



It is always quite a challenge to get sufficient copy for our September newsletter, as it is hard to track people down during the holiday period. Still, Sam and I chased people without mercy and have managed to pull together a varied group of articles describing the many ways in which people in their own unique ways are working away to improve services to families. Of course, for our colleagues in Australia, it is the middle of winter, so they have lots of time on winter evenings to write articles for our newsletter!

Through the Meriden Programme, we have provided training in a number of sites in Australia over the past couple of years, and it is nice to see this bearing fruit. Brendan O’Hanlon and Carol Harvey describe the interesting developments that are taking place in Melbourne in relation to family work.

Ann Davison provides an interesting article on providing Carers’ Assessments. Although legislation in the UK stipulates that carers must be assessed and have their own care plan, we are all aware of how difficult it has proved to ensure that all carers receive such an assessment. Ann has some innovative suggestions for ensuring that the percentage of carers who receive assessments continues to increase. Another area where implementation of family work has been difficult has been on home treatment teams. It is often difficult for staff on these teams to understand their role in relation to families because of the short period of time that they are usually in contact with individuals. Once again, Imogen Reid describes an innovative approach to training adopted by her and her colleagues, and it is heartening to read the testimonial by a member of the home treatment team following training. This is from someone who would previously have been unsure about becoming involved with the family. Both of these articles remind me that implementation difficulties are often overcome by the imaginative use of novel strategies by committed individuals. We should learn from their inspiration.

Other examples of innovative adaptations are provided by Steven Cox and Jazz Kainth. A couple of years ago, we developed a carers education and support training package as part of some work we were doing between Northern Ireland and the Republic of Ireland. Since then, we have adapted this programme for use with two other specific groups of families – those whose families have alcohol and substance misuse problems and those from Black and Minority Ethnic (BME) families. Steven Cox describes the training that was commissioned by the Warwickshire Drug and Alcohol Action Team (DAAT) for use with those with alcohol and drug problems and their families. It is hoped that support groups will be rolled out by those trained over the coming year. Jazz Kainth describes one of the roll-out groups that has already taken place for Black and Asian families in Birmingham. Those who were trained from the Chinese Community have already delivered one eleven-week support programme. We hope to develop this area further and to develop more training materials including a DVD with BME families through a grant provided by CSIP.

We have our usual announcements of forthcoming events – of which it feels there are many, an interesting book review by Tony Gillam, and of course an account of my meeting with Tony Blair. I always feel uncomfortable at events like that and award ceremonies as I feel I am just a representative of a very large team – the now very large Meriden extended family. What we do works because thousands of people do what they do – it would be nice if more than one person could attend such events. I would very much like it if everyone who is working so hard to achieve what we are trying to achieve for families can feel acknowledged in a small way by my attendance at the event. He did look a bit surprised when I wished him well in his retirement – maybe it wasn’t the thing to say!

Until the next time – keep up the good work!

Dr Gráinne Fadden

Building Family Skills Together

By Brendan O'Hanlon, Melbourne, Australia

Building Family Skills Together is a two-year implementation and research project that aims to establish and sustain family interventions as part of routine care within an Adult Mental Health Service in Melbourne, Australia. The project title reflects a belief that family work should bring together the experience of service users, their families and mental health workers to build knowledge and skills that promote recovery for the whole family. Behavioural Family Therapy (BFT) was identified as the model of family intervention for the project because of the evidence supporting its effectiveness and because it can be implemented within mental health services.

Building Family Skills Together is a collaborative venture between a research program, The Psychosocial Research Centre (PRC), a clinical mental health service, the North West Area Mental Health Service (NWAMHS) and The Bouverie Centre, a specialist family service. Chris Mansell & Gráinne Fadden from the Meriden Programme have also contributed significantly to the project by providing training and invaluable knowledge and support about direct practice and implementation issues.

The project focuses on the incorporation of BFT within the case management of people experiencing serious mental health difficulties who are under the care of the Moreland and Broadmeadows Continuing Care Teams of NWAMHS. The teams are located in the socially and economically disadvantaged northern suburbs of Melbourne. The active implementation phase of Building Family Skills Together started in April of 2006 when Gráinne and Chris conducted a five-day training program in BFT that included 12 staff from the NWAMHS. A unique feature of Building Family Skills Together is the 'embedding' of Family Practice Consultants from The Bouverie Centre in each of the teams. The Family Practice Consultants work alongside staff in seeing families, conduct Mentoring Groups in BFT and initiate Implementation Working Groups to enable the organizational changes necessary to support and sustain work with families. Another novel aspect of the project is the training of two Carer Consultants from NWAMHS in BFT. Carer Consultants are Carers who are employed by mental health services to directly respond to families and to promote services that better meet the needs of carers. In Building Family Skills Together they have a particular role in helping to engage families in BFT.

Building Family Skills Together includes a significant research component that compares the outcomes for

service users and families receiving BFT with families recruited from two neighbouring services where BFT is not available. The evaluation will also examine the impact of the project for staff and the operation of the services. A smaller qualitative project is examining the process of implementation with a particular emphasis on better understanding the experience of staff as they try to incorporate BFT within their practice.

