
2. To what extent is it possible to implement SSFC in a youth mental health setting?

Methods

Setting

This SSFC implementation project was conducted in two headspace centres (one peri-urban, one regional) in Victoria and two headspace centres (one regional, one remote) in South Australia.

Research design

Using an action research design methodology, a number of research activities and measures were used to address the research questions. Action research has been identified as useful in both facilitating implementation of new practices and understanding the processes involved.[35, 36] Although a mix of quantitative and qualitative measures were used, only the quantitative methods and results are reported here.

Practice Model: Single Session Family Consultation

SSFC is a brief practice model (1-3 sessions) for engaging and meeting with families or other social network members to clarify how they might be involved in care and to address their needs in their role in supporting their relative experiencing a mental health difficulty. Session durations are typically 1-1.5 hours with follow-up telephone calls.

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Training and implementation strategy

The training and implementation plan was developed and co-ordinated by the third (project manager for headspace) and fourth (responsible for involvement of The Bouverie Centre) authors. A two-day training program was conducted by an experienced family practice consultant from the Bouverie Centre at each of the four centres. Eighty practitioners from headspace and local partner services were trained although only 20 salaried headspace staff participated in data collection. The family practice consultants supervised SSFC-trained practitioners via monthly practice development groups (totalling 15 sessions over six months across the four sites). A one-day 'booster session' was also provided by the family practice consultants at each site. This involved further training around challenging areas of practice, such as managing conflict, and further support regarding implementation.

A mental health practitioner led and coordinated implementation activities at each site. Tasks of site leads included heightening awareness of family needs, co-working with colleagues, facilitating changes in organisational policy and procedures, and collecting evaluation data. The four site leads met regularly with the headspace project manager via teleconference.

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Data collection

Client and family member experiences of SSFC

The experiences of headspace clients and their families concerning the SSFC sessions were evaluated using a one-page feedback form completed by clients and family members after each session. The form used items from the Session Rating Scale[37] and provided immediate feedback to the practitioner about the extent of alliance between them and the family, and the family's experience of the session including whether it was helpful in addressing some of their needs.

Implementation of SSFC

Practitioners were asked to keep a 'SSFC log' to record: any discussion about the possibility of SSFC with a client or a family member; and, each SSFC session which they conducted. They recorded presenting problems and outcomes of sessions using a SSFC Session Record Sheet.

Impact of SSFC training and implementation support

Before SSFC training, headspace-employed staff participants completed three questionnaires: 1) a modified Family Inclusive Practice Questionnaire (FIPQ)[38] where higher scores represent practitioners' perceptions of greater family–focused practice to include family members in care of their clients; 2) a modified version of the Family Interview Schedule (FIS) to measure perception of difficulties in implementing family interventions[39]; higher scores represent practitioners perceiving less difficulties in providing family interventions; and 3) an adapted Organisational Readiness Tool (ORT)[40] to measure practitioners' perceptions of organisational practice in supporting changes,

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where higher scores represent better perception of organisational functioning and practice in implementing changes. Existing questionnaires were modified so as to capture relevant aspects of the SSFC model and took about 35-40 mins to complete in total. Unique identifiers were generated for the practitioners to enable pre-post comparison. The FIPQ and FIS were re-administered after the training. All three questionnaires were re-administered 6-months post-training using web-based data collection software to identify any changes in family inclusive practice and organisational implementation.

Analysis

The site leads sent the de-identified forms to the first two authors for data entry and analysis. Quantitative data were analysed descriptively (item scores, range and any changes over time) using SPSS 21.[41] The project was approved by the Health Sciences Human Ethics Sub-Committee of the University of Melbourne (Reference: 1441416).

Results

Client and Family Experiences of SSFC

A total of 200 invitations were made to young people and their families to participate in SSFC; these were recorded as declined on 79 occasions (39.5 % of the total invitations). Of these 79 occasions, 68 (86% of 79) involved the client declining SSFC and a family member declined on 11 occasions (14%). Since the young person was usually invited first, the family member was unlikely to have been invited or to have known about the possibility of a SSFC session in these instances.

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There were 129 client feedback forms and 191 family feedback forms completed. Both clients and their families rated the SSFC sessions very positively with a mean score of at least five (possible scores from zero to six) on all dimensions. Family members' ratings were slightly higher than those of the young person except for overall rating of the session where ratings by both groups were the same (Table 1).

Implementation of SSFC

Data from the log forms submitted by practitioners reported 131 sessions which were conducted involving 103 families. The number of sessions conducted per practitioner ranged from 0 to 14 with a mean of 6.6 sessions per practitioner. Two practitioners did not see a family using SSFC.

