



MERIDEN

The Meriden Family Programme

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When the Meriden Family Programme was established in 1998, it naturally took a couple of years for everything to get off the ground and to get the Programme going. I have been looking back to see when we began to produce newsletters and have found the first edition was published in June 2001, and was described as a means of keeping in touch with those trained in family work through the Programme. The first article noted that there were then 74 trainers in the West Midlands, over 80 training courses had taken place, and 850 therapists trained. The early newsletters were small – 8 pages – mainly black and white, with just the blue Meriden logo on the front. The reports at that time were mainly about what was happening in the West Midlands in England.

Since then, we have had 17 years' worth of newsletters! The size has got bigger, with some bumper editions. The paper has got glossier, and there's a lot more colour. What's interesting though, is that the newsletter is as popular as ever. In spite of technological advances in terms of communication and the development of our website, people still love to read the newsletter as a means of keeping in touch. There are always interesting stories, and people love to read in a more informal way about what is happening in other areas and services.

What the newsletter has done very well I think, is to allow people to share what they are doing in a practical way in their services and so the articles have provided a very good means of sharing good practice in a timely manner, allowing people in different parts of the world to make contact with each other. We have been able to publish ideas that probably would not meet the strict criteria of publication in scientific journals. This type of communication is really important, and there are always new developments that people want to report on.

been neglected even though they can have complex issues linked with stigma and the fact that the crime may have been committed within the family. It is great to see attention being paid to their needs, and to hear about the new Carer Toolkit for Secure Services. We also have interesting reports from Uganda about how family work is continuing to develop, and from Japan where the first training course in Behavioural Family Therapy took place in March this year.



We have two items on Carer Peer initiatives – a new area that has been underway in Castlebar, Ireland for three years and an article describing the first training course we have run in Birmingham. This is something that will hopefully develop more over the coming years so that the expertise that family members bring can be more influential in informing the development and delivery of services for families and carers. On a creative note we have an article on the Gift Box initiative from New Zealand, and a review of a book by one of our veteran trainers, Tony Gillam, on Creativity and Wellbeing.

For me, as I retire from the Programme, it is great to see that there continues to be such a richness of material to be published and such enthusiasm. I feel I should be saying something wise and meaningful in this, my last edition as editor of the newsletter! The newsletter will of course continue, and I will be reading it with interest – I must remember to get my name on the mailing list! What can I say? It is nice to be leaving at a point where the evidence for family work remains robust, where implementation is supported by policies and guidelines, where clinicians and managers are enthusiastic and committed to developing services for families, and where family members, carers and service users are much more engaged and listened to in services.

My very best wishes to you all for the future. Keep up the good work!

Dr Gráinne Fadden



The current edition has an interesting mix of articles reporting on family work related activities both within England and internationally. There are two items on the needs of families in forensic or secure settings. Families in these services have often

First Behavioural Family Therapy Course in Japan

By Kazuhiro Sakai, Atsushi Sato, Kazumi Yoshino, Yoko Komatsu,
Miyoko Nagae and Mirai So



Trainers and delegates on the first BFT course to take place in Japan

The first Behavioural Family Therapy (BFT) course in Japan was held in Tokyo from the 17-21 March 2018. Planning and delivering the course took a lot of preparation and planning, especially as none of us live in Tokyo. Twenty three applications were received from all over Japan and participants were selected to attend according to the following six conditions:

That each participant:

- Has experience of working with service users and their family members
- Has experience of home visiting as a mental health professional
- Has the organisational environment to work with family members using the family work skills learned on the course
- Can continue the practice under supervision for more than one year after the BFT training
- Has the motivation to develop the family work in Japan
- Is a member of the group overseeing the development of family work in Japan

15 participants were selected for the course: 3 nurses, 8 social workers, 3 occupational therapists, and a peer support worker. Some of them were family members as well as a professionals. As you can see from the map, people from several regions in Japan took part in the training. Supervision has been set up as we start to implement the programme.

The course started with a DVD greeting message from Dr. Grainne Fadden which had been recorded and sent to us in advance of the course. Although we have only 5 trainers in Japan, we managed to carry out the mission of delivering the first training course. It was pretty exhausting but it also became a very precious experience.

The five days made us realise the importance of teamwork and reconfirmed that teaching is learning. The trainees said they learned a lot from the course but we feel we also learned a lot from them. They asked a lot of questions and that made us think a lot. It is very rewarding to hear them say they'd like to deliver family work to many families in Japan when the course was finished. Kazu commented: *'I've been delivering family work myself to several families since I finished the BFT course in Birmingham in June 2015 but it is limited what one person can do. It's a small step but also a big first step that 15 new family workers are now preparing for implementation in various places and organisations in Japan'.*

We plan to hold three more BFT courses in Japan within a year. Each course will train ten people. One will take place in June in Sapparo (Hokkaido) where Kazumi is based. Following that, there will be a course in Obihiro (Hokkaido) and then another in Kyoto in March 2019.