There have been significant challenges in establishing BFT as part of case management and progress has been slow in terms of the numbers of families actively engaged in family work. At this point, a large number of staff within the teams have completed training. However just over half of these have seen a family. Consistent with experience in other settings, there have been difficulties in relation to staff identifying 'suitable' families, incorporating BFT within their other case management duties, and time and confidence in working with families. Despite these obstacles, the experience of family work has been overwhelmingly positive with compelling accounts from families and staff describing not only significant changes but also very incredibly moving moments as the staff, service users and family members share their knowledge and experiences. Important changes are also occurring within the teams and wider service that will support family work into the future. For example, the introduction of more flexible working hours and time in lieu arrangements, the routine reporting of family contact data to staff, and changes to position descriptions and record keeping practices.

The difficulties and obstacles experienced have prompted considerable learning and curiosity about working with families and changing practice in mental health services. For example, one idea currently being explored is that low levels of routine contact between services and families reduces the likelihood that families will be offered or accept BFT. This exploration led to a successful submission for a Research Fellowship to map the nature of contact between families and the service and to understand the reasons for differing levels of contact. Ultimately, this might suggest how Family Sensitive Practice, a concept promoted by The Bouverie Centre that aims to create a culture of family inclusion in mental health services, can support the provision of intensive family interventions such as BFT.

*Brendan O'Hanlon
Implementation Coordinator
Building Family Skills Together
The Bouverie Centre, La Trobe University
Melbourne, Australia
B.O'Hanlon@latrobe.edu.au*

Meeting the (Former) Prime Minister

We are not used to receiving letters from Downing Street and were therefore surprised when a letter arrived with 10 Downing Street stamped on the back. Inside was an invitation from the Prime Minister and Mrs Blair requesting the 'honour' of my company at a reception that they were hosting in London in recognition of those 'delivering excellence in Public Services'. The purpose of the event was to thank frontline workers for their role in relation to this. The invitation was accompanied with instructions about security and protocol at the event.

The venue was Lancaster House where many state visits are hosted. The sunny June evening afforded the opportunity to take drinks and canapés in the gardens prior to the arrival of the Prime Minister. He arrived slightly late as his regular meeting with the Queen had overrun. Mr Blair mingled freely with those in attendance, chatting and joking, and posing for photographs.

Addressing those who attended, he said:

'Everyone who is here has done something extraordinary. You make a difference to people's lives. You make their lives better, and as Prime Minister, I want to thank you for that'.

He commented that everyone there represented teams of people, and asked that his thanks be passed on to



Gráinne Fadden with Tony Blair and other guests

everyone. So thanks to the Meriden extended team far and wide for the wonderful contribution you make to supporting families.

The Prime Minister continued to chat to those who attended. The group included representatives from the police force, fire services, prison services, education and health services. After he left, the beautiful state banquet rooms at Lancaster House were open for all to view and wander around.

When leaving the event, everyone was given a souvenir booklet on 10 Downing Street with an inscription from Tony Blair 'With thanks for all your hard work and dedication'. Mr Blair resigned a couple of weeks after the event.

*Gráinne Fadden
The Meriden Programme*

5-Day Behavioural Family Therapy (BFT) Course focussing on EARLY PSYCHOSIS

**Uffculme Centre, Birmingham
18-22 February 2008**

Following a series of highly successful courses over the past two years and increasing demand from around the country, we have decided to run another 5-day BFT course looking specifically at issues in Early Intervention Services in February 2008.

The cost of attending this 5-day course is £750 per participant. This includes refreshments and lunch, the course manual and all other course materials.

**For further information and sample programme,
please contact Sam Farooq on:
Telephone: 0121 678 2712
Email sam.farooq@bsmht.nhs.uk**

**This five day skills-based training course
on working with families in early psychosis will
cover the following topics:**

**National Policy and Guidelines on family
work in early psychosis**

Literature update on family work in early psychosis

**The response of families
Issues relating to grief, loss and other
emotional reactions in families**

Diagnostic uncertainty

Confidentiality conflicts

The needs of siblings and young people

Communication skills

Problem solving skills

**Integrating different models of family work
in early psychosis services**

Implementing family work in early psychosis services

Carers' Assessments and Services Project (CASP) in Cambridgeshire

By Ann Davison, Carers Strategic Development Manager
Cambridgeshire Carers' Assessment and Service Project

“What is the point of doing a Carers' Assessment?” Even now, in 2007 colleagues from all services ask this question, and I have to take a deep breath before pointing out to them that Carers' needs are as diverse as the needs of those they support. Statutory services wouldn't dream of providing any significant support to service users without an assessment, so why do we assume we know what's right for Carers without asking them, and why not use a Carers' Assessment as a template to ensure we cover all bases in this dialogue?

In a 2007 survey “Carers' priorities for a new National Strategy for Carers”¹, top of Carers' wish list was ‘recognition by professionals’; prioritised more highly than improved welfare benefits, higher even than better services for the person they care for. In a social care landscape where changing demographics dictate that family and friends will be increasingly relied upon for community support, professionals need to respond better to this message.

In 2005, having been appointed as one of two generic Carers' Development Managers across Cambridgeshire, we began by asking Carers how to prioritise areas that needed improvement. Among other outcomes (which have been separately pursued) the consultation highlighted Carers' need for relevant information at the right time, and access to time off from caring responsibilities.

Both of these objectives could be met by a timely and purposeful Carers' Assessment, and so we set about developing a structured, and project managed campaign to increase the number and quality of Carers' Assessments and Services (CASP) delivered across Cambridgeshire.