SSFC Session Record Sheets revealed that most of the presenting problems and needs concerned family relationships (80.3%), although support (51.4%) and information about the young person's condition (48.6%) were also prevalent. The most common service provided was guidelines and strategies (72.5%), followed by problem solving (64.8%), information on client's condition (56.3%) and information on community services (45.1%).

Impact of SSFC Training and Implementation support

The modified FIPQ scored 0.89 on Cronbach's Alpha reliability test for pre-training assessment. Most of the changes over time were not significant. We only report significant changes in items and

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focus on pre-mid (immediate changes post-training, 9 of 45 total items) and pre-post (more sustained changes after 6 months of project implementation, 3 of 45 total items) time points. The full findings are available on request from the authors. The significant improvements reported immediately after the training covered aspects of practitioner knowledge, confidence and skills and workplace supports (Table 2). The areas of significant improvement maintained 6-months post training were: support for supervision in the workplace; clarity about workplace policies and procedures for working with families and the practice of speaking to each family member individually before they attend a family session (Table 3).

For the modified FIS, it scored 0.84 on Cronbach's Alpha reliability test for pre-training assessment. Nine of the items improved immediately after the training (between pre and mid stages) showing feasibility and usefulness of SSFC, and greater practitioner confidence in working with families. Two items maintained improvement at 6-months after training: familiarity with approaches to working with families and confidence in working with families. One item showed improvement only at 6-months after training (travel to family sessions) (Table 4).

The ORT scored 0.90 on Cronbach's Alpha reliability test for pre-training assessment. After implementing SSFC for six months, there were statistically significant improvements for half of the items (Table 5). Reported improvements were varied, with the largest improvements for: supervision and mentoring; clear policies and protocols to support family involvement; support from co-workers to include families; and agreed upon process for recording family work. There was improvement in sum scores of perceptions of organisational readiness (Table 5).

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Discussion

Our study results support the utility of SSFC as a model for involving families within the headspace context. This is evident at the level of the acceptability of SSFC to young people and their families and extent of implementing SSFC in the participating centres. In addition, this project was implemented in four diverse sites covering peri-urban, regional and remote centres in two Australian states, suggesting the broad applicability of the SSFC model and the associated implementation strategy.

The proportion of clients and families participating in sessions as a proportion of the total number of invitations was 60%. Compared to the study of Consumer Centred Family Consultation with a proportion of 15% (2,334 sessions out of 15,819 invitations),[22] our study had a higher uptake of SSFC sessions. Interpreting the reasons for these differences is difficult because it is likely to reflect a combination of client, family, practitioner, service context and implementation support variables. One of the possible reasons could be that CCFC was offered to a range of clients with short-term to chronic mental illness who were generally older in age, while SSFC was offered to young clients facing emerging mental health problems. In addition younger client age has been associated with more frequent contact between practitioners and family members in mental health services.[42, 43] The higher rate of uptake of SSFC compared to CCFC may also reflect the relatively high intensity of implementation support (including a funded on-site role) provided to practitioners in this study.

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The rate of young people and families directly declining SSFC in the current study is still noteworthy at 39.5%. The practitioners who offered SFFC were new to the model and would likely improve their ability to negotiate family involvement with more experience.[10] Further, engaging clients to address their social support needs and supporting them to achieve family-related goals may facilitate the pathway to family involvement.[44] While this finding is useful in providing an indication of the attitude of clients to SSFC, it is a less valid measure of family member attitudes to SSFC since not all families of clients invited to a SSFC were invited to participate themselves. An important implication is that exclusive reliance on client-mediated opportunities for family involvement runs the risk of not addressing the needs of a considerable proportion of families who may be struggling with the mental health difficulties of their child, some of whom are likely to feel unheard by practitioners and services.[6] This finding highlights the value of providing more than one pathway for responding to the families of young people accessing mental health services and of the importance of collaboration between multiple agencies.[9, 45]

SSFC appears to be an acceptable form of family involvement for those young people and their families who did participate, as indicated by high ratings of the helpfulness of sessions, the relevance of the topics discussed and the extent of alliance with the practitioner. This finding is consistent with a recently published study conducted within the headspace context that reported high levels of therapeutic alliance between practitioners and families participating in a family intervention similar to SSFC.[34] Another advantage of SSFC in the current project was that it was delivered by the young person's practitioner rather than by a specialised family practitioner, making SSFC an accessible and cost effective intervention that could be easily provided in headspace

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centres across Australia. The apparent acceptability of this approach also challenges the proposition that family involvement is a threat to the therapeutic alliance between a young person and a practitioner since it was the young person's practitioner who conducted the family sessions.[46]

Practitioners reported significant gains in confidence and familiarity in working with families and knowledge of aspects of SSFC. Perceived improvements in skills and knowledge after the training persisted at six-month follow-up, as indicated in the FIPQ and FIS responses. This is an important finding given the difficulties in implementing family interventions in mental health services and practitioners' anxiety about working with families.[14, 47] This points to the acceptability of SSFC to practitioners, many of whom were new to family work, and to the potential for this form of family involvement to be incorporated into routine practice.

