



The December issue already! It is hard to believe that we are at the end of another year. We have tried to get the newsletter out before the Christmas postal rush in order to get the detailed programme for the family conference to everyone.

You will notice that the newsletter is packed with interesting articles on varied aspects of family work. Sometimes, those of us who work in this area can become disheartened and feel that not very much progress is being made. However, looking at the range of articles that we now have submitted for the newsletter, in addition to the wide range of presentations that will be given at the family conference, it is clear that there is plenty of activity in relation to all aspects of family work.

This edition of the newsletter contains a mix of reports of events that have happened, articles informing us of approaches that can be used to help families where there are mental health problems, and information on forthcoming events. I hope there will be something that everyone will find of interest. We now frequently receive many messages from readers who find the newsletter a valuable source of information, either for themselves as individuals or for the family support groups that they link with.

In terms of reports on events that have taken place, there are interesting articles on the new Caring for Carers support group that has started in Stoke on Trent, and a report on a very successful Transcultural Family Work Event that took place through the Meriden Programme. We also have a report from Nick Dutton on how he and his colleagues in North Staffordshire are attempting to ensure that those who are trained in family work actually put it into practice.

Kevin Jones has provided a really interesting article on the work of the European family movement, EUFAMI. It would be good if carers in the UK linked up more with this European group, as to date the contact with the group from the UK is not very extensive. Kevin has included initial details of a carers conference which will take place in Poland in September 2007, which some carers will be interested in attending.

Catherine Clarke describes in detail how she as a mother has been able to help her son with psychosis using the pre-therapy approach. She provides many interesting examples of how she has been able to use this effectively to help with her son's care. For those interested in the whole area of Early Psychosis, there is an article by Matthew Ovens from Australia on the topic of grief and loss for families of young people experiencing psychosis. This has important implications for how services should meet the needs of people in this situation.

Throughout the newsletter, readers will find information on a number of publications that are available relating to family work, and also information on a new CD produced by young carers in Birmingham, which is now available. There is also information on forthcoming training events provided through the Meriden Programme, and of course detail in relation to the March conference.

You will have received a detailed programme for the 'Working with Families' conference being held on 19 & 20 March 2007. I have been really impressed with the range of papers and workshops that have been submitted for presentations at the conference, and I think you will see from the detailed programme that it will be an exciting and dynamic event. Once again, I think that there is something for everyone who is interested in the area of family work right through the whole age range of young people through to older adults. Make sure that you register early, as accommodation at the conference venue is limited. I look forward to meeting many of our readers at the conference, which will be a fantastic opportunity for people to network with colleagues and friends who have similar interests.

Finally, may I take the opportunity to wish you all a wonderful time over Christmas – I hope you have a restful and stress-free time with family and friends, and I hope that the New Year is productive and fruitful for you all.

Dr Gráinne Fadden

Active Carers

In 2005, the Meriden Programme developed an eleven week programme offering information and support to carers, and an associated three day training programme for the teams of professionals and carers who would deliver this. The programme was first delivered as part of a cross-border initiative between Northern Ireland and the Republic of Ireland. It is now being adapted for different groups. Di Morris describes how it has been adapted by a group in Staffordshire to meet local needs.

As I contemplate writing this we are sitting here in the pub celebrating the success of the delivery of our first session of the Carers Training based on our experience with Meriden earlier this year – more about that later.

There's a certain amount of excitement in the air (NOT fuelled by alcohol I can assure you) as we reflect on the evening and have a bit of a giggle about some of the things we've learned about each other thanks to our icebreaker, Human Bingo. We've agreed to maintain confidentiality as one of our ground rules but I'm sure no-one will mind you knowing that one of us buys shoes in the children's department due to the dainty size of her feet (yes we couldn't believe it either), another of us admits to knowing the name of the café in Coronation Street and more embarrassingly one of us can hum the theme tune from Eastenders (we will maintain your secret). We would certainly recommend this as an introductory activity as it got us all moving and talking and did what it said – broke the ice.

Anyway, where did our journey start? Earlier this year a group of us participated in the three day 'Caring for Carers' Training Programme facilitated by Meriden. There were thirteen of us altogether, a mixed group of carers and social and health workers and I can honestly say that everyone benefited from the experience. Not only did we learn a lot especially about ourselves and our different skills and abilities but Gráinne Fadden, Chris Mansell and Peter Woodhams left us feeling very inspired and determined that we would develop a support group for local mental health carers. The hard work had begun.

The Meriden 'Caring for Carers' course itself consists of eleven sessions focusing on various aspects of support for carers, coping strategies and information-sharing. In our first meeting we identified that we needed to perhaps reduce this for a variety of reasons – time, cost, venue and commitment of trainers to name a few. Once we had a venue thanks to Karen who has been a trainer and supervisor in the Meriden Programme for a number of years, and had identified the roles that people would play, we were able to look at the sessions which we felt would be most useful for our needs. We reduced the course to 8 sessions, which we felt was a realistic number given our constraints and also due to the fact that most of the meetings would be run

over the winter. Dark nights and cold wet weather aren't always the best incentive for enticing people out of their homes but we hoped that we could promote our training as a unique opportunity for carers, and that this would be our "selling" point.

We've met regularly to plan and develop our work and it hasn't always been as problem free as we could have hoped. For example, when one of our team moved to a new job out of the area, we had to re-allocate tasks and re-arrange the timing of the sessions. When our venue started major building work, we took this in our stride and prayed it would be finished in time. Through all of our planning we stayed positive – this attitude and a sense of humour has got us to where we are now, not in the pub but delivering our first session to our first group of carers.



Back row left to right: Linda Maidment, Di Morris, Debbie Faulkner, Karen Ware, Jayne Aston Middle row: Sue Tams, Marion Tomkinson, Sue Rushton, Sue Gibson Front row: Mike Gibson, Theresa Lockett

Tonight, nine carers and eleven trainers participated in the first session of our course. We decided that for our first session all our trainers would be present to enable everyone to meet us all and to demonstrate our commitment to the programme, I can't begin to tell you how we all feel about that. Words that spring to mind are "elated", "humbled", "excited", "relieved" and "exhausted". The carers all gave positive feedback and expressed their intention to continue attending the group training which has boosted our confidence and determination beyond belief. After this session because we have looked at the strengths of our team we will not all be participating in each session. We will however continue to meet regularly and will amend our material as necessary.

We would all like to thank Meriden for the inspiration and continuing support that they have given us, so thanks Gráinne, Peter and Chris – you are fantastic, long may you continue.

Di Morris
Training and Development Officer
(Mental Health), Stoke-on-Trent Social Care

An Introduction to EUFAMI – the Voice of Families and Carers in Europe

EUFAMI is the European Federation of Associations of Families of People with Mental Illness. It is the representative body for family-run voluntary organisations across Europe, which promotes the interests and well-being of all people affected by severe mental illness. It was founded in 1992 under Belgian law as a non-profit organisation with a Board of Directors drawn from all its member associations.

Its roots go back to 1990 when at a European congress held in De Haan, Belgium, family members from all over Europe shared experiences of helplessness and frustration in the face of severe and misunderstood mental illness. They resolved to work together to help themselves and the people that they cared for.

More than 15 years later EUFAMI has 48 member associations from 28 European countries. Member associations are either national or regional organisations that provide support and campaign for positive change for family carers and people with a mental illness. EUFAMI campaigns on behalf of many millions of people across Europe affected by severe mental illness. It aims to represent their concerns in the European institutions such as the EU Commission and the European Parliament, the World Health Organisation (WHO) and other European and international forums and bodies.

EUFAMI's principal aims are threefold:

- To achieve a continuous improvement throughout Europe in mental health, the quality of care and welfare for people with a mental illness, and the level of support for their family and friends
- To enable its member associations to combine their efforts, and act jointly at European level
- To strengthen and assist the member associations in their efforts to improve health conditions in their own areas

EUFAMI believes that carers must be acknowledged as equal partners alongside professionals supporting the person with mental illness and recognises that carers need support in their own right and have many unmet support needs that must be respected and recognised. Additionally EUFAMI believes that all people with a mental illness have the right to appropriate social care and health care services and that all people affected by severe mental illness have the right to share in the opportunities, responsibilities and fulfilment of everyday life.

The Federation works with partners and stakeholders in the public and private sectors that share its concerns and beliefs and together seeks solutions for mental health issues, furthering better quality of care and welfare for people with a mental illness and support for their family and friends.

EUFAMI has ongoing programmes and activities which are aimed at defending the rights and interests of family members of people with a mental illness as well as the people with a mental illness themselves, in order to enable them to reach their fullest potential. As part of its activities, it also highlights examples of best practice in care and treatment, in order to promote positive change throughout Europe.

It currently has a very successful anti stigma campaign, Zerostigma, operating in 13 countries across Europe to combat the stigma surrounding mental illness and discrimination against people with a mental illness. A central part of this campaign is the promotion of a positive image of mental illness in order to counteract ignorance and misinformation.

Over the past four years, EUFAMI has facilitated the development of a very unique peer-to-peer training programme for families and carers, users and professionals. This training programme goes under the title PROSPECT and is currently being run in 14 countries across Europe as well as being used as the basis for training in countries such as Albania and Moldova.

From time to time, and when the need arises, EUFAMI publishes Policy Papers on common issues in Europe. Policy Papers, internally referred to as Position Papers, are currently available on Family Carers' Needs, Medication, Treatment and Care and Rehabilitation and Recovery. Due to concerns expressed by its members on the state of mental health services across Europe, EUFAMI's policy group will shortly begin research on this subject and, in time, issue a paper on its findings which will also include EUFAMI's official position on the subject.

With respect to some of its achievements to date, probably one of the more rewarding ones is that EUFAMI now, after many years of work, is recognised by the main players in the health field as the legitimate voice of the families of those affected by severe mental illness – organisations such as the WHO and the EU Commission's appropriate Directorate, known as DG Sanco.

Now more than ever, there is a need for organisations such as EUFAMI. For example, the European Union is becoming more united at a legislative level and has become much more important. Even though it does not have any competency for delivering health services (only public health policy), it is becoming much more influential. Therefore there is more and more need for associations to operate at this high level. This of course does not mean that national activity takes a lower level of importance or ceases completely.

National/regional organisations just cannot operate at this European level in any effective manner. This is a role that is undertaken by umbrella bodies, such as EUFAMI. EUFAMI has the resources, staff and time to interact with member national/regional organisations to collate the appropriate information and data, and be able to put forward a composite and united message.