Progress made includes a radical streamlining of previous Carers' Assessment process and guidance, adding the option of a ‘Carer's Short Assessment’ form for Carers (and assessors) who find a longer document intimidating. Also providing a self-assessment version. This re-provision of user-friendly forms is now being replicated within the CPA documentation used by the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. Similarly, the associated guidance for practitioners has been updated, simplified, and halved in length. A programme of training involving Locality teams countywide has been launched, and across Cambridgeshire:

- More Carers' Assessments are now being carried out with clear practical outcomes, including referral to

specialist Carer Support workers (both generic and voluntary organisation based mental health workers)

- The circulation of our local Carers' newsletter and information directory is climbing.
- Despite budgetary pressures, Cambridgeshire continues to promote services (usually through small, one-off direct payments) delivered to carers in their own right. CASP Project clarification and practice guidance has ensured that this option is understood and consistently applied across different geographical and service areas.
- A ‘Young Carers’ Protocol has been drawn up, to help with the identification and support of Young Carers in Cambridgeshire.
- We've begun to ask practitioners to put Carers at the centre of provision where ‘respite’ is being commissioned to give Carers a break. This has to follow a Carers' Assessment to ensure that the Carer has time to explore what time off they need, and how best to deliver it, rather than fitting in with (often) block residential respite contracts.
- We now have a mechanism to gather Carers' feedback on the ‘respite’ experience, and channel this into the commissioning of respite contracts.
- Recording of Carers' Assessment on the CCC social care database is now the task of specialist inputters, allowing better tracking of where Carers' Assessments are, and are not being delivered.

Alongside this improvement project, local voluntary organisations including Alzheimers and Age Concern had been commissioned by the Primary Care Trust to provide ‘outreach’ Carers' Assessments to those Carers not in touch with statutory services, in this way reaching out to a number of hidden and hard to reach Carers.

Historically, colleagues within mental health services have given a whole range of different reasons for non-completion of Carers' Assessments. These include:

- Carer and service user relationship conflict
- Making formal and constricting the therapeutic relationship between the practitioner and Carer
- Tension between the role of Carer and the recovery model
- Friction between health and social care practitioners about who is responsible for Carers' Assessments
- Confidentiality
- And a particular favourite of mine, the existing high level of partnership and engagement with Carers which Older People's Mental Health Team (OPMHT) practitioners have.

None of these fig leaves will really disguise the fact that most of the resistance comes from the practitioners' side. If a Carer provides 'regular and substantial care'² their life is going to be significantly impacted by caring, and they will probably be interested in any dialogue, which could lead to a better understanding of their options.

The 'Partners in Care' campaign³ "Carers and confidentiality" leaflet is available to help practitioners gain confidence in permission seeking to share information with Carers where this will be helpful to both parties.

Carers overwhelmingly want to do the right thing, but they often suffer from a potential information overload; and would value information that's relevant to them at the right time, rather than having to find their own way through a maze. Especially within mental health services, where anxiety or preconceptions about mental illness can become a barrier to positive engagement, a Carer's Assessment can potentially provide an important tool to assist the recovery of the individual through: providing a gateway to the provision of information on the illness itself, medications and other therapies, as well as helping carers begin to explore issues such as interdependence and routes to independence.

Within Older People's Mental Health Services, Carers of people with dementia experience greater strain, distress and higher levels of psychological morbidity than Carers of other older people⁴. If these family Carers are really our partners, we need to ask them about how they are coping, and offer practical help – what is this but an unrecorded Carers' Assessment? In light of the recent National Alzheimers Society Report⁵ which told us that there are now an estimated 424,378 people with late onset dementia living in 'private households' (almost twice as many as the 244,185 who live in care homes) the need to promote the sustainability of the caring relationship for those who suffer or care for someone with a dementia has never been greater.

Over the last fifteen months, we have been delivering on phase one of the project, with the developing realisation that, like the Forth Road Bridge, the CASP Project will need continuing attention to keep up with the development of public policy. Department of Health Guidance on the "New Deal for Carers"⁶ has already told us to link Home Based Emergency Cover Planning for Carers with Carers' Assessments and Reviews.

While the CPA process already directs care co-ordinators to compile contingency plans for service users, the new initiative relates to the cover which needs to be provided should a Carer be unable to carry on due to illness, family problem, or other emergency. The level of backup required will vary between a reassuring phone call from another family member or friend, to provision of substitute care through a care worker (for those at greater risk). The Department of Health is clear that the delivery of this emergency cover will link with Carers' Assessments and Reviews, which are here to stay. In the meantime, we need to ensure that care co-ordinators are helped to make emergency planning another of the real benefits of a Carers' Assessment. Through training and user-friendly documentation, we can make the CPA Carers' Assessment an opportunity and not a burden.

References

- 1 Carers UK 'Our Health, Our Care, Our Say for Our Caring Future - February 2007
- 2 Standard Six of the NSF for Mental Health refers to all Carers who provide "regular and substantial" care for a person on a CPA
- 3 <http://www.partnersincare.co.uk/>
- 4 http://www.alzheimers.org.uk/News_and_campaigns/Policy_watch/Carersupport.htm
- 5 http://www.alzheimers.org.uk/News_and_Campaigns/Campaigning/PDF/Dementia_UK_Summary.pdf
- 6 <http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Healthreform/NewDealforCarers/index.htm>

Staff Changes

Michelle Palmer, our Assistant Psychologist, has been offered a scholarship from the Economic and Social Research Council to undertake a PhD at the University of Birmingham. This is quite an achievement as only a very limited number of scholarships are awarded each year, so well done Michelle!