At an organisational level there were wide ranging, significant and sustained positive changes, at least as perceived by practitioners. Significant improvements noted by practitioners in their workplaces included greater provision of support and supervision and fewer difficulties in including families. This suggests that the multifaceted implementation strategy adopted in the project was successful in moving beyond practitioner adoption of SSFC towards organisational assimilation of the model.[44, 48] Although six-month post-training follow-up is a relatively short time frame in terms of a new practice being routinized, anecdotal accounts suggest that SSFC is still being used in at least three of the four centres involved in the project two years after implementation.

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The 'active ingredients' of the implementation process are not clear although the utility of the model, active training methods, post-training supervision and provision of a funded in-house champion whose work included facilitating organisation change, all appear significant. The latter element is particularly important given the funding required in scaling up this intervention within headspace or any other youth mental health context. Developing family intervention competency guidelines for clinicians may be useful in improving the uptake of interventions, especially in engaging clients who initially decline family involvement.[44] These are also elements consistent with current understandings of effective training and implementation approaches.[49, 50] This project however did not engage clients and their families to be part of the implementation process, which some argue may help with successful implementation.[44] Peer-led family interventions also have potential benefits.[51]

The main purpose for this project was to pilot a family-inclusive SSFC model for young people facing mental health problems and facilitate service development in headspace long-term; thus, the study was designed to be pragmatic and feasible although is limited by the lack of a control group. A second limitation is the use of questionnaires modified for the purpose although the modified instruments scored highly on reliability testing. The rationale to use existing routinely used scales was aligned with the main purpose of the project: to facilitate program implementation and ensure that the evaluation process was not too burdensome for practitioners, clients and families. Further confirmatory studies should consider using instruments with good psychometric properties within a robust research design with a control group to determine the effectiveness of SSFC in youth mental health services.

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Conclusion

This project has provided preliminary evidence that SSFC is feasible to implement as a routine intervention in mental health services for young people and has overcome some of the barriers in providing family interventions in these settings.[10, 18, 52] Moreover, SSFC was shown to be an acceptable intervention for young people and their families in a youth mental health context. The implementation strategy warrants further investigation as an effective approach to practice and organisational change.

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Table 1. Feedback from clients and their families

	Clients (n=129) Mean (S.D.)	**Family members (n=191) Mean (S.D.)**
Relationship (0-6) Question: I felt heard, understood, and respected.	5.0 (1.4)	5.6 (0.8)
Goals and topics (0-6) Question: We worked on and talked about what I wanted to work on and talk about it.	5.1 (1.3)	5.4 (0.9)
Approach or method (0-6) Question: The therapist's approach is a good fit for me.	5.2 (1.1)	5.5 (1.0)
Helpfulness (0-6) Question: Session was helpful in addressing some of my needs.	5.2 (1.2)	5.4 (0.9)
Overall (0-6) Question: Overall, today's session was right for me.	5.2 (1.1)	5.2 (1.3)

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Table 2. Family Inclusive Practice Questionnaire (MID – PRE)

		MID - PRE				
		Mean MID (SD)	**Mean PRE (SD)**	**N**	**Mean Diff (CI)**	**p-value**
1	My workplace provides supervision, mentoring and/or consultancy (external or internal) to support workers in family inclusive practice	5.59 (1.32)	4.55 (1.92)	29	1.03 (0.40, 1.67)	0.002*
11	I have adequate knowledge needed to conduct an interview with families or when there is more than one person in the room	6.18 (0.82)	5.29 (1.21)	28	0.89 (0.34, 1.45)	0.003*
13	I am knowledgeable about how the client's difficulties impact on their family members	5.96 (0.74)	5.54 (0.88)	28	0.43 (0.07, 0.79)	0.020*
17	I am clear about when and how I would invite other people into my client's session	5.75 (0.93)	5.11 (1.20)	28	0.64 (0.12, 1.16)	0.017*
18	At my workplace, policies and procedures for working with families are very clear	4.57 (1.17)	3.93 (1.51)	28	0.64 (0.11, 1.17)	0.019*
22	I usually speak to each family member individually before they attend a family meeting	4.36 (1.56)	3.41 (1.76)	22	0.96 (0.22, 1.69)	0.013*
33	I do not have the skills to work with clients about how their difficulties impact on their family members ^	5.96 (0.79)	5.50 (1.07)	28	0.46 (0.06, 0.87)	0.025*
37	I have confidence in my ability to work with families	6.14 (0.71)	5.39 (1.03)	28	0.75 (0.33, 1.17)	0.001*
44	I regularly work collaboratively with the family members of my clients	5.61 (0.83)	5.18 (1.19)	28	0.43 (0.07, 0.79)	0.020*
	SUM Scores	244.20 (23.61)	233.74 (24.86)	28	10.46 (3.49, 17.44)	0.005*