Belonging to a European organisation, can increase the power and strength of working locally. Two perfect examples which demonstrate this are:

- At the WHO sponsored Ministerial Health Conference held in Helsinki, Finland in January 2005, EUFAMI was present and fully participated in the ensuing debates and discussions and was instrumental in having families mentioned in the subsequent Declaration which was published at the end of the Conference.

- Since late 2005, when the EU started a process to develop a Mental Health policy for the EU, EUFAMI once again has been fully engaged in this process. As well as contributing to the various consultation meetings in Luxembourg and elsewhere, the Federation fully consulted with its members and submitted a consensus paper in response to the Green Paper.

Every four years, EUFAMI hosts a major International Congress. The next one will take place in Toru, Poland from the 14-16 September 2007. The title of the Congress is 'Touching the Stars' and the theme is on Remission and Recovery in mental illness.

For more information about EUFAMI, log onto the website www.eufami.org

**Kevin Jones
Secretary General, EUFAMI, Leuven, Belgium**

IAN FALLOON'S MEMORIAL

We met on Monday, 2nd October to pay tribute to Ian and his life. It was a warm and touching meeting attended by both family and colleagues, many of whom spoke of their recollections of Ian. Tributes had also been sent in to be read out at the event. A number of people attended who were in Birmingham for the Early Intervention conference, which started the next day. At times there was sadness, but also so much admiration for what Ian had achieved, for his energy, courage and commitment.

There were themes that recurred throughout the tributes paid. Many remembered Ian's laugh – 'If Ian saw or heard anything funny, he laughed until he cried'. His family talked about how loved they felt by him, how supportive he was, and the fact that he put into practice in his family life what he talked about in his work. There were many amusing anecdotes – such as the time in his eagerness to film a role-play of a family therapy session when in Australia, he thought he would use the seating area of the motel room he was staying in, but the lighting wasn't right. He wondered why the sales assistant in the camera shop was looking at him strangely when asking her for stronger light bulbs so that he could make a movie in a motel room!

Many colleagues spoke about how Ian had inspired their work early in their careers, for example, Max Birchwood, who described Ian as a 'free-thinking maverick' who had always been willing to give of his time. Pat McGorry, in talking of Ian's energy right up to his death had a lovely quote: 'Some people die while they are still alive', and that Ian was one of these.

Alan Rosen and Viv Miller from Australia presented Ian's family with a posthumous award 'In recognition of his exceptional contribution to mental health services in Australia and New Zealand'. There were many suggestions of awards in Ian's name as a way of honouring his memory, an idea that will be pursued by Ian's family.

The following tributes arrived too late to be read out at the event.

"I knew Ian at the Maudsley in the 1970s, when he astonished me with the energy he put into his RCT of social skills training (I still have the manual he produced). He was a good mate then, and later, when our paths diverged (though they crissed and crossed) he was an always amiable colleague. His contribution to the field was major indeed, and he will be sorely missed, personally and professionally." Professor Paul Bebbington, UCL

"The passing of Ian Falloon is a great loss for the international mental health community. As we all know, he substantially changed our expectations for the fate of those among us who develop a major mental illness. First with his explorations of work with families, then with very early treatment and now with dissemination and optimal therapy, he has changed the prognosis for the worst of the afflictions affecting the human mind. It is sad and tragic that his life was taken at such an early age.

I had the pleasure of spending considerable time with him in April this year. He was in pain, but still planning for the future of even better lives for those with serious illness. Who can forget his laugh, and his passionate commitment to improving the lives of so many of our fellow beings. Let us hope that he had some sense of his worthiness as he left us." Dr William McFarlane, Maine, USA

I will end with a quote from Ian's extended family, the Holmes family in New Zealand:

'If there is one passing wish it is for you all to continue the passion of Ian and to continue the good works of service to others. And should you ever happen to pass a lone grave in Maidstone, Kent where a New Zealand soldier lies buried, Ian Holmes, killed in action, October, 1940, tell him his nephew Ian Robert Holmes Falloon made a damn good attempt of making a difference to the world'

An inspiration for all of us to try to continue to make a difference.

Gráinne Fadden

Pre Therapy

A Carers Perspective of Prouty's Contact Work

Background

My first experience of Pre Therapy was in 1998 on a Person Centred Approach (PCA) Diploma Course; the module was titled 'Psychological Contact' (Rogers, 1989). Although at that time I only discovered the rudiments of this approach, I was deeply intrigued, and remember thinking it was a wonderful way to release people who were trapped psychologically within their own being. My analogy was akin to a bird, freed from the constraints of a cage, being able to soar at will. I wrote an assignment about psychological contact with relative ease, however little did I know then that I would later be using this work in earnest to help my son in his emotional distress.

In full acknowledgement of the many clinicians who are Pre Therapy experts, my intention here is to convey to carers and professionals my own understanding of this unique approach. As a carer, my perspective is influenced by the medical treatment of my son, and I introduce factual examples that have impacted his care. Some readers may find some issues challenging, I ask only to have an open mind and be reflective about my article.

Pre Therapy was devised in 1976 by psychotherapist Professor Garry Prouty. The philosophy of humanistic psychotherapists Eugene Gendlin and Carl Rogers provided solid values for Pre Therapy development. Gendlin's existential-phenomenological approach deeply values each person's current 'way of being' within the world, including verbal and non-verbal 'here and now' behaviour. Existential contact is the right to simply exist and to be recognised as a member of our humanity. The Rogerian PCA therapeutic process promotes clients' self-knowledge and self-awareness by giving clients the freedom to be their own guide in the therapeutic process. This is fostered by clinicians' attitudes of congruence, unconditional positive regard and empathy.

Through training by Gendlin, knowledge gained from Rogers, together with his experiences with his autistic brother, Prouty developed a natural aptitude for making contact with client groups who were difficult to engage. On being encouraged to impart his skills to others, he took ten years to fathom out 'what' he was actually doing, together with 'how' he was in relation with clients before finally having his first book published (Prouty, 1994).

Pre Therapy is the theory and practice of psychological contact. Rogers introduced the concept of psychological contact in his 1957 paper, 'The Necessary and Sufficient Conditions of Therapeutic Personality Change'. He stated that for psychotherapy to progress 'two persons must be in psychological contact'. This process was minimally described

as having 'some perceived difference in the experiential field of the other' (Rogers, 1989). My understanding of this process is when I affect a change with another person, which is appropriate to our shared situation I know the other person is in psychological contact with me. The response, either negative or positive, is important, for then I know the person is on my wavelength.

Although most people are oblivious to experiencing psychological contact, I am very aware of my personal levels of contact. My contact begins to dip when I daydream, worry excessively or lose concentration. In these periods my contact with others and the world is replaced by my fantasy world. Not for long though as I have the ability to reverse this process, leave my fantasy world, and regain my ability to participate adequately within the world. I am able to do this because my own sense of self is secure and strong and so I am able to reconnect with others and the world around me. In regaining psychological contact I am able to dialogue and engage with others within our shared reality. It is impossible to be in continuous contact all the time.

When my son experienced his psychosis, he landed in his world of psychotic reality. Losing touch with his previous sense of identity, he became unaware of his own sense of self in relation with other people and his current surroundings. Furthermore he was unable voluntarily to regain our shared world of reality, appearing to be stuck within his psychotic world. Because he was not in psychological contact, clinicians' experienced difficulty in engaging with him. Rogers' psychological contact comes to light here, as it is imperative for the client and the clinician to be in psychological contact with each other; this provides the optimal conditions for the clinician to engage with clients for a progressive therapeutic relationship.

The Theory of Pre Therapy

All persons who are able to engage meaningfully experience 'Expressive Contact Behaviour' (Prouty, 1994). Prouty describes three processes in which we can be in contact: Reality Contact Function, Affective Contact Function and Communication Contact Function. **Reality Contact Function** is connected to sense of being a part of the world and includes our awareness of time, other people, objects and events. **Affective Contact Function** originates from awareness of our feelings, moods and emotions and is an inherent part of our human existence. The accessibility of our affective self helps us to feel a living being, instead of being robotic. Our **Communication Contact Function** is our ability to convey our thoughts and feelings in ways others can understand. When all three processes are fully functioning we are able to lead our lives adequately and to the best of our ability.

Problematic functioning is known as Pre Expressive Behaviour and describes persons functioning at a low level where the Contact Functions of Reality, Affect and Communication are below the level of psychological contact. Persons are out of touch in varying degrees with themselves, other people and their surroundings. Client groups include Autism, Alzheimers Disease, Severe Learning Difficulties and persons experiencing emotional regression, severe depression, dissociation and psychosis. Behaviour is depicted by withdrawal, isolation, catatonia, frozen terror, hallucinations and delusions. Body language may be bizarre and verbal communication may be fragmented or jumbled up and may appear absolutely meaningless to objective observers. Prouty perceives clients' low functioning behaviour to be important since the combination of the verbal and non-verbal expression is a person's communication of their Pre Expressive Self. Persons at this stage are unable to convey in a meaningful way what is actually troubling them and which is yet to be disclosed. This is the client's current way of being within the world and 'how' they are viewing and experiencing the world. Their process, in line with the underpinning philosophy of PCA, needs to be respected and valued.

Using Pre Therapy in Practice

Pre Therapy provides the practical skills for clinical staff to enable them to make contact with clients who are functioning at a low level – it enables clinicians to know 'what to say' and 'how to be' with clients; the primary objective being to encourage clients to get back in touch within themselves, other people and the world. The skills involved are called **Contact Reflections**, where the clinician focuses on the Contact Functions of the client through their verbal and non-verbal behaviour together with the current surroundings. The clinician works with only what he clearly hears and sees. Corresponding with Reality Contact Function, the situational reflection includes all things, people and time that are within the current environment of the client. The aim is to entice clients to make contact with our shared world of reality. I have found this situational reflection invaluable for 'grounding' my son. One evening at home my son escalated into a florid psychosis and began to shriek in sheer terror about his imminent execution. I reflected: 'You are at home'. 'It is ten o'clock in the evening'. 'You are in the sitting room'. 'The cat is on the chair'. 'It is dark outside'. 'Daddy is sitting with you'. All of these are **situational reflections**. Within a few minutes he stopped shrieking and became calmer to such an extent that as the police radio sounded, he began to ask questions about the radio frequency. My son was back in our shared reality (Clarke, 2005).

Facial Reflections relate to facial expression and are associated with the Affective Contact Function. When my son looked sad, I would say, 'You look sad', and this helped him to get in touch with his feeling of sadness, being able to express his sadness emotionally (Clarke, 2005).