Michelle will be leaving us at the end of September to begin life as a full-time student again, but will maintain links with the Meriden Programme as she will continue to have an honorary contract with us.

We wish her the best of luck and are confident that she will be successful in her studies and future career!

Also, as many of our readers know, two members of our Administration Team recently left us for pastures new. We have a new member of staff who will be with us for the next few months to assist with the administration work of the Team.

We'd like to welcome Maria Albanese, who has been with us since June 2007 and works for us on a part-time basis. Many of you will already have had some contact with Maria as she is fast coming to grips with the work of our small office based team and the extended Meriden team across the world.

Maria's contact details are as follows:
Telephone: 0121 678 2896
Email: maria.albanese@bshmt.nhs.uk

Family Work Skills Training in a Crisis Resolution and Home Treatment Team

Imogen Reid, Lynda Parnham and Sarah Coffey – Avon & Wiltshire Mental Health Partnership NHS Trust

National context

Crisis resolution and home treatment (CRHT) teams were established in response to the NHS Plan (DOH, 2000), with guidance regarding the structure of such teams being detailed in the Mental Health Policy Implementation Guide (DOH, 2001). The aim of such teams is to offer home assessment and treatment as an alternative to hospital admission for people experiencing an acute mental health crisis. Chisholm & Ford (2004) in their review of the interventions offered by CRHT teams include support to carers/ families, the provision of information about the crisis and the service user's illness, interventions aimed at increasing resilience including problem solving and stress management and the development of relapse prevention plans.

Chisholm & Ford also suggest that the training package offered to crisis team members should include working with family members and the social support system. Rigby (2007) in a review of the existing literature noted that carers do seem to prefer home treatment to in-patient care. However, it was also noted that many of the studies reviewed did not measure the potential detrimental effects on carers nor did they discuss the training needs of teams in order to enable them to offer appropriate interventions to carers.

Local context

The Swindon Crisis and Home Treatment Team (CRHT) was established in 2004. The CRHT team is multi-disciplinary, consisting of staff with nursing, social work, medical and psychology backgrounds. When the CRHT team was established it was envisaged that the team would work with carers as well as service users, for example the Operational Policy for the team refers to "providing support, information and education for relatives and carers" and "linking... relatives and carers to other services for ongoing support" (Swindon CRHT Operational Policy, 2004). Within the Swindon CRHT team it was recognised that reducing admissions to the local in-patient facility could lead to an increased burden on carers (Rigby, 2007). Staff within the CRHT team were keen to look at ways of improving the service offered to carers as part of their crisis and home treatment provision.

Within Swindon, there is also a well established Family Work for Psychosis service, providing longer-term family work. Three staff within the CRHT team had completed Family Work training but had struggled to implement these skills in routine practice, due to the demands of working in a CRHT team context.

Development of local training package

All three of the authors had completed Family Work training and were keen to look at the development of a training package tailored to the specific needs of the Swindon CRHT team. Imogen Reid is the Family Work Co-ordinator for Swindon and the Clinical Psychologist for the Outreach & Recovery Team, Lynda Parnham is the Clinical Psychologist attached to the CRHT team and Sarah Coffey is a Mental Health Worker with the CRHT team. In the early stages of planning, we approached the CRHT team manager and the Acute Services manager, recognising the importance of ensuring managerial support for the project (Smith & Velleman, 2002; Bailey, Burbach & Lea, 2003). Both managers were supportive of the project.

When we started to develop the training package, we were aware that there was very little literature regarding the use of family work within CRHT team settings. Invaluable advice was gained from Gráinne Fadden who had delivered family work training to CRHT team staff elsewhere. She emphasised:

- The importance of helping CRHT team members to view themselves as part of a wider system, recognising that there are some interventions that they can deliver but that they may also need to link up with other services. They play a key role in engaging families on behalf of the service.
- The importance of tailoring the training package to the specific circumstances of CRHT team staff.
- The importance of ongoing support and supervision for CRHT team staff in implementing family work skills (Fadden, 1998).

In planning the training we were also conscious of the need to ensure that those providing the training would have sufficient credibility with team members, and of the need to tailor the style of the training to the needs of the team. The trainers all had experience of providing family work but Sarah Coffey, in particular, was also able to draw on her experience as a front line member of the team to indicate how the interventions we were discussing could be incorporated into routine team working. Based on Lynda Parnham's experience of providing other training to the Swindon CRHT team, we ensured that the package we constructed had a strong emphasis on practical, clinical tools and that a playful and creative tone was maintained throughout the training.

The aims of the training were:

- To increase the awareness of the needs of carers and the positive role that they can play in supporting individuals

- with psychosis, particularly in a CRHT team context.
- To increase the awareness of local resources for carers.
- To provide CRHT team staff with the opportunity to develop family work skills, particularly around the provision of information and problem solving.
- To enable staff to consider when a referral for longer term family work might be appropriate.