Note:

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1. Positive mean difference means improvement in the item.
2. ^ means reversed coded items that are changed to similar direction as other items.
3. * means statistical significance of at least 0.05.

Table 3. Family Inclusive Practice Questionnaire (POST – PRE)

		POST - PRE				
		Mean POST (SD)	**Mean PRE (SD)**	**N**	**Mean Diff (CI)**	**p-value**
1	My workplace provides supervision, mentoring and/or consultancy (external or internal) to support workers in family inclusive practice	6.00 (1.37)	4.53 (1.71)	19	1.47 (0.55, 2.40)	0.004*
18	At my workplace, policies and procedures for working with families are very clear	5.26 (1.28)	3.58 (1.22)	19	1.68 (0.91, 2.46)	<0.001*
22	I usually speak to each family member individually before they attend a family meeting	3.94 (1.51)	2.94 (1.39)	18	1.00 (0.02, 1.98)	0.046*
	SUM Scores	236.72 (43.71)	227.60 (23.80)	19	9.13 (-15.12, 33.38)	0.439

Note:
1. Positive mean difference means improvement in the item.
2. * means statistical significance of at least 0.05.

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Table 4. Family Intervention Schedule

		MID - PRE					POST - PRE				
		Mean MID (SD)	**Mean PRE (SD)**	**N**	**Mean Diff (CI)**	**p-value**	**Mean POST (SD)**	**Mean PRE (SD)**	**N**	**Mean Diff (CI)**	**p-value**
1	The availability of appropriate families that I can work with	1.85 (0.93)	2.31 (1.23)	26	-0.46 (-0.86, -0.06)	0.025*	2.00 (1.16)	2.16 (1.12)	19	-0.16 (-0.67, 0.36)	0.527
2	The allowance of time from my organisation to work with families	2.07 (1.02)	2.36 (1.22)	28	-0.29 (-0.62, 0.05)	0.088	2.32 (1.25)	2.58 (1.22)	19	-0.26 (-0.79, 0.27)	0.310
3	The integration of my work with families with my caseload or other responsibilities at work	1.96 (1.02)	2.37 (1.04)	27	-0.41 (-0.82, 0.01)	0.054	2.58 (1.26)	2.74 (0.99)	19	-0.16 (-0.62, 0.30)	0.482
4	The burden of work – too much work, too many demands	2.29 (0.90)	2.43 (0.92)	28	-0.14 (-0.50, 0.22)	0.424	2.84 (1.17)	2.58 (1.02)	19	0.26 (-0.27, 0.79)	0.310
5	The non-applicability of existing approaches to working with families due to my current working context	1.65 (0.89)	2.09 (1.20)	23	-0.44 (-0.80, -0.70)	0.022*	1.88 (1.15)	2.13 (1.03)	16	-0.25 (-1.02, 0.52)	0.497
6	The lack of support by managers or colleagues for the value of working with families	1.43 (0.63)	1.46 (0.84)	28	-0.04 (-0.32, 0.25)	0.802	1.32 (0.75)	1.32 (0.67)	19	<0.001	-
7	Collaboration of colleagues in allowing me to work with families they are involved with	1.46 (0.66)	1.58 (0.78)	24	-0.13 (-0.38, 0.13)	0.328	1.35 (0.61)	1.53 (0.72)	17	-0.18 (-0.59, 0.24)	0.382
8	The travel to the family session	1.82 (0.81)	2.06 (1.03)	17	-0.24 (-0.62, 0.15)	0.216	1.18 (0.41)	2.00 (1.10)	11	-0.82 (-1.41, -0.23)	0.011*
9	Having to work outside my usual working hours	1.84 (0.90)	2.53 (1.54)	19	-0.68 (-1.17, -0.20)	0.008*	1.80 (1.23)	2.60 (1.35)	10	-0.80 (-1.80, 0.20)	0.104
10	Lack of familiarity with approaches to working with families	1.36 (0.49)	2.14 (1.04)	28	-0.79 (-1.17, -0.40)	<0.001*	1.67 (0.59)	2.28 (1.13)	18	-0.61 (-1.13, -0.10)	0.023*
11	Keeping family discussions on track	1.85 (0.68)	2.42 (0.81)	26	-0.58 (-0.82, -0.23)	0.002*	2.06 (0.94)	2.22 (0.65)	18	-0.17 (-0.52, 0.19)	0.331
12	The clash of working with families with the other needs of the client	2.08 (0.63)	2.73 (0.96)	26	-0.65 (-0.98, -0.33)	<0.001*	2.37 (1.34)	2.58 (0.84)	19	-0.21 (-0.96, 0.54)	0.561
13	A lack of confidence in working with families	1.44 (0.51)	1.93 (1.04)	27	-0.48 (-0.91, -0.05)	0.030*	1.58 (0.77)	2.05 (1.03)	19	-0.47 (-0.91, -0.04)	0.035*