Body Reflections refer to body posture and help clients sense their body as their own. During one occasion when my son was mute he slowly lifted his arm towards his chest. I reflected, 'Your arm is pointing to your chest' and at the same time lifted my arm to my chest. This body reflection helped my son to express some words, which led to him having an animated conversation with me within our shared reality (Clarke, 2005).

Word for Word Reflections involve reflecting clients' words and phrases back to them: it is important to reflect just the words that are clearly heard. This reflection encourages the all important communication contact.

Reiterative Reflections are based on previous reflections that have initiated a client response, which are then repeated in order to encourage further contact with relating.

On the ward one morning, my son was pacing up and down the dining room. He seemed completely oblivious to my presence – it was as though I was invisible to him. He was muttering quietly and I eventually heard the word 'Monkey' repeated many times. Each time I heard this word, I reflected 'Monkey' back to him. Then he suddenly stopped pacing and turned around to look at me. I knew at this point he was beginning to make psychological contact with me, and therefore increasing his contact with our shared reality. I then reflected, 'When I said monkey, you looked at me' – a reiterative reflection. The word for word reflection of, 'Monkey', encouraged my son to say different words – 'Magic' and 'Tricked' (Clarke, 2005). His communication gradually increased, which ultimately led to him talking with other clients at the dinner table about the current meal. By making contact with my son using the reflections, he began to reclaim his own sense of self thereby loosening his tenacity with his psychotic experiencing.

To me, the reflections are analogous to offering a life-line to someone drifting alone on the ocean, lost, frightened and vulnerable. The person is able to assess who is offering the lifeline, decide whether it is safe to take hold and choose to move towards safer and secure ground.

Implications of Pre Therapy for Clinicians

Clients who experience psychosis are very sensitive people and will assess whether a clinician is trustworthy or is likely to deceive them. Clients instinctively sense those clinicians who are sincere and truly care and it was these clinicians my son automatically respected, simply because within their authenticity, they respected him. Within this scenario he felt safe and secure. In other scenarios where he felt disrespected and insecure, clinicians experienced my son as being 'difficult' which resulted in him being given more medication. Clinicians' spoken word, together with 'how a clinician is 'being' with a client is extremely important and has an enormous impact on how clients interact with clinicians.

With Pre Therapy, it is necessary that clinicians work with a sensitive manner, not only because of the client's sensitivity, but because Pre Therapy reflections are powerful and increase clinicians potential for entering the clients' private phenomenological world. The contact reflections are most effective when clinicians' attitudes are non-directive, non-critical and performed with compassion, humility and respect for the patients' Pre Expressive effort of communication. Being curious and interested in 'what' is going on for clients is part of having a phenomenological disposition.

The reflections may seem simple. However in practice there are many nuances that enrich a clinician's ability to facilitate clients' movement towards the shared reality. For clients to progress, consideration of their comfort level is vitally important. All reflections are practiced to achieve an increase towards the Expressive Level of Behaviour, whilst ensuring minimal distress for the client, as well as for the clinician.

A client's psychotic world without people is generally preferable to interacting within the shared world of reality with people. The close proximity of other people invades clients' psychotic space and has the potential for creating distress and fear. In order to protect their psychotic space, a client's defensive reaction is one of fear with the escalation of the inevitable negative response of psychotic material.

One example occurred when my son was experiencing a mixture of psychotic and congruent material on a secure unit. The nurses were getting too physically close to him for his comfort level and he responded by becoming increasingly annoyed with them. This in turn increased the charge nurse's anxiety, which resulted in the nurse manhandling my son into the isolation unit. In similar situations when my son has asked me to 'go away', I do exactly that, as giving psychological space in metres decreases his anxiety and distress. It also fulfils my need at this point in the process, which is to feel safe from potential physical aggression. By keeping a spatial distance the client feels safer and importantly provides a clinician safety factor.

The pace of the reflections in the Pre Expressive level needs to be gauged with the client's own pace of experiencing. If the tempo of reflections is too intense, clients may feel overwhelmed whereas keeping the speed of the reflections slow and spaced out helps to maintain clients' comfort level. Due to my naivety before I learnt this nuance my son became increasingly distressed. A few weeks later when we were out walking he volunteered, 'You did them [reflections] too quick, Mum.' Rapid expression from the patient will leave little time for the therapist's response; in which case, periodic reflections at the therapist's own pace can then be used.

Through regular contact with clients by using reflections, clinicians' safety is yet again improved. When my son had been sedated, he was left on his own for many hours on the

ward, simply because he was being quiet and 'no problem' according to the nurses. However at these times he would be ruminating round and round his own psychotic world, spiralling ever further deeper into his Pre Expressive Level. It is fortuitous for clinicians to make regular contact with clients instead of waiting for a psychotic explosion with the inevitability of both verbal and physical violence. By making contact, clinicians are able to prevent clients psychotic experiencing from deepening.

I find the reflections useful in finding out where my son is functioning within his level of reality. Every morning as he gets up, I greet him with a sentence e.g. – a situational reflection – 'It's a nice sunny day out there'. From his verbal and non-verbal response, I am able to assess 'where', he is in his level of functioning: I am then more informed as to how frequently to make contact with him and also what type of contact is appropriate. Bearing in mind that clients experiencing psychosis have a preference for avoiding contact with people, if my son is functioning at a low level, I refrain from asking questions or making requests from him as by doing so would set myself up for his negative response. By framing statements concretely, the potential for clinicians being rejected by the client is avoided.

Pre Therapy as a Route to Therapy

At the St Camillus Hospital in Belgium, one acute ward is dedicated solely to clients experiencing psychosis and Pre Therapy is practised as a ward milieu within a multidisciplinary setting; Pre Therapy and reflections are a 'way of life' on the ward (Prouty et al, 2002). Van Werde, the Lead Psychologist, trains nurses with the contact reflections and it is the nurses' primary responsibility to make contact with clients and to progress them psychologically towards the Expressive Level. When clients are admitted in severe distress, nurses make contact every fifteen minutes. As the client becomes more in contact with our shared reality, the contact by nurses with reflections is increasingly spaced out. Clear communication is essential: so the nurse will say to the client, 'I need to return to the office and I will come back to see you in fifteen minutes'. This leaves the client without any doubt where he/she stands in relation with the nurse: the nurse is coming back. At home when my son's psychological contact begins to dip, I am very explicit; he knows my intentions to interact with him up front and therefore he has a clear understanding of what is going to happen. Thus he is able to adjust himself to my presence and contact.

The reflections are an art and clinicians become skilled in balancing, gauging frequency of reflections and the spatial and temporal dimensions. All are factors, which have the potential to decrease client anxiety and evaluation of clients functioning of psychotic experiencing and congruent experiencing.

As clinicians make contact with clients in this Person Centred way, the sense of client isolation decreases and the process of relating gradually increases within our

shared reality. As all the Contact Functions are gradually strengthened and maintained, clients are able to engage in the daily activities of life. When clients are safely secured within the Expressive Level of Behaviour, they have a fully informed choice about embarking upon psychotherapy.

Prouty addresses this in his Pre Symbolic Psychotherapy work, whereby using the contact reflections and Person Centred responses, he achieved the movement from hallucinatory experiencing which is 'reality based' not conscious experiencing, towards integration into conscious experiencing (Prouty, 1994). Persons experiencing psychosis have the potential for recovery.

Using Pre Therapy as a Mother

Before I first decided to work with Pre Therapy, I debated as to whether it was ethical for me to use this approach with my son. As his suffering deepened and I felt ever more drawn towards trying to help ameliorate his hallucinations, eventually I began to realise that provided I kept to my boundaries – I am not my son's psychotherapist – I was being ethical. Many times I am asked whether my son is fully recovered and I sadly respond in the negative. The following issues I think have contributed:

When my son was on the ward I worked with him whenever I thought he would benefit and his suffering alleviated. However, as a visitor my time was limited and when I left him, although standard contact was made by nurses, through 'one to one' observation, offering of 'nurses time' and attempts to try to engage with him, contact in the Pre Therapy sense was not available.

An important and necessary part of Pre Therapy work is to maintain and strengthen all the three contact functions so the patient gradually becomes firmly anchored in the Expressive Level of Behaviour. So even though I was successful in 'grounding' my son, I was not in a position to maintain and strengthen this grounding. Additional work was required for him to become healthy functioning in all three contact functions whilst he was an inpatient. This is perhaps the reason why Pre Therapy is so successful when worked as a ward milieu.

My son's recovery is hindered by his inefficient functioning of Cytochrome P-450 2D6, which was discovered by my son having a Genotyping test. The CYP 2D6 is an important cytochrome for metabolising and excreting neuroleptic drugs. Consequently his body has accumulated excessive amounts of neuroleptic drugs and has resulted in him experiencing severe adverse reactions together with repeated Supersensitivity Psychosis. So although I worked with him, Pre Therapy progress was limited by this neuroleptic-genetic combination.

My son's genetic inability to metabolise psychotropic drugs, inevitable sections with enforced neuroleptic treatment, cyclic readmissions, long stays on wards and units, and his

experiences of feeling misunderstood and unheard, have increased his despair, distrust and fear of being treated within the mental health system.

These are factors that I think have contributed to my son's lack of recovery.

Conclusion

Living and working with my son, Prouty's approach is common sense to me. Pilot studies are available showing Pre Therapy efficacy with measuring scales which depict clients' reality, affective and communication processes in comparison with control groups. Research is continuing at the Catholic University of Louvain. In addition to the official bibliography-based Pre Therapy web site, I have devised www.psychological-wellbeing.com with more information.

Currently, Person Centred care is referred to in many Department of Health national policies e.g. Ten Essential Shared Capabilities 2004, New Ways of Working 2005 and The Chief Nursing Officer's Review of Mental Health Nursing 2006. Pre Therapy is deeply Person Centred.

I truly believe that the key to psychological healing lies within the relationship between the clinician and client. I think my son would undoubtedly benefit from a therapeutic healing relationship with clinicians who embrace the values of the PCA and who are actively being Person Centred themselves: these optimal conditions promote psychotherapeutic growth. Clients' initial contact is with nurses and I think if nurses are able to work with Pre Therapy within the warmth of Person Centred values, clients' trust will be gained, simply because clients would perceive nurses' care and their ability to help in a humanistic way.