It was agreed that the training would be offered over six sessions of one and a half hours duration. Subsequently, Lynda Parnham agreed to offer monthly supervision specifically focussed on the implementation of these skills in practice. However, both Lynda and Sarah would also be available for more informal discussions and, at team handovers, would be able to prompt CRHT team members to consider the needs of carers. The CRHT team manager provided ongoing support by agreeing that alterations could be made to staff rotas to maximise the number of staff who were available to attend the training and by encouraging staff to prioritise attendance.

The topics covered were:

- Session 1:** Rationale and evidence base for the use of family work and its specific use in CRHT team
Local resources for carers
- Session 2:** Impact of someone within the family becoming unwell
Core skills in engaging with family members, including active listening, validation of concerns and modelling good communication
- Session 3:** Providing information
- Session 4:** Supporting families in problem solving
- Session 5:** Handling tricky situations including confidentiality, dealing with high levels of distress in family members
- Session 6:** Implementing skills in routine practice
Problem solving around barriers to implementation.

Training

The training was delivered in October-November 2006 by Lynda Parnham, Imogen Reid and Sarah Coffey. Alan Bradley, the Mental Health Support Worker from Swindon Carers Centre contributed to the first session. Eight staff attended the training, although even with support from the manager attendance was erratic. The feedback from the training was very positive. Staff particularly appreciated the practical, skills based nature of the training package.

Reflections after training

Since the training, a number of positive outcomes have been noted:

- The Mental Health Support Worker has noticed an increase in the number of referrals for carers' support received from CRHT team staff.
- Several CRHT team staff have reported examples where they have employed skills covered in the training package, for example providing information to families

and using validation skills in their interactions with family members.

- CRHT team staff who have been involved in seeing families have reported that colleagues have respected that their appointments to see families should take priority over other commitments.
- To date, nine families have been discussed as potential family work cases. Six families have been offered some kind of family intervention as part of their contact with the CRHT team and in two cases referrals for ongoing family work were also instigated.
- As the CRHT team often has repeated contacts with particular service users and their families, the team have started to care plan for the future inclusion of family intervention in subsequent contacts with the team.
- A core group of six staff continue to attend the Family Work in CRHT team supervision group.
- Ongoing supervision and opportunities to co-work with colleagues who have more experience of working with families have been highly valued.

We would like to end by including some reflections from one of the CRHT team members who has been involved in offering family work to one of the families seen by CRHT team:

“Following Crisis Team family work training this was my first attempt at family work and I was apprehensive due to varied and strong characters within the family.... I was also under the impression that the work would be boring and mundane and not particularly taxing. How wrong I was! The work proved immensely rewarding. I would recommend this work to anyone. It is stimulating, rewarding and of great value to the client and their family, a fact best summed up by the family itself: “This is the only time we sit and talk to each other, openly and honestly”. In modern society, how many families would be in this position, making time for this type of communication? As a result of this experience, I will actively seek out this type of work, where appropriate, in the future.”

Acknowledgements: We would like to thank Alan Bradley for his contribution to the training and Gráinne Fadden for her advice in the early stages of planning. We would also like to thank Phil Cooper, Team Manager of Swindon CRHT for his support and the Swindon CRHT team members for their positive engagement in the training programme.

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Training Programme for Families and Friends of People Affected by Alcohol and/or Drug Misuse: Information Sharing, Coping Skills and Support

**By Steven Cox, Cognitive Behavioural Psychotherapist, Clinical Nurse Specialist –
The Meriden Programme and Birmingham and Solihull Mental Health NHS Trust**

Introduction

The Meriden Programme was commissioned in 2007 by the Warwickshire Drug and Alcohol Action Team (DAAT) to deliver a pilot, innovative three-day training course to equip local staff and carers to deliver 11 week carer education and support packages to families and friends of those primarily affected by alcohol difficulties (Fadden, Mansell & Cox 2007). This was to be based on previous successful training delivered for carers of those with mental health problems in Ireland (Fadden, Mansell 2005) and Staffordshire, and for families from different ethnic groups in Birmingham (Fadden, Mansell & Conneely 2006).

This package was based on the principles of Behavioural Family Therapy (BFT) as advocated by Falloon et al. and was adapted for substance misuse services. I was very grateful to Warwickshire Substance misuse services and two carer/user consultants from Carers in Partnership for their help and expertise in doing this. What became clear during the project was that the experience of having a friend or family member with an addiction problem is common, and that confusion, anxiety, pain and frustration are frequent responses.

Policy and research background

Government policy for carers is clear and the White paper 'Our Health, Our Care, Our Say' (Department of Health, 2006) enhances and strengthens this in a 'new deal for all carers.' The UK legislation should lead us all to be mindful of carers in the services we deliver. There certainly is already a long list of previous legislation and policy that says carers should be included (e.g. The Carers Recognition Act, 1999). 'NHS and local authorities should ensure partner agencies have protocols to provide support to carers' (Cass, 2005). The case for carer inclusion is explicit, support for carers is likely to be a cost effective use of resources, and it is correct in principle (Cass, 2005).

There is evidence that working with the family helps (Baker, 2000). Families affected by addiction problems are important for two related reasons. Firstly, involvement of family members in the treatment of their relatives with addiction problems can enhance positive outcomes. Secondly, family members in these circumstances show symptoms of stress that merit help in their own right (Copello et al., 2000). The NICE guidelines on psychosocial intervention and drug misuse (July, 2007) outline a number of family interventions including Community Reinforcement

approaches, Network Therapy, Behavioural Couples Therapy, many of which have the principles of BFT firmly embedded within them. BFT is a family stress reduction model and is adaptable for specific needs. Connect (formerly Drug Concern) in Birmingham, which supports families and friends of those with addiction problems have embraced Behavioural Family Therapy in the delivery of its services.