There is a plan to train further people in BFT in Birmingham in July 2018, and to train three further trainers and supervisors in March 2019 in Birmingham. It's not an easy mission but it is worthwhile to carry out if you think family work is hopefully going to be delivered to quite a few families soon.

Last but not least, we couldn't make it to invite Meriden staff to Japan to join us during the first BFT course in Japan but we were supported through supervision and e-mails especially by Dr Gráinne Fadden and Mrs Julia Danks. Their advice was very helpful indeed. Without it, I wonder if we could survive the five days. So thank you very much for supporting us!



Visiting Delegation from Japan

By Dr Gráinne Fadden, Director, Meriden Family Programme

From 20–22 March 2018, we welcomed three social workers from Japan who were keen to learn from our services in Birmingham. They were Takashi Shiomitsu (Lecturer, Bukkyo University College of Social Welfare), Noriko Ohta (Facility Manager, Activity Support Centre, Social Welfare Corporation NARAYUINOKAI) and Haruna Shinoda (Facility Manager, Activity Support Centre, Social Welfare Corporation MOE). They were accompanied by their interpreter Mrs Keiko Eden.

In Japan, services are still predominantly hospital-based, so the group wanted to learn more about how we manage service users in the community and minimise the use of hospital admission. They were therefore particularly interested in meeting with our staff from Street Triage, Bed Management and the Psychiatric Decision Unit. They also visited an Assertive Outreach Team and spent time with Mrs Jenny Tasker (Team Leader and Social Worker) and Mr Peter Tyack (Social Worker).

They are very aware that if services are to develop more in the community in Japan they will need to provide more support to carers and families. They learned about the work of the Meriden Family

Programme, and met carers who had benefitted from the approach. They spent time with our partner organisation, Home Group, and were impressed with the idea of 'Pause', a drop-in centre in Digbeth, Birmingham.

The visit gave them much to reflect on along with reading and resources to take forward the development of services in Japan.



The Japanese delegation with Gráinne Fadden (centre) and Peter Tyack (right)

The Gift Box: An Innovative Approach to “Re-recovery”, Resilience-Building, Health and Wellbeing

By Dr Patte Randal, Hamilton, New Zealand

I’m thrilled to have this opportunity to write about The Gift Box, which is the culmination of my life’s work. The Gift Box is a physical resource kit that consists of a brightly patterned box containing a number of items to help people who have challenges to their mental health develop ways of overcoming these. I’m a doctor trained in psychiatry and I have personal experience of recovery from psychosis. Much of the thinking and ideas that have gone into creating The Gift Box have arisen from my own lived experience as well as that of the people I have served.

“Re-recovery” is a term I made up when I was trying to explain how life works. It denotes the idea that we all tend to re-recover the same old ground in our lives, and can get caught in vicious cycles if we keep on doing the same old things that don’t work well. However, if we see crises as opportunities to reflect on these patterns, (and if we have the right support) we can create victorious cycles instead. I have visualised this “re-recovery” journey as a hopeful spiral (See Figure 1).

Last year I was at an ISPS (International Society for Psychological and Social Approaches to Psychosis) conference in Liverpool when I heard Shelagh Musgrave give a very eloquent keynote presentation about her lived experience as a mother of a child with mental health issues. I showed The Gift Box to Shelagh (pictured above) and she quickly appreciated the concepts and later expressed an interest in helping to create a version specifically for family

members and carers. I think this is a great idea and I would be very interested in supporting such a venture!

I have been using these resources over many years and I have seen many people with serious “mental illness” diagnoses and supposedly “poor prognoses” leave the long-stay rehabilitation

setting in which I worked to take up university study or employment, sometimes as peer support workers, following intensive collaborative use of this approach. Truly the vicious cycles have ultimately transformed into victorious cycles. This often seemed to happen following completion of a collaborative “re-recovery” plan and then, paradoxically, the next episode of psychosis. Sometimes things get worse before they get better! Being able to reflect safely once more on one’s story of what happened, within the context of a trusting relationship, and to see the patterns more clearly seems to help with learning and developing self-responsibility and self-management.