Pre Therapy is an approach that does not deny, collude or smother psychotic distress. It enables clinicians to know 'what to say' and 'how to be' with clients: it has the potential to bring more clinician safety and satisfaction and also to bring more humanity to the mental health environment. With overwhelming importance, Pre Therapy is an open door, an opportunity for clinicians to assist clients on their path to full recovery.

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Working with Families – Developing Caring Partnerships

19-20 MARCH 2007

Holiday Inn (formerly Stratford Moathouse) Stratford-upon-Avon, UK

The detailed programme for the conference is now available. We are happy to announce a wide range of workshops and presentations in addition to the keynote addresses advertised earlier. There will be 33 papers presented in the sessions listed below. In addition, there will be 21 workshops on a range of themes relating to family work.

Paper Sessions

- Family work in Assertive Outreach Teams
- Recovery and hope for families
- Family work in in-patient settings
- Qualitative research in family work
- Working with families with dementia and in older adult services
- Family work in Early Psychosis services
- Family issues in early psychosis
- Meeting the needs of whole families – interagency working
- Supporting parents with difficulties
- Different ways of developing services and providing support for carers

- Guilt, family work and psychosis
- Family awareness training for people working in in-patient services
- Involving carers in the training of professionals
- Empowering families to become allies and advocates
- Working with families where there is substance use and psychosis
- Keeping the family in mind – meeting the needs of whole families
- Family work in early psychosis – the needs of siblings
- Transcultural family work – working with families from different cultural backgrounds
- Holding on to hope and building on family resilience
- Working in Mental Health Trusts to promote mental health and social inclusion for parents with mental health difficulties and their children
- Developing mutually understandable explanations of mental illness for children and parents: The work of the Kidstime workshops
- Informing and supporting carers – An introduction to a new carer education training package that can be adapted for different groups
- Developing family inclusive mainstream mental health services
- White water rafting: Care Pathways for families experiencing first episode psychosis
- Confidentiality issues in working with families

Workshops

- National strategy for ensuring that families receive support
- Sharing clinical practice – a casebook of family interventions for psychosis
- Adapting Behavioural Family Therapy for use within older adult services – implementation and evaluation
- What contribution can Systemic Family Therapy make to work with families where there is an adult with a psychiatric diagnosis?
- Developments in family work: methods and modifications
- Working with young carers and their families

Details of papers and workshops will be on our website (www.meridenfamilyprogramme.com) from early December, including abstracts in order to facilitate delegates in their choice of which sessions to attend. Register now for this event, which promises to be stimulating and dynamic.

For further details please check our website on www.meridenfamilyprogramme.com.

To register for the conference please contact: Conference Line, 5 Leopold Road, Wimbledon, London, SW19 7BB
Tel: 0208 944 5050 Fax: 0208 944 0866 Email: meridenconference@conferenceline.co.uk

The Meriden Transcultural Family Work Forum

“Cultural Diversity in Family Work” Learning Event

On Thursday 21 September 2006, the Meriden Programme hosted its 3rd annual learning event focusing on the issues faced by Black and Minority Ethnic (BME) carers and family members. As with previous events, the day was well attended by over 70 clinicians, staff, family members and service users representing a wide variety of organisations from across the West Midlands and further afield. The day included a variety of speakers and an extensive selection of small workshops, which focused on showcasing best practice, the service user and family perspective and the relationship between faith, spirituality and mental health.

The morning was opened by Paula Conneely, Clinical Specialist with the Meriden Programme, who gave an overview of the work of the Programme and the Transcultural Family Work Forum (Meriden’s BME special interest group). Presentations then followed from Tunde Ife, Care Services Improvement Programme (CSIP) and Rameri Moukam, Chair of the Heart of Birmingham BME

A selection of workshops followed. Clive Brown and Bal Baines from “**AXIS**”, the award winning Birmingham Health & Social Care BME Mental Health Support Team, spoke about their services with particular reference to their use of person centred planning. Person centred planning was described as a way of gathering information, mapping out what is important to someone and making a plan from this. Family members are often involved in this process and Clive described how doing this work can be useful in engaging families in family work. He acknowledged that it was often a reality that it could be difficult to get some families together, particularly to sign up to ongoing family work, but that by getting family members to appreciate how important they are in each other’s lives, it would help them to recognise how they might benefit from further family intervention.

Cath Gilliver, Clinical Coordinator at Birmingham’s **ICAP** (Immigrant Counselling and Psychotherapy service) led a workshop focusing on BME issues and the experience of the Irish community. She gave an outline of ICAP’s history and services, being set up in 1996 to offer counselling, psychotherapy and mental health promotion work to the Irish community in particular. Cath set the scene by speaking about the issues faced by the Irish, acknowledging that in Birmingham over 112,000 people identified themselves as ‘Irish’ within the last census and yet cultural stereotypes and stigma still remain. She referred to anti-Irish feeling (especially during the 1970s) and the longer-term impact of migration with many first generation Irish men forming an ageing population with significant mental health and support needs. The workshop then split into three groups, allowing participants to explore the case studies provided by Cath.

Penny Greenaway, Women’s Mental Health Lead for **North Warwickshire PCT**, Carole Murray, Staff Nurse, and Madge Broomfield-Reid, Carer, gave an inspiring account of how services and families can work together in achieving goals. Their presentation “Challenging the Myths”, focused on how both in-patient and community services worked alongside the Broomfield-Reid family in their journey towards Recovery and Madge’s sons move to supported accommodation. Workshop participants gave some positive feedback, commenting that the session was “inspiring” and that it was “useful to obtain the service-user/carer view of how services can work together”.

Following the lunch break, which was welcomed as an excellent opportunity for networking, Norma Johnson and Cheryl Moulton were able to give a presentation on the “**Antenna**” service based in the **Barnet, Enfield and Haringey Mental Health NHS Trust**, London.



From left to right: Carole Murray, Penny Greenaway and Madge Broomfield-Reid (North Warwickshire PCT).

subgroup and creator of “Pattigift”, a family owned African centred acute psychiatric service based in Birmingham. Tunde gave a thought provoking and engaging presentation based on the principles of Breaking the Circles of Fear/Delivering Race Equality and referring to the African/African Caribbean world experience. This was reinforced by Rameri who spoke passionately about the issues facing BME communities with particular reference to African centred models of psychology.

Norma, Lead Nurse for Community Services, and Cheryl, Antenna’s Team Leader, jointly spoke about their innovative service which adopts an assertive outreach approach to working with black African Caribbean service-users and their families. Comments from those who attended the day reinforced the clear and informative nature of their presentation which gave a comprehensive overview of the team’s model of outreach working and the proactive ways in which they engage and work with service users their families, friends and community.

Novelette Aldred then gave a brief introduction to herself and the Birmingham based “**Tranquility**” service, which she described as being set up in 1997 to provide practical and therapeutic interventions of a culturally sensitive and spiritually inclusive nature; holistically addressing issues concerned with “mind, body and soul”. Novelette then introduced the concepts which would be covered in more detail within her afternoon workshop.

Following the two presentations, delegates were invited to participate in one of three further workshop sessions, facilitated by Novelette Aldred, Tunde Ife (**CSIP**) and Yasmin Malik and the Bains family (**Wolverhampton Primary Care Trust**).

Novelette’s workshop explored the deep connections between thoughts, imagination, feelings, body physiology, actions (behaviour) and spirit, and reflected upon how each of these is currently reflected (or not) within routine mental health services. The “separation” of mind and body within the medical model was referred to, and the fact that questions about spirituality/religious beliefs/faith are not typically asked about on mental health assessment forms. The use of language and meaning was further explored using ‘Things Mama Used To Say’* a set of cards with Jamaican proverbs written on them in Patois.

Tunde’s workshop, described by participants as “active”, “lively and interactive”, expanded further on his earlier presentation, reflecting on issues raised by the “Breaking Circles of Fear” report and exploring in more detail the issues of fear, stigma and prejudice experienced by BME users of mental health services.



Tunde Ife (CSIP).

Tunde’s dynamic style and passion came through strongly with one participant stating, “I felt I learnt not just in my head, but in my heart”.

A further workshop in the afternoon was facilitated by Yasmin Malik, a Community Psychiatric Nurse and trainer in family work from Wolverhampton.



From left to right: Cheryl Moulton and Norma Johnson (Antenna Service – Barnet, Enfield and Haringey Mental Health NHS Trust).

Yasmin introduced Vishal and Gulzar Bains, an Asian family from her locality who engaged and benefited from Behavioural Family Therapy (BFT). As father and son, Vishal and Gulzar were able to speak about their experience of services and the way in which family work positively impacted upon themselves and their extended family. Again, participants welcomed the opportunity to speak with a family directly, and spoke of how it provided an “encouraging account of family and statutory services using family work to a successful conclusion”.

Following the workshops, delegates met once more to offer feedback on the day as a whole. In general, the day was well received with those who attended giving encouraging and positive feedback. Comments included;

“Enjoyable and insightful talks and workshops”

“This day really moved me”

“Good day overall and raised important issues to think about”

Paula Conneely
Meriden Programme
 Email paula.conneely@bsmht.nhs.uk

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Parental Loss and Grief in the Presence of Recent Onset Psychosis in an Adult Child

Introduction

To begin this article on parental grief it is important firstly to briefly outline the mental health research and practice context.

Patterns of interactions between families and their seriously mentally ill relative historically have been portrayed as (indicating) exaggerated and maladaptive traits among family members...(and) have often been viewed as phenomena that preexisted and possibly caused the mental disturbance. Indeed, not only have such theories of causality lacked validation, they have also served to alienate family members and mental health professionals.

An alternative to causality theories is to view aberrant or extreme family traits as possible reactions to the presence of catastrophic illness in the family. One prominent reaction described by family members is grief for the loss of the relationship with their relative...reflected in statements like "We feel like we lost a child" and "It's as though he has a terminal illness, except he never dies". (Miller et al, 1990, p. 1321)

Fortunately, the literature is now beginning to focus more on the experiences and needs of parents, carers and families.

Family Loss and Grief Research in Schizophrenia

There have only been about a dozen studies (Medline, PsycINFO) that have explored the issue of loss and grief experienced by parents with a son or daughter with schizophrenia. These qualitative studies have found that families, and particularly parents/carers, often experience significant loss and grief in response to the development of serious mental illness in an adult son or daughter. Most of these studies have looked at loss and grief in the presence of long-term mental illness. There has been very little research into loss and grief experienced by the parents of young people going through their first episode of a psychotic illness.