Some 74% of users of drug services experience mental health problems. Most have affective disorders (depression) and anxiety disorders. Mental health disorders were often not picked up by staff working in Substance Misuse Services.' (Weaver et al., 2002).

Whilst the case for including families and friends of those with addiction problems is clear, some have found that services are reluctant to address the needs of carers and families. Adfam, the charity for Families, Drugs and Alcohol, proposes that 'the stigma and discrimination against families affected by substance use is an abuse of human rights and must end, the voice of families should be heard loud and clear and families need specific services offered by well trained and caring people.' (Adfam, 2006). The Social Care Institute for Excellence (2006) review of carer participation in health reported 'The practice survey showed little activity aimed specifically at substance misuse problems'. There seems to be an emerging case for change for involving families of those who misuse substances. Services for families seem patchy, commissioning targets may be focused on the substance use, and confidentiality and user motivation for change might be reasons for not including significant others. Probably most importantly there is uncertainty about whether government policy on carers applies to substance misuse services.

Course content

The course was delivered in February 2007 and was extremely well received by the four carers and eight professional attendees. Plans are now well established in Warwickshire to roll out 11-week carer education and support programmes across the area with support from the Meriden Programme. The structure of the course and accompanying manual included family and friends' experiences, information sharing, understanding medication and services, recovery and hope, communication skills training, problem solving and looking after yourself. The course was delivered by two professionals and a carer, with someone who had previous alcohol problems also delivering a session.

Carers, family and friends

In the substance misuse field the term carer is rarely recognised and it was felt more useful to use the term 'family and friends'. This is a point worthy of note because there is some confusion around whether government policy on carers applies in substance misuse and this could be a contributing factor.

General information about alcohol and drug misuse

This included general facts and figures e.g. recommended weekly drinking limits.

The risks of alcohol misuse

Education about the risks of alcohol e.g. lowered mood, liver disease etc.

A multi-causal model of substance misuse

This had additional information on dual diagnosis and comorbidity of substance misuse and mental health problems and also discussion about a strong family link in substance misuse problems. There was discussion of peer, family and community influences and role models.

Understanding and assisting in treatment

Key points about user motivation and 'do's and 'dont's'. Practical tips for harm reduction e.g. food eaten at regular intervals such as soups, bananas or cereals.

The cycle of change

Information about the course of addiction using the model by Prochaska, Norcross & DiClemente (1994). Outlining the cycle of pre-contemplation, contemplation, decision to quit, action, maintenance and relapse or abstinence phases of addiction.

Medication and services

Including Campral, Chlordiazepoxide, Antabuse and alcohol in the home, Methadone (what it is and is it for life?); how families can assist in medication management; the way national and local services are structured e.g. what is CAT, CDT, DAAT?

Recovery for family and friends

There was a lively debate about whether the ideas of recovery for carers of those with mental health problems could be applied to substance misuse. It became clear speaking to carers and a recovered substance user that they clearly could, but needed to be adapted somewhat. It is important that families and friends of those with an addiction can recognize their own emotions, detach with love, set a vision for their own life and look after themselves as well as their relative, and ensure their own wellness.

Communication in families

The Life Drama Triangle (Berne, 1964): This model was included to help discuss the communication trap some families become embroiled in when substance misuse affects the family. The carers in the group felt this very

relevant to their own experience and related to the roles of victim, perpetrator and rescuer (Berne, 1964).

Saying 'No': It was felt important to add another communication skill for substance misuse and to train family members to be able to say 'No'.

There was some discussion about what should be included in this skill and if it should include a traditional 'broken record' assertive 'no' and whether an explanation for saying 'no' should be included.

Signs of relapse and crisis planning

This was included in amended form to include crisis planning. This worked well and there was general agreement as to its usefulness. Crisis planning involved thinking about previous crisis situations e.g. intoxicification and heated arguments/aggression, planning a future positive plan of action and emergency crisis contacts further facilitating positive boundary setting and contingency planning. It was also useful to get carers to identify and think about possible triggers and high-risk situations for relapse or intoxicification e.g. certain people, places, times or emotional states.

Outcomes

Twelve people participated on the course. Feedback was good, and the principles of family work have been enthusiastically embraced by staff and carers in North Warwickshire. Developing this training has been very interesting and challenging for a number of reasons. There can be resistance to the idea of working with families in substance misuse services. Carers and families may be low on commissioners' agendas. The similarity between carers of those with substance misuse issues and mental health problems' experience was striking. There was a large overlap, and the carers on the course talked about their long-held beliefs that their relative had mental health problems too, some diagnosed, some not. The carers on the course felt the content was 'spot on'. It has been a steep learning curve for me, despite having worked in substance misuse services for 18 months previously and having done much joint work with Drug Concern. What has been very pleasing is some of the strong relationships that have been built.

Having a carer consultant as a trainer on the course worked well and I think was seen as progressive by participants. Many professionals and carers commented on how useful it was to train together, to be in the same room and to try to understand and empathise with each other's position and experience. Having a 'recovered alcoholic' (her words not mine) come and talk about her recovery experience was also extremely useful. I was left thinking it really is a good training model for health education generally.