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		MID - PRE					POST - PRE				
		Mean MID (SD)	Mean PRE (SD)	N	Mean Diff (CI)	p-value	Mean POST (SD)	Mean PRE (SD)	N	Mean Diff (CI)	p-value
14	A concern that there will be conflict in the meeting with families	1.82 (0.72)	2.29 (1.12)	28	-0.46 (-0.89,-0.04)	0.035*	2.00 (0.94)	2.32 (1.00)	19	-0.32 (-0.71, 0.08)	0.111
15	The anticipation that family members will be hostile to me or the service	1.68 (0.77)	2.18 (1.06)	28	-0.50 (-0.90, -0.10)	0.017*	1.84 (0.77)	2.16 (1.12)	19	-0.32 (-0.74, 0.11)	0.137
	SUM Scores	26.14 (7.01)	32.19 (9.41)	27	-6.04 (-8.72, -3.36)	<0.001*	28.87 (10.09)	32.70 (10.19)	18	-3.82 (-7.04, -0.60)	0.023*

Note:
1. Positive mean difference means deterioration in the item.
2. * means statistical significance of at least 0.05.

Table 5. Organisational Readiness Tool

		POST - PRE				
		Mean POST (SD)	Mean PRE (SD)	N	Mean Diff (CI)	p-value
1	My workplace provides supervision and mentoring to support and encourage workers to undertake family inclusive practice	6.06 (1.21)	4.61 (1.65)	18	1.44 (0.78, 2.13)	<0.001*
4	You are encouraged here to try new and different techniques	5.94 (1.39)	5.22 (1.35)	18	0.72 (0.04, 1.4)	0.038*
5	There are clear policies and protocols that support family involvement as part of routine practice	5.53 (1.38)	3.71 (1.45)	17	1.82 (0.97, 2.68)	<0.001*
7	I feel overwhelmed by the amount of work or the size of my case/workload I have to deal with ^	4.78 (1.44)	3.94 (1.43)	18	0.83 (0.15, 1.52)	0.020*
8	I often receive support from my co-workers to help me be more inclusive of families in my work	5.61 (1.29)	4.50 (1.30)	18	1.11 (0.50, 1.72)	0.001*

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		Mean POST (SD)	Mean PRE (SD)	POST - PRE N	Mean Diff (CI)	p-value
11	Management expresses a clear vision for and commitment to family focused practice	6.00 (0.97)	5.22 (1.31)	18	0.78 (0.06, 1.49)	0.035*
14	Frequent staff turnover is a problem for this program ^	6.00 (1.78)	5.22 (2.21)	18	0.78 (-0.12, 1.67)	0.084*
16	I feel “bogged down” by the system ^	5.61 (1.54)	4.89 (1.78)	18	0.72 (0.16, 1.28)	0.015*
19	Staff here are always quick to help one another when needed	6.50 (0.51)	5.89 (0.90)	18	0.61 (0.10, 1.13)	0.023*
20	We have an agreed upon process for recording family work	5.94 (1.44)	3.06 (1.39)	17	2.88 (1.82, 3.94)	<0.001*
24	Other workers here are strongly committed to including families in our work with primary clients	5.78 (1.00)	4.89 (0.96)	18	0.89 (0.30, 1.48)	0.005*
27	It is clear that the management here expects us to implement family inclusive practice in our routine clinical care	6.11 (0.96)	5.11 (1.18)	18	1.00 (0.30, 1.70)	0.008*
	SUM scores	170.54 (26.20)	152.71 (21.95)	18	17.84 (8.12, 27.56)	0.001*

Note:
1. Positive mean difference means improvement in the item.
2. * means statistical significance of at least 0.05.

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