There have been even fewer studies that have attempted to measure the level of loss and grief in families with a seriously mentally ill member. Following an exhaustive search of the literature of the past thirty years, I could find only 4 published quantitative research studies (Miller et al, 1990; Atkinson, 1994; Davis & Schultz, 1998 and Patterson

et al, 2000). Only one of these (Davis & Schultz, 1998) included an investigation of grief in relation to the gender of the parent.

Ambiguous Loss and Disenfranchised Grief

Rycroft and Perlesz (2001, p. 59f.) encouraged family therapists to be alert and responsive to the presence of losses other than death within families, and to understand the constraints on the resolution of grief experienced by family members in these instances of more ambiguous loss. Symbolic or psychosocial losses may be suppressed, avoided, or expressed through physical or psychological symptoms. They usually have an impact on family functioning and family relationships. It is useful to help families make sense of these types of losses in a way that is constructive and non-pathologising. Ambiguous losses are usually recognisable by the absence of public validation, documentation or ritualisation (Doka, 1988). Disenfranchised grief is a grief that cannot be openly acknowledged, socially validated, or publicly mourned (Doka, 1988). In the author's experience as a family therapist working in first episode psychosis programs, there have been countless occasions when parents have spoken of their difficulties in dealing with the ambiguous loss and disenfranchised grief experiences in relation to their son or daughters illness (Ovens, 2000, pp. 135-136ff.).

Grief and Gender

The only published research that was found which has compared the levels of grieving between mothers and fathers is the Davis and Schultz (1998) study previously mentioned. The researchers stated that in the literature dealing with child disability, the tendency was that "males were assumed to be less affected, because they expressed less emotional distress than females" (p. 371). The results of the study showed no significant differences in levels of grieving between mothers and fathers. They also found that the number of contact hours spent with the adult child did not significantly influence the level of parental grieving.

Who took part in the study

The participants in this study were parents who lived in the Sector catchment area and could read English fluently who had a son or daughter with a recent onset psychosis who had been a client of Early Psychosis Intervention Programme (EPIP) for between 6 and 30 months.

The "Mental Illness Version – Texas Inventory of Grief" [MIV-TIG] (Faschingbauer et al, 1977; Miller et al, 1990)

was chosen as it was the only currently available viable measure of parental grief in a mental illness context. This instrument has three parts, the first two of which were used in this study; part A – which measures initial grief, and part B – which measures current (ongoing) grief. (Miller et al, 1990; Atkinson, 1994; & Patterson et al, 2000).

Some of the findings

A total of 24 parents completed and returned the questionnaire instruments on attachment and grief. These constituted 10 married couples, 3 women whose partners did not respond and 1 other male respondent. Table 1 below shows the detail of the scores for the parent group for initial and current grief overall. The total current grief score has also been halved* in order to facilitate comparison of initial and current grief scores.

There was a significant increase (11%) over time in the parental grief mean scores from 26.6 to 29.5. One would normally find, for example in bereavement, a decrease in grief scores over time (Atkinson, 1994; Faschingbauer et al, 1977; Videka-Sherman, 1982). These results suggest that the parent group in this study were grieving more after 13-16 months had passed since the onset of psychosis as compared to their initial grief near onset.

Table 1

PARENTS	N	Minimum	Maximum	Mean	Std. Deviation
Total: Initial grief	24	9 (8)	40 (40)	26.6	7.9
Total: Current grief *	24	10 (8)	40 (40)	29.5	7.6
Total: Current grief	24	20 (16)	80 (80)	59.0	15.1

* Total current grief mean halved for comparison with initial grief mean

Higher levels of grief were experienced by parents who were younger and from a non-English speaking cultural background. Parents also tended to have higher levels of grief if their affected adult child had completed more schooling and at some stage had been hospitalised for treatment.

Understanding the Experience of Parental Loss and Grief

Parental grief in relation to an adult child with a serious mental illness has been conceptualised as resulting from various losses (Atkinson, 1994; Davis & Schultz, 1998; MacGregor, 1994; Miller, 1990 and 1996; Ryan, 1993; Rycroft and Perlesz, 2001; Tuck et al, 1997 & Stein & Wemmerus, 2001), including:

- The loss of how the child used to be, including the particular qualities of the relationship.
- The loss of the imagined, idealised child.
- The loss of the child's full potential, how they might have been, who they might have become and what they might have achieved.

- The loss of the family structure as it was.
- The loss of a normal life for the parents and their adult child.
- The loss of parental freedom.

These losses also come with the added complication of enduring reminders, due to the ongoing symptoms and disability of the illness. Importantly there is also the further complication of the challenge balancing the dynamic tension between the need to grieve and the need to maintain hope for the future.

The three highest scoring responses for the parent group in the 'current' section of the MIV-TIG were:

- That they missed the way their adult child used to be.
- That they couldn't avoid thinking about how their adult child could have been.
- That it was unfair that their adult child became mentally ill.

These first two significant issues in particular, marry well with the list of losses described above in conceptualising the phenomenon of loss.

Three of the four studies that have measured parental (and carer/relative) grief in the presence of serious mental illness used the MIV-TIG. This enables a comparison between the studies. Table 2 summarises the results of these studies and also includes the findings of this study.

There are a number of important observations that can be made from this table of grief research studies:

1. Parental levels of grief are generally **high** in the presence of serious mental illness in an adult child.
2. The average level of parental grief **increased** (and to a similar extent) over time in all studies regarding a loved one with serious mental illness (Miller, Atkinson & Ovens).
3. The average level of parental grief **decreased** over time in the serious head injury and death studies (Atkinson).
4. The current (**ongoing**) level of grief in the presence of serious mental illness was very similar to the initial level of grief in the case of **death**.

It was also noted that the average levels of grief in this study were a little higher than in the other three studies. I can only speculate as to why this was the case. Perhaps grief was higher for the parents because of the added complications of the demographics of the Liverpool-Fairfield Area with its recognised socioeconomic disadvantage and/or the high level of drug abuse in the area. Alternatively it might be due to a 'paradoxical' effect of having a dedicated family worker in the EPIP team. Parents of clients in EPIP usually received prompt education (including grief counselling)

fathers grieve as much as mothers. The practice implications are clear: fathers need to be included in family work in first episode psychosis and for that matter in any other serious mental illness treatment program.

Parent Education re Normal Grief Responses

Atkinson (1994, p. 1139) has suggested that; "Openly discussing the diagnosis and prognosis of schizophrenia with family members may decrease the (unresolved grief) morbidity of the disease with regard to the family." Davis

Table 2

Study	Diagnosis	Illness duration	Initial grief	Current grief (½)	Client mean age at onset	Parents mean age
Miller 1990	Schizophrenia & Bipolar	2-5 yrs	20 (7)	24 (1)	?	–
Atkinson 1994	Schizophrenia	1-5 yrs	24 (6)	27 (2)	22 (3)	–
“	Head Injury	“	32 (3)	21 (2)	22 (3)	–
“	Death	“	31 (2)	14 (2)	21 (1)	–
Patterson 2000	Schizophrenia & related dis.	~ 9 months	?	26 (?)	23 (7)	44 (12)
Ovens 2002	Schizophrenia, related dis., & Bipolar	6-24 months	27 (8)	30 (8)	20 (2)	49 (5)

from the author regarding their son or daughter's illness, which might have actually sped up and intensified the grieving process in the short to medium term, with better resolution in the medium to long term.

Bruce & Schultz (1992) argue that the presence of prolonged grief in parents of disabled children is a natural and understandable response, and is not due to a failure to accept the reality of the child's disability, but rather is the product of complicated loss, characterised by the absence of a clear lost 'object'.

Horowitz (1988, p.53) maintained that the mind is unconsciously motivated to process "important new information until there is a change in either the external stressful situation or the inner models of reality reach accord." If awareness of the loss overwhelms the individual, avoidance processes may be activated to regulate the flow of information and therefore dampen distressing emotions. Therefore the presence of impulsive and defensive mental processes are indicative of an individual actively dealing with loss. It may be that they overlooked the presence of overwhelming grief that may be precipitating the avoidance.

Parental Gender and Grief

As indicated earlier there is only one other study (Davis & Schultz, 1998) which has actually measured and compared the grief of mothers and fathers. The results of this study concur with those of Davis and Schultz in finding that

and Schultz (1998, p. 377) have also encouraged the "education of parents that grief is a normal and adaptive response which usually entails phases of intrusive and avoidant psychological processes and may be protracted".

In this study, in the early stages of their son or daughter's illness, parents most commonly reported that:

- It was difficult to maintain work responsibilities
- They were unusually irritable
- They couldn't keep up with their normal activities
- It was hard to sleep.

It would therefore be useful to alert parents that they can expect these difficulties to occur in the early stage of their son or daughters illness, and that these are normal and potentially time limited reactions to the traumatic events in their lives.

Macgregor (1994) has suggested that parents can themselves become familiar with the literature about grief and loss. It is helpful for them to pursue social support from friends, family, self-help groups and spiritual groups, and they might also want to seek out a counsellor who is trained in the area of grief. She goes on to say that mental health professionals must not continue to ignore the issue of grief, and that parents of mentally ill children need education about and validation of their grief. They also need connection with other parents who are in similar circumstances to them to reduce their sense of isolation and ignominy.

Grief Counselling for Parents of Adult Children with Psychosis

How can clinicians respond appropriately and therapeutically to parents of young adults developing serious mental illness? Rycroft & Perlesz (2001, pp. 61–64ff.) and Miller (1996, pp. 634–636ff.) have both adapted Worden's (1982) model of the important tasks of grief therapy. They have been combined and summarised below as a guide to working with parents experiencing grief in relation to their son or daughter with a serious mental illness.

Phase One: Reminiscence:

1. **Acknowledging the reality of the loss.** Bearing witness to and validating family members' experience of their loss. The therapist must listen intently for the specific meanings of the loss.
2. **Sharing the overt and latent Affect and Experiences of the losses.** The therapist needs to sit with these sometimes intense feelings and with the families' sense of helplessness, resisting the temptation to move the family too quickly towards accepting the present and to look to the future.