Some feedback from participants

Which parts of the training did you find most useful?

'Found all facets to be necessary'

'Small group work, particularly coping with difficult scenarios'

'Supported practice'

'The carer involvement'

'Practice groups. Feedback. Carer input'

'It was all useful but the recovered alcohol user's story was the most powerful and thought provoking'

'Group work'

'Communication skills'

Summary and conclusion

There is evidence that support for friends and families in substance misuse services is at best patchy and at worse, wholly inadequate. This training to deliver education and support for families and friends devised by Meriden, working in collaboration with North Warwickshire substance services, and including carers and recovered alcohol users, was well received and considered highly relevant. The 11-week programme is due to be rolled out across Warwickshire in 2007.

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Launch of DVD 'Breaking Silence'

Ashram Housing Association has developed a short film about mental ill health in second generation South Asian women and looks at cultural conflicts which can lead to mental ill health.

The story is influenced by the experiences of a service user who suffered mental ill health as a young single mother without the support of her family. The production uses a fictional character to illustrate the conflicts many women face between their Eastern and Western values and takes the viewer through a series of life experiences aimed at highlighting the issues many women face. It is hoped that this DVD will raise the issue of self harm and mental ill health particularly among the South Asian community where the subject is considered taboo. Self harm and mental ill health are often hidden and considered to be a growing problem in the South Asian community.

Caron Thompson, Project Manager at Nissa Ashram said "It is important that we highlight issues such as this to the wider community because the subject is still taboo in many families and women are suffering in silence. With this DVD we aim to raise awareness and funding to be able to support many more women within their communities hopefully breaking the stigma attached to mental ill health."

Satveer Nijjar, the service user whose experiences are covered in the film said: "I hope that my experiences in collaboration with the work of Ashram to produce this film will encourage mental illness to be spoken about more in our communities. If even one woman comes forward to access services I feel that the work of the DVD has been achieved."

This ground breaking DVD will become part of a training pack that will be delivered to raise awareness of mental ill health in the South Asian community. The DVD will be launched on 10 October at an event being held in Birmingham to celebrate World Mental Health Day.

The aims of the day are:

- To celebrate World Mental Health Day and highlight services and initiatives that seek to support and promote our mental health and well-being.
- To actively engage stakeholders across the Heart of Birmingham area on the subject of mental health and its impact on Black and Minority Ethnic Communities.
- To challenge the discrimination experienced by people with mental health issues.
- To launch Ashram Housing Association's ground breaking DVD 'Breaking Silence' and draw attention to the impact of mental health issues within South Asian communities and local service response to such issues.
- To provide the opportunity for key stakeholders to look at current areas of concern and discuss options for addressing these concerns.

For more information please contact Nissa Ashram; telephone 0121 772 3356; email nissa@ashramha.org.uk

Caring for Carers

Ashram Housing Association's Mental Health Service and the AXIS project have worked together in partnership to deliver an education package to carers of individuals with mental ill health. This training package has been designed to specifically target carers and is the first of its kind to be delivered in Birmingham.

The first course took place at the University of Birmingham and ran for 11 weeks. The training aims to identify the needs of carers and to provide relevant information, advice and guidance for facilitators to respond accordingly. The first training session targeted Black and Minority Ethnic (BME) carers and was a great success. All those who attended said it was a positive experience and they had learnt a great deal of very useful information. The training programme was originally developed by the Meriden Programme through an initiative funded by the Care Services Improvement Partnership (CSIP). Ashram and AXIS adapted the content to cater for the targeted group.

The Meriden Programme developed an eleven-week support and education programme specifically to meet the needs of those from Black and Minority Ethnic groups, and provided training a group of 17 professionals and carers in January 2007 to enable them to acquire the skills needed to deliver these support groups.



Participants of the Caring for Carers course

There were four facilitators throughout the course, including Loris Tapper, a carer herself, who was paramount in emphasizing the importance of carers voicing their opinions and taking part in some of the many groups that are run across Birmingham specifically for carers.

Over the duration of the course the group bonded and there were many issues and barriers that have been identified. This information will be taken and raised in line with the work of the Community Development Workers role to raise awareness of mental ill health. The programme will be rolled out again in the near future to target an even a wider audience of carers.

*Jazz Kainth, Community Development Worker
Heart of Birmingham PCT/Ashram Housing Association*

Development of DVD Looking at Family Intervention in Black and Minority Ethnic Communities

The Meriden Programme recently put in a bid and was successful in obtaining a grant from the 'Improving Access to Psychological Therapies Regional Network Development', which is facilitated by the Care Services Improvement Partnership. The grant will be used to develop a DVD, which will show how evidence-based family intervention has been successfully delivered to families from Black and Minority Ethnic (BME) communities.

The DVD will consist of:

- Families talking about their experiences of family work
- Families being filmed replicating sessions from the family work they have been involved in, or simulated role play situations
- Clinicians talking about their experiences of working with families from BME communities

The content of the DVD will be developed through the Transcultural Family Work Forum, which is run by the Meriden Programme.

The Meriden Programme has been instrumental in developing family work across the West Midlands. During the Programme's ongoing contact with clinicians over the last 9 years, there have been a number of issues raised relating to whether some parts of the model of family work are appropriate to people from different cultures.

During family work training courses, trainees often question how the model can be applied in different cultural settings. For example, the way in which communication skills training is structured tends to relate to white European patterns of communication. Having this DVD would enable clinicians attending the training to feel more confident about delivering evidence-based family work to people from BME communities, and be very clear about the effectiveness of this approach across a range of cultures.

The DVD will be developed in partnership with another agency which will have the resources to support the filming and creation of the DVD. It is hoped that DVD will be ready by the end of 2007.

*For further information about this please contact: Martin Atchison, Clinical Specialist – The Meriden Programme
Tel: 0121 678 2727 Email: martin.atchison@bsmht.nhs.uk.*

'An Integrated Approach to Family Work for Psychosis'

By Gina Smith, Karl Gregory, Annie Higgs

Reviewed by Tony Gillam, Worcestershire Early Intervention Service, Worcestershire Mental Health Partnership NHS Trust

Consultant nurse Gina Smith has been busy lately. No sooner had I finished reviewing *Changing Outcomes in Psychosis* (of which Gina was one of the editors) then I received a copy of *An Integrated Approach to Family Work in Psychosis*. While Gina helped to edit the *Changing Outcomes* book, she is one of the authors of this new book on family work along with her colleagues Karl Gregory and Annie Higgs. Gina, Karl and Annie are all mental health nurses by background who now co-facilitate the 'Integrated Approaches to Serious Mental Illness' course at the University of Gloucestershire. To some extent, then, this is "the book that goes with the course," and readers may experience it as incomplete, as if it is supplementary to the course rather than complete in and of itself.

This book is subtitled 'a manual for family workers' so you might expect a fairly straightforward, practical, 'how-to' kind of book rather than a more theoretical exploration of family work. The volume is divided into two sections 'Understanding Family Work' and 'Delivering Family Work for Psychosis'. The first section, which covers what exactly is meant by family work, why it should be offered, who is involved and the logistics of when and where to offer family work is, in many ways, more useful than the section on delivering, which – if you will excuse the pun – somewhat fails to deliver. There is an extensive section on the wide range of assessment tools which can be used with families (perhaps a reflection of the Thorn training of the authors) but the reader might be left asking, "And after all that, what do I actually do?" That said, there are some useful tips – for example, the authors suggest that critical comments made by family members about the service user can be positively reframed as an expression of concern rather than mere criticism. The importance of engaging families at the point where the service user is an inpatient is also stressed – "a crisis is an opportunity for change."

Any book that encourages clinicians to be sensitive to the needs of families is welcome. If the authors can make the book attractive,

readable and easily-digestible, that is even better because too few text books seem to have any regard for the person trying to read them. The authors have tried hard to write in an uncomplicated style but to have both summaries and key points at the end of each chapter seemed repetitive and unnecessary.

There must have been a number of challenges facing the authors of this family work 'manual'. First, family work – in the sense of behavioural, psychoeducational family work – has sometimes been caricatured as being an oversimplified 'manualised' approach. So, how do you write a simple manual for family workers (or would-be family workers) that does not reinforce the myth that family work is a kind of painting-by-numbers intervention? Second, how – without infringing copyright or simply replicating a previous family work manual – do you produce something substantially different to earlier practical guides? (One thinks of the workbook used by the Meriden Programme as part of its family work training, but also *Family Work for Schizophrenia: A Practical Guide* by Liz Kuipers, Julian Leff and Dominic Lam, or *Managing Stress in Families* by Ian Falloon, Marc Laporta, Gráinne Fadden, and Victor Graham-Hole).

The solution here seems to be to cover in some detail the preparation for the family work – (how to choose a venue and a co-worker, how to manage the environment, establish supervision arrangements, and conduct the assessments) with little exposition of how therapists might share information with families or enhance the family's communication skills. It is all a bit reminiscent of Ionesco's absurd play *The Chairs* in which a long period of time is spent putting out chairs for a lecture to an invisible audience given by an orator apparently incapable of speech. I am not suggesting the authors do not express themselves clearly – only that practical strategies are conspicuous by their absence.

Sadly, *An Integrated Approach to Family Work* disappointed me because I felt it represents a missed opportunity to promote family work and enhance its practice. It lacks the richness and warmth of Gina Smith's excellent family work case study in *Changing Outcomes in Psychosis*. More experienced family workers will find it too simplistic. Meanwhile, I fear that newcomers to family work, in the absence of a training course, will be left mystified as to what is really involved in working with families.

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MERIDEN CONTACT DETAILS

The Meriden Programme, Tall Trees, The Uffculme Centre, Queensbridge Road, Moseley, Birmingham B13 8QY

Gráinne Fadden, Director	0121 678 2892	Steven Cox, Clinical Specialist	0121 678 2794
Marie Crofts, Clinical Specialist (on secondment)	0121 678 2896	Sam Farooq, Business Manager/PA to Dr Fadden	0121 678 2712
Chris Mansell, Clinical Specialist	0121 678 2729		
Martin Atchison, Clinical Specialist	0121 678 2727	Fax Number:	0121 678 2891
Paula Conneely, Clinical Specialist (on maternity leave)	0121 678 2710	Email Addresses:	firstname.lastname@bsmht.nhs.uk
		Website:	www.meridenfamilyprogramme.com

We are constantly striving to keep the contact details we hold for you on our databases up to date.

If your details have changed please let us know. Email sam.farooq@bsmht.nhs.uk or telephone Sam on 0121 678 2712.