Phase Two: Readjustment to the loss:

3. **Reorganisation of the Family System around the losses.** Encourage parents to acknowledge and address all the unmet needs that arise from the loss. The therapist should gently remind parents that it is virtually impossible to reorganise around losses that remain unrecognised or unacknowledged (Boss, 1991).
4. **Reinvesting Emotional Energy in other Relationships and Life Pursuits.** Help the parents in trying to find a balance between grieving and living. In the case of ambiguous loss, this task is vexed. It is important to be as specific as possible in acknowledging what has been lost, whether it be closeness, intellectual stimulation, fun, and so on, and to seek these in other relationships. However the stigma of mental illness means that social support is likely to be decreased and the family more isolated.
5. **Accommodating to the loss through the relationship with the mentally ill person.** Rather than saying "goodbye", help the parent to say "hello" to the healthy aspect or partial self that does exist in the mentally ill person. Help them to make an alliance with their mentally ill relative's healthy aspect or partial self, capitalising on what is available to them in terms of their relationship with the affected adult child.

Particularly with ambiguous loss, it is important to remember that there can be a cyclical process of revisiting any or all of these tasks and feelings. This work needs to be done at a comfortable pace for the individual you are working with. This study has found that high initial grief predicts high ongoing grief, therefore it could be possible in the early stages of illnesses, to estimate which parents may have high levels of ongoing grief, and who may benefit significantly from grief counselling.

Conclusion

This study strongly supports the meagre literature demonstrating that in the presence of psychosis in an adult child, parental grief is measurable, is present at high levels, and usually ongoing.

Bloch et al (1995, p. 413) stated that confining counselling for caregivers to such traditional dimensions as education or attempts to reduce emotional expressiveness denies them the opportunity to deal with other equally relevant concerns. On the basis of this study it could be argued that other relevant concerns, such as loss and grief, are not just equal, but compelling, and deserve some priority in family intervention programs in mental health services.

Therefore it is argued that the recognition and assessment of grief and the provision of grief counselling should be available to families and particularly parents of young people with an emerging serious mental illness. Early validation and provision of grief counselling may be effective in reducing the development of long term unresolved grief as experienced by many parents. Mental Health Services also need to be attentive not to inadvertently exacerbate what is already a complicated and difficult grief process characterised by ambiguity and disenfranchisement, by either denying or pathologising parental grief responses.

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A City and Guilds Course for informal carers

City and Guilds in partnership with Carers UK, has developed a personal development and learning tool for informal adult carers called 'Learning for Living.' This consists of an online learning resource for carers and a nationally recognized qualification. It is the first qualification of its kind in Europe aimed at unpaid carers. The certificate in personal development and learning for unpaid carers aims to give carers the confidence and support to achieve their personal goals, and is designed specifically to help unpaid carers back into employment or on to further training. It has unique online content specifically designed to help support carers in their role. It aims to help a carer develop as a whole person, increasing current skills and knowledge, self-confidence and computer skills, whilst delivering recognition and reward for carers using a flexible approach.

First introduced in 2005, the certificate is designed to support personal development by developing carer knowledge and skills, plan for future education, training, employment and leisure and by boosting carer confidence and opening possibilities of returning to the workplace. It can be used by carers in accreditation of prior learning (APEL) towards continued professional development.

Included in the training is:

- Moving forward
- Taking care
- Living with others
- Managing as a carer

Training is flexible and designed to fit around other commitments. The four units each require around ten hours of learning. Carers can take an informal or an accredited route (City & Guilds, 2006). The award is completed over thirteen academic weeks through either a paper based portfolio or online learning and each module requires one assignment.

To find out more I visited the Hall Green College of Further Education in Birmingham, where staff were helpful, friendly and informative. Having worked in mental health services for over 17 years, and spending most of my life locally it was an enlightening experience for me. Here in 2005, a 'Learning for Living' course had been delivered to a group of carers via Headway – a charity that supports those affected by brain injury and this had been a pilot. Fifteen to twenty carers had done the training and it was due to be evaluated. Headway had successfully bid for European Union funding to help support the training. Facilitators have experience in the area they teach, and were part of the Health and Social Care Department. The

college was keen to build partnerships with local carers groups and share funding. Funding for places on the course is 'means tested' and some carers might have to meet some of the cost. To run a course also needs a minimum of 16 applicants to make it financially viable. There is a big drive from City and Guilds nationally to help deliver on the governments 'carers' agenda and this course should be available in a similar way at further education colleges across the country.

Local Further Education Colleges – a community resource

My field trip brought other dividends too. The college also runs a very well subscribed 'Dementia Awareness' Group that has had a huge take up. One hundred and twenty carers have done this course over the past nine months, and in 2006 it cost only £40 per person. From a wider mental health perspective a division of supported learning for students is also offered. It delivers training in partnership with Solihull Mind (a service user charity), for service users and is 'mental health' friendly. Useful courses include confidence building, basic literacy and numeracy, retail, IT, horticulture and creative writing. Classes tend to be small, under 10 people, which helps and sometimes courses are held on a Saturday morning, when less people are about, which again can be helpful for those who are anxious in social situations. Support workers and one to one supervision is available, and full time students have

Contact Numbers and Websites

To find out more about
Learning for Living nationally:
Email: **carers@cityandguilds.com**
Website: **www.learning-for-living.co.uk**
Telephone: **0207 294 8217**

To find out more about City and Guilds training
and to access local information and contacts visit
www.cityandguilds.co.uk
(look under 'health and social care' or 'care').

To find out more about or to apply for the
Learning for Living course, Dementia Awareness
training or supported learning at Hall Green
College, Birmingham, contact the college on:
Email: **admissions@sbc.ac.uk**
Telephone: **0121 694 5000**

To find out more about Dementia Awareness
training nationally visit **www.asset.ac.uk**

an individual learning plan. A member of staff here was open with me about her own mental health experience, which I found admirable and a very positive sign indeed. Eighty per cent of the College's contracts come from local organisations. The College had no prior link with Birmingham and Solihull Mental Health Trust.

My overall impression of the Learning for Living programme was that it was a real breakthrough for informal carers – an opportunity to have all the skills often required for informal caring for loved ones recognized formally and nationally. I found myself thinking that mental health carers' groups in particular would probably want to consider accessing the training both locally and nationally. I also reflected that maybe mental health services should look at building community links here too. I was struck by the keenness of the College to build links with the local community and their openness and flexibility. Although the College was bustling when I visited, the students and staff seemed generally friendly and helpful, and I got a parking space. The division of supported learning appeared very mental health friendly. Overall it was a very positive adventure and the only question I was left with was about 'how, if I were an isolated mental health carer, I might access the course myself in the immediate future?' I also rued if, when we work in mental health, we don't always see the valuable community resources, sometimes on our doorstep, that can play a valuable part in a holistic recovery from mental health problems? I pondered the recent emphasis in mental health on the 'social inclusion' of service users and does this need to be explicitly considered for their carers too? It does seem, though, that the government, mental health and education services are increasingly recognizing the expertise and effort of all of the UK's carers and 'Learning for Living' is clearly another valuable step forward in the journey towards 'caring for carers'.

Steven Cox

Family Work Service Coordinator, Cognitive Behavioural
Psychotherapist, Clinical Nurse Specialist –
Birmingham and Solihull Mental Health NHS Trust

Special thanks to Muirah Mees & Paul Gittens at Hall Green College, Cole Bank Road, Hall Green, Birmingham, B28 8ES for their help and time.

Family Work in Older Adults Services Training Course

The Meriden Programme will be running a five-day Behavioural Family Therapy training course focussing on working with families within Older Adult Services from 5–9 February 2007. The course will be held at the Uffculme Centre in Birmingham and will include:

- National Policy and Guidelines on carers from Older Adult Services
- Literature review on supporting families in older adult services
- The response of families to mental health
- Issues relating to grief, loss and other emotional reactions in families
- Confidentiality conflicts
- Role changes within families
- Communication skills
- Problem solving skills
- The sharing of information
- Adapting the model to consider the needs of each individual family

For further information please contact Martin Atchison on 0121 678 2727 or email martin.atchison@bsmht.nhs.uk

To book a place please contact Marie Murphy on 0121 678 2895 or email marie.murphy@bsmht.nhs.uk

Applications must be received by 10 January 2007.

Comments from readers

Many people write or email us expressing their thanks for the newsletter, and say how much they appreciate it. Some of the comments are included below:

“As always, the Meriden magazine is excellent – I have just received my latest copy and everything in there is something I want to read carefully and digest – you obviously have a good team producing it.”

“It is interesting and helpful to receive the Meriden newsletter regularly. I am so hungry to hear more regarding anything that can help us to understand and help, as carers.”

“It puts me in touch with people that I don't know, but who share similar experiences. I feel as if I know them, and always love when it arrives.”

Supporting Carers from Black and Minority Ethnic Groups

Around 18 months ago, Carers in Partnership established a sub group to develop a strategy to help carers from Black and Minority Ethnic Group communities become more involved in influencing service improvements, particularly within their own communities. The membership of the group has changed significantly during this period but the current group is really committed to try and bring about better services and meets regularly to develop strategies and actions.

I co-ordinate and lead this meeting at present on behalf of Carers in Partnership, and I am very grateful to these members for their interest and enthusiasm: Paula Conneely (Meriden Family Programme), Gurdip Sangha (Sandwell Carers Mental Health Team), Bal Bains (AXIS – Birmingham Social Services), Dave Smith (Stoke-on-Trent Social Services), Amy Cui (Chinese Community Centre – Birmingham), Ranjit Senghera (CSIP), Michelle Bhalroo (Irish Community Centre – Birmingham) and especially our well known carer from Birmingham, Loris Tapper.

Making real progress in this area is not easy but we have been really excited that we have been able to facilitate a project which will train up around 20 people who, by working in teams within their own locality, will be able to deliver a carers' education course which specifically addresses carers from BME communities. The training course which will trigger this is to be run in January by the Meriden team and myself, so hopefully we will be able

to report on progress in the next newsletter. The outcome that really delights us all is that hopefully this is an initiative which will benefit BME carers specifically in several parts of the region, and maybe we will have the opportunity to extend this benefit even further by running another training course later next year.

Other initiatives that we have undertaken include a scoping exercise of the specialist services available to BME carers in the region. The results of this will be available shortly. We also ran two very lively and well supported events for BME carers earlier in the year (one in Birmingham and the other in Wolverhampton) which were aimed at giving carers a little more knowledge, and encouraging greater carer involvement.

In order to make real inroads into the development of carer involvement, there is still much work to be done in providing more educational opportunities and we really hope that what we have put in place already is a good and sound start.

Our next task is to review our strategy in the light of our achievements to date and we would welcome any suggestions, constructive comments and/or volunteers, particularly carers.

Peter Woodhams
Carers in Partnership
woodhamspema@btinternet.com

Love that CPA (please!!) An Ode to the Care Programme Approach

For thirteen years the CPA
Has been in frail existence.
But the role it plays, in so many ways
Needs help, needs our persistence.

It's a very good plan, since it all began
But to my great despair
Its not been clear to the folks who care
How it works, or how it can.

My friend Dave's been known to rave
That a plan can only be
As good as those who run it
But that's not enough for me.

I have grave concerns, you see,
That stretching to infinity
Are reasons why professionals
Can't give consistent care.

Infirmity, maternity,
Shock dispatch to eternity,
Promotion, relocation –
Mean the same folk can't be there.

Which makes it so important
That the dreaded written record,
That history of what has been –
Gives a constant, solid ground.

The paperwork, it seems to me,
Is a passport to normality,
When I'm not there, I'll know his care
Will continue, safe and sound.

As my son makes his journey
You and I will come and go
But if that passport's up to date
He'll find his way, I know.

Celia Soden

A School Based Emotional Health Service: An Overview

The World Health Organisation (2003) cite twenty to thirty percent of school children require psycho-social interventions. The experience of a School Based Emotional Health Service, serving a high school and year six of feeder primary schools in the Stafford area, is that students present with a social-emotional construct: a conglomerative picture of social, familial and interpersonal difficulties that, (whilst many cases would not cross diagnostic thresholds or meet specialist CAMHS referral criteria), are no less complex or debilitating than those of many specialist Child & Adolescent Mental Health Service (CAMHS) cases.

Students and families do not want to be pathologised, (Philip, 2003), they want real, tangible support for themselves and their families that is not overwhelming or complex. How to achieve this through soaking into their local communities is the issue to consider.

The School Based Emotional Health Service is run as a separate subsidiary of the Stafford locality CAMHS Team, and has one Nurse Specialist based within a High School for four days each week (on a three year secondment basis at present), serving students of that school and from year six of the feeder primary schools. We are one year into a three year collaborative project between the NHS Healthcare Trust and high school, with service user, referrer, parent/carer, and school-based staff feedback comments (collected through questionnaire) currently being analysed to enable any needed re-shaping according to feedback.

The interface between differing services (Primary Care Trust, Healthcare Trust, Education Authority, Youth Offending Services, Health & Social Services) can be problematic to negotiate (Boateng, 2003) given the differing political contexts, agendas and structures of those organisations. That is potentially compounded through individual parties within those organisations feeling vulnerable to or encroached upon by the service, and it is not always easy to gain ownership or even cooperation from all stakeholders.

Service objectives are provision of early assistance to distressed students, promoting emotional and mental well-being, supporting students, staff, parents and families of students (where appropriate, and in a school context), and contributing to teaching within the curriculum on emotional and mental health issues. Services offered vary from consultation, advice and support, counselling, information and resources, to more structured interventions and some group work for students and for parents. That

is delivered in tandem with the range of agencies that work within the school and across the local community. The focus is on practical solutions for managing distress, both short term and long term – many consultations are intermittent ‘one-off’ episodes as students use the service as they choose.

The service philosophy determines the term ‘mental health’ as meaning a positive state of emotional, social and cognitive well being in individuals, groups and communities (World Health Organisation, 1986), as well as considering other mental health issues where necessary. The service aims to fully involve all participants and stakeholders in the process, to encourage genuine dialogue between parties and empowerment and autonomy for young people – who are also involved in the 360 degree appraisal of the Nurse Specialist. Promoting resilience in young people and teaching and equipping them with a range of coping strategies to try to prevent stress and emotional difficulties is a primary function of the service.

The range of issues addressed covers a spectrum from bullying to self-harm, low self-esteem to abuse, dependency (illicit substance) issues, through to formal mental health issues such as mood disorder, obsessive-compulsive presentations, Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder.

Access to the service can be through self-referral by email, text, phone, note or self-referral form (left in a secure postbox), or by arrival in person (appointments permitting). Referrals are accepted from parents, school staff, and other professionals or voluntary sector staff. For appointments students make their own way or are collected from lessons by office staff on the basis they are required at the general school office. The Nurse does not collect students from classes.

The school are aware a student is being seen but session details are confidential (excepting there being any child protection concerns). Every student seen is supported and encouraged to involve parents and other relevant parties in supporting their progress and management of stress or distress. That process is guided by students themselves, given that they demonstrate ‘Fraser competence’. ‘Fraser competence’ relates to having sufficient maturity and wisdom to understand the likely implications and consequences of making a decision. Therefore if a student demonstrates that they understand how they could use the service, and the implications of parental or other party non-involvement they could be assessed as competent to choose complete confidentiality. The exceptions would be the presence of child protection or serious child welfare

concerns, or issues of public interest which force disclosure to the appropriate parties. This would be assessed in much the same way as capacity to consent. Generally the experience is that students will, once rapport and trust have developed, allow close involvement of relevant parties, but there are also occasions on which for reasons of child protection the initial involvement of the carers or family would be inappropriate.

The service users can be defined as teaching and school-based staff, and all elements of services within the local community. That breadth means consultation with a wide range of personnel is central to the evolution of the service in a meaningful way that actually benefits the local community. Training is provided for teaching staff. The school day has been re-structured to facilitate periods dedicated to pro-active health promotion and health-related/emotional well-being discussion with student year groups.

The catchment area is a locality recognised as suffering health inequalities with three of the catchment area wards being within the top ten percent across England and Wales on indices for deprivation (ID, 2000). Services are lacking within these areas (there are for example no GP services locally accessible in these wards), but due to geographical separation of these wards by a measurably more salubrious ward there is no qualification against criteria for financial assistance to these wards to combat deprivation.

Ongoing and dramatic increases in the psychosocial problems of children and adolescents in Western societies and failure to address this, has a negative effect on the development of young people, their academic achievements, employment opportunities and, ultimately, the mental health of society as a whole. "Children are our future. Through well conceived policy and planning, Governments can promote the mental health of children, for the benefit of the child, the family, the community and society." (World Health Organisation, 2005).

The school age group is known to be at particularly high risk for issues such as deliberate self-harm and suicide/para-suicide. The Mental Health Promotion Guide 'Making it Happen' (DOH, 2001) laid out the responsibilities of Social Services, Primary Care and Mental Health Services for clarifying coherent action in respect of mental health promotion within all groups of society.

The Truth Hurts report (Mental Health Foundation, 2006) supports School Based Emotional Health Services as a way forward in the management of these issues. As the high school attained specialist sports college status, the opportunity was taken to link with the broader objectives of influencing the health of the community. That has been through liaising with various agencies on a broad range of issues such as lack of available fresh vegetable supplies across the wards, play areas and activities for all groups,

supporting local community initiatives through the Police and Church, raising accommodation and workforce issues, and creating greater awareness locally of the available support networks.

The service currently has over eighty users, with a referrals processing time of less than seven days (processing time inclusive of non-working days). The average age of referred students (inclusive of self-referrals) is thirteen years seven months. In all one hundred and twenty students have been seen, with thirty nine having being discharged from the service (many of whom may return to access at some point). Fifty nine students were male and sixty one female. Of all students seen 15.7% had a prior diagnosis, with attachment disorder accounting for 20% of diagnoses, Autistic Spectrum Disorder and Hyperkinetic Conduct Disorder accounting for 26.6% each, Epilepsy constituting 13.6%, and Mood Disorder and Dyspraxia also each impacting upon 6.6%.

It does provide an interesting and thorough picture of the community and of how it fits together, that health services and professionals generally might rarely see. The responsibility of using that knowledge therapeutically, constructively and proactively to benefit a community, in tandem with other issues outlined necessitates robust managerial and clinical supervision. In the experience of this service a CAMHS background (discipline immaterial) and understanding is necessary for school based practitioners, making membership of a Locality CAMHS Team imperative.

The debate over who should fund the issue is not likely to be resolved here, but responsibility should be shared between Health, Education, Local Authority and Youth Offending Services. The NHS is an obvious employer in the context of ethics, healthcare protocols, support and professional development.

The early evidence is that the service impacts on the quality of life of those students it sees, and that attendance and engagement improve. Whether that is sustained or sustainable will be visible only over the longer term.

The stated experience of Education services can be that the NHS is ponderous in comparison with the autonomy of a school to act quickly to address given situations or respond to local need. The service has a steering group overarching Health and Education, with school input vital.

It is difficult to prove the efficacy of such a service in quantitative terms, and the standard query "How do we demonstrate and quantify the number of CAMHS referrals diverted because of the school based service?" is actually an indicator of the difficulty in quantifying where the school based service actually sits in terms of conventional tiers, remits and existing health models. The reality is that the service is uncovering unmet need, encountered as students with a social-emotional construct (rather than formal

mental health disorder), which traditionally fits between gaps in services. Who will own the future of such services is not currently predictable, and how their value is construed and measured not yet defined.

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A Robust Strategy for Implementing Family Work

We are aware from our experiences over the years that it is easy to train staff in family approaches but far more difficult to ensure that clinicians implement the skills they have learned. One of the Trusts in the West Midlands, North Staffordshire, has taken a firm approach to the implementation of family work, and set clear expectations for both therapists and managers. The impact of this has been that many more therapists than in other Trusts have completed the family work required in order for them to receive accreditation. While no single approach to implementation is likely to be effective, there are lessons here for other Trusts struggling with implementation issues.

Meriden-trained family work trainers in North Staffordshire have been offering at least one training course in Behavioural Family Therapy (BFT) per year for healthcare staff since 1998. Like many of our colleagues in other Trusts we soon found that the enthusiasm of a significant number of trainees evaporated shortly after completion of the 5 day training component of the course, so that a very poor rate of completion of all commitments (working with families, submission of therapy tapes, case studies and attendance at supervision) was being achieved.

Efforts to ascertain why this was the case were often met with the claim that line managers were not allowing staff sufficient time to complete the work. Trainers felt that such a problem could potentially deal a fatal blow to efforts to establish family work in the Trust.

In order to increase the proportion of staff completing their training and to identify more accurately the reasons for any failures to do so, the trainers decided to take a more robust approach to granting places on the training

courses. To secure a place on BFT training now, both the candidate and their line manager are required to meet with trainers so that a clear understanding of the nature of the commitments involved is established for all concerned. Should they wish to proceed after this, both candidate and manager are required to sign a contract to say that the manager will allow time for completion of all aspects of the course, and that the candidate will complete the work. The candidate thus secures training in BFT interventions and the manager takes a step towards offering a service to families experiencing long term stress. Places are not offered if either party cannot agree to the contract.

Subsequently, in cases where trainees show signs of defaulting (e.g. failing to attend supervision; missing deadlines for the submission of therapy tapes and case studies) reminder letters are sent from the training department to both trainee and manager. Should a trainee withdraw or default (and every effort is made by trainers to support staff in order to avoid this) letters are sent making it clear that the individual is not authorised to practice Behavioural Family Therapy. In addition an annual refresher day is mandatory for all practitioners in order to remain registered by the Trust.

Prior to the introduction of the contract, only a small proportion of our trainees completed the full course and consequently, few families received a service. Now the majority of trainees complete their commitments. We currently have 37 accredited family workers and though as a Trust we are far from achieving the goal of cementing family work for psychosis as a routine clinical intervention, we have made modest progress in the right direction.

Nick Dutton
North Staffordshire Combined Healthcare NHS Trust

Synopsis of Books

Heide Lloyd describes a number of books she has written and how they can be of benefit. Heide has used her direct experience of mental health difficulties, and the needs of her own children to inspire her work.

Titles of Books

- Children and Bullying
- Children Can Understand
- Unicorns and Magic Rainbows

These books can be helpful in:

- Finding ways of supporting, educating and developing coping strategies for children in families where a parent/main carer or other special person has mental health problems.
- Promoting adult awareness of the needs of children who live in families where someone suffers from mental ill health.

Children and Bullying is written and illustrated by hand deliberately to enhance a child friendly interaction with the material. Each page holds a complete message of its own. The booklet is short to avoid boredom/over-loading of information. It aims to be cross cultural, age appropriate and supportive in the event of experiencing bullying. It also aims to reassure children that it is 'OK' to ask for help. Another important message enhanced in the booklet is that of giving some insight into the very damaging and isolating experience of being bullied, in the hope that children can begin to understand the consequences of their own actions should they partake in the bullying of another child/children. Care has been taken to relay this message without appearing to be judgemental, hence the use of the characters 'Ashley Brown Mouse' and 'Harriet Hamster' throughout the booklet. The booklet is designed to be accessible to children whether it is through schools, public libraries, voluntary organisations or statutory bodies working with children and families.

Children Can Understand is written for professionals to use with children who have specifically experienced difficulties in a familial or other setting due to the presence of a parent or other significant person with mental health problems. The introductory notes to use with 'Children Can Understand' clearly outline the objectives of the booklet. Again, as with 'Children and Bullying', each page supports an individual message. The 'Ashley Brown Mouse' character is also used in 'Children Can Understand' to provide a storyline, which can be developed as appropriate to the needs of each individual child.

Unicorns and Magic Rainbows is a message for children, again with relevance to children who are living with someone who has a mental illness. The fairy story presentation is designed to make the book look appealing and to be of interest to any child – regardless of whether they find themselves living with a parent/main carer who has a mental illness or not. This book is deliberately designed to be accessible to children whether it is through a public

library, school library or via a professional working with children and families where mental ill health is experienced (and other child oriented outlets). I firmly believe that its fairy story presentation enhances its attractiveness to young children (between the ages of 2 – 11 years approximately). The introduction is written specifically for the young reader and can be used either in a supportive role when reading the book (or when the book is being read to a child), or as an introduction to the younger community about the effects upon children when a parent or special person in a child's life suffers with mental ill health.

Format of Books

Each book can stand alone in its own right, but could also be linked in with other materials covering the same issues.

The books 'Children and Bullying' and 'Unicorns and Magic Rainbows' are formatted so that they can be read by children alone or be looked at with an adult to provide interesting and stimulating conversation; which can help to provide further insight where/when this is necessary for the child (or group of children – for example in a classroom discussion).

Rationale

The rationale for the material is that approximately 1 in 4 adults each year suffers from mental ill health. About half of those adults will have dependent children. Extensive research, as illustrated in the publication 'Crossing Bridges' edited by Dr Adrian Falkov, highlights the long and short-term effects upon children's mental health if their immediate fears, neglect, involvement in delusional episodes, etc, are not addressed. Therefore, it seems essential that material be available in order to support and educate children in an age-appropriate manner. Currently the educational tools in respect of mental illness and the stigma associated with mental illness are adult targeted and only very rarely child directed.

This means that unless literature becomes available directly for children the 'pick-up' rate of hidden and suffering children will remain largely undisclosed at a time when they most need help.

Target Groups

Target groups include schools, public libraries, university libraries, school libraries, doctors' surgeries, professionals working within the mental health arena – for example, psychologists, social services, psychiatrists, child and family centres, etc.

Department of Health initiatives are already attempting to stimulate awareness in adult mental health services with regard to the existence of children in families where a parent/main carer presents to services with a mental illness. Child mental health services support this directive and are also striving to promote awareness in inter and intra agency communication.

Children Can Understand is also available through the Meriden Programme. For further information contact Heide Lloyd at heide@lloyd8888.fsworld.co.uk

Heide Lloyd

I'm Not Alone: a Teen's Guide to Living with a Parent who has a Mental Illness

(2006) Michelle D. Sherman and DeAnne M. Sherman

This imaginative and creative book is designed for use by children aged 11-18 years, where a parent experiences mental health problems and/or associated substance misuse. Written by mother and daughter team Michelle and DeAnne Sherman, the book is helpfully divided in to 3 main sections adopting a "workbook" type format in which the young reader is encouraged to write and reflect on specific issues and topics raised by the text. The book itself is written in very informal, user-friendly language and guides the reader through each relevant section. Rather than a text designed to be read from start to finish, the reader is encouraged to work through each section at their own pace, as and when appropriate. In addition, the book gives clear information at a basic and readily understandable level. Key issues addressed are "What is this all about and why is it happening to me?", "How can I cope with my strong feelings?" and "What should I tell my friends?".

Part one of the book refers to "The Basics", giving general information on different types of mental health problems and exploring the impact they can have on the individual concerned and their wider family. Strong emphasis is placed on normalising many of the feelings and emotions experienced by the young person, and links are made with the experience of physical health problems within a family. A number of key messages are reinforced throughout the text, such as the young person not being "to blame". Again, the issues raised are reinforced by written exercises and space for reflection.

Part two continues the theme of emotions, but expands on this in terms of developing coping mechanisms, looking after self, support mechanisms and sharing information with others including the sensitive topic of friends. It introduces the 7 "C"s (p.55, National Association for Children of Alcoholics) as a way of reinforcing its key message:

"You didn't Cause it. You can't Cure it. You can't Control it. You can help take Care of yourself, by Communicating your feelings, making healthy Choices and Celebrating being yourself"

(from the Kit for Early Childhood Professionals, NACA)

Part three draws the workbook to a close and summarises the key lessons learnt. It also contains a list of frequently asked questions and their answers, a useful glossary of terms and contact details of a variety of support networks and organisations.

In summary, this is an excellent workbook, which can be used to help guide teens through a difficult journey, hopefully answering many of their questions, making sense of their feelings and imparting both a sense of understanding and, above all, hope. Perhaps the only consideration for professionals and families wishing to recommend this workbook to teens from outside of the USA, is the way in which case studies and examples are given within an American context (i.e. references to the American school system) and that the contact numbers and support organisations cited are all based within the USA.

Reviewed by Paula Conneely,
Clinical Specialist – Meriden Programme

www.seedsofhopebooks.com
www.BeaversPondPress.com

ISBN 1-59298-118-6

Meriden – Training Trainers Course 2007

We are pleased to announce our next Training Trainers course which will take place from Monday 2nd to Friday 6th April, 2007.

We normally hold this later in the year, but this time are linking it to our family conference which is being held at the end of March. As a number of people whom we have trained in Behavioural Family Therapy in Australia would like to become trainers in the approach, we are holding the training course near to the conference venue so that they can attend both events.

The course is open to all those who have completed the basic training in Behavioural Family Therapy, and who have practiced their family work skills following training. Over the five days, participants will develop the skills necessary to deliver training in family work effectively through practicing presentation and facilitation skills. The course also covers the skills needed for supervising family work.

For further details, please contact Sam Farooq on 0121 678 2896 or email sam.farooq@bsmht.nhs.uk

Birmingham Central / South Crossroads Young Carers CD: 'Journey'

The Young Carers Project has been running since 2003 and was developed following a growing awareness that there were many young carers who needed support, but who were unable to access a service which was suited to their needs. The service has 103 young carers on their register and offers a wide variety of practical and emotional support to young carers.

The idea of the CD was to highlight the issues raised for young carers while at the same time getting the young carers to enjoy themselves. The majority of the 25 tracks on the CD were written by Ivora Ferreira-Bean along with the Young Carers Workshop, and illustrate the hopes and fears and the reality of the lives of those children that the project supports. They are mainly of the young carers reading out poems with music playing in the background but there are songs also. The tracks describe such issues as the loneliness and despair that young carers face on a daily basis and their need for help and support. The track called 'Sick' begins:

'If there's anyone out there that can help.
Can you help me work this out?
'What is my life all about? I'm sick of the sick,
I'm sick of the pain
I'm sick of the feelings, I'm sick of the game.'

There are also positive messages on the CD, about how and where young carers get their support from, of the occasions when the person they are caring for is well, of the positives that exist from being in a caring role. There is a sense of pride in the way in which the young carers deal with their situations, that though it is very hard and often a very uncertain place to be, they deal with their situations in such a way that gives them strength. The track 'Being a Young Carer' ends with the lines:

'Being a young carer is tough each day,
when sometimes you want to get away
Being a carer brings tears and laughter,
with joys of happy ever after
I'm proud to be a young carer'

The lyrics for all the tracks are printed on the sleeve so it is a useful way of enabling people to appreciate how life as young carer really is and would be a good way of raising awareness amongst teams around the issue of young carers.

The CD was launched at the Crossroads Opening Doors (for Carers) event on the 31 October at the Birmingham Council House where the group performed two of the tracks live. Copies are available from the Crossroads Young Carers Project, Dell Meadow Centre, Bells Lane, Druids Heath, Birmingham, B14 5RY telephone 0121 474 5555 or email: bcsxrdsyoungcarers@yahoo.co.uk – there will be a charge of £1.50 for postage and packaging. Copies will also be available at the Meriden Family Work Conference in March 2007.

Family and Multi-Family Work with Psychosis – A Guide for Professionals

**GERDNA-RAGNA BLOCH THORSEN,
TROND GRØNNESTAD and
ANNE LISE ØXNEVAD**

Foreword by Julian Leff. This accessible, jargon-free guide will be of great interest to anyone interested in investigating the potential for using family work to treat those with psychosis.

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