Shelagh Musgrave

Figure 1

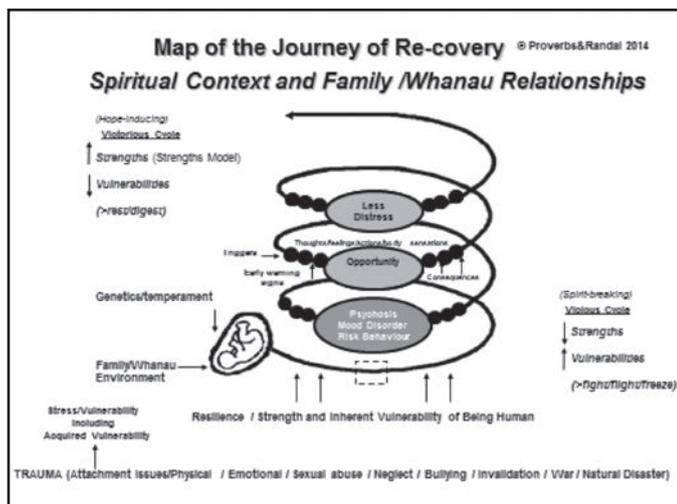
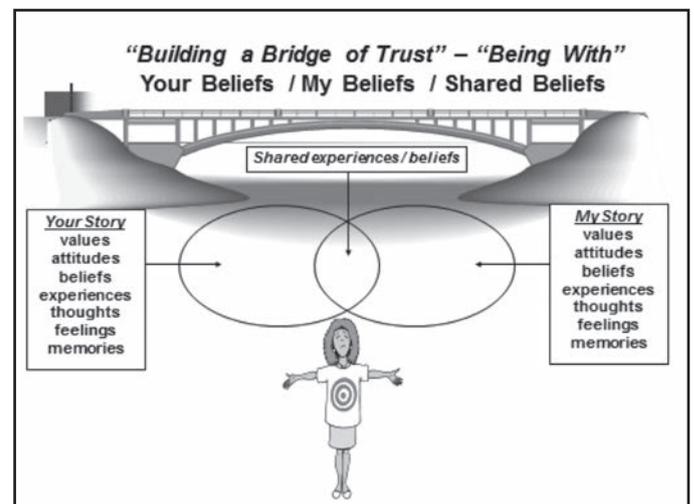


Figure 2



Amongst other things, The Gift Box contains a set of laminated colourful posters that depict the spiral “Map of the Journey of Re-recovery” (Figure 1) and “Building a Bridge of Trust” (Figure 2).

It also contains a set of colour-coded prompt cards (Figure 3) identifying actions; thoughts; feelings and body-sensations in 6 subsets:



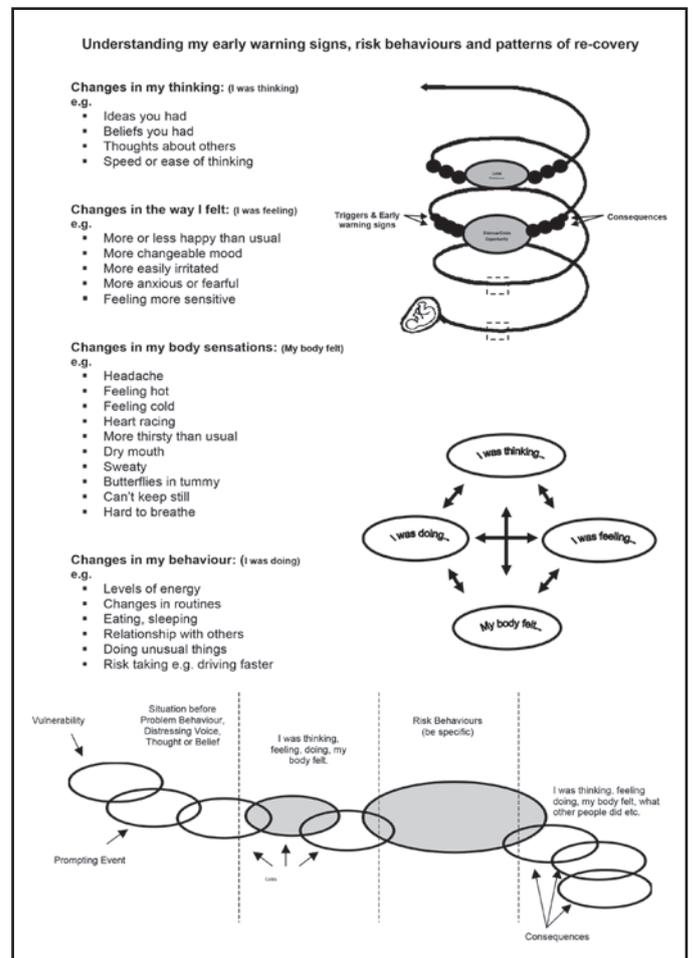
Figure 3

These cards were the brilliant brainchild of a young man, Joel, and his peers with whom I collaborated 10 years ago, when they were in residence at the hospital where I worked. Joel recognised that he and his fellow psychosis-sufferers needed prompts to enable them to identify everything they were unable to name spontaneously about the behaviour patterns or “chain reactions” that led to vicious cycles (Figure 4), and often to hospital admissions. The cards are the result of extensive discussion and creative deliberation with Joel and his peers and combining these with ideas from a number of other sources. Their use helps identify, normalise and validate extreme states as each individual picks out relevant cards, dialogues about them and writes down the details of their lived experience and plans for how to create victorious cycles (Figure 5) in the Collaborative “Re-recovery” Plan workbook. This includes the spiritual/existential aspect of life.

The Gift Box also contains a “feelometer” (a ruler-type of instrument with a moving cursor) that helps identify how we’re feeling at any given moment and what small steps we might take to help us to experience less distress.

This innovative approach will assist the paradigm shift that needs to happen in the mental health care system away from a predominantly biomedical model towards a truly recovery-oriented and self-discovery approach. It also helps the person identify their story of “what happened” to them, rather than the usual emphasis on “what’s wrong” with them. Experiences such as early childhood traumas including attachment issues, emotional, physical or sexual abuse, and/or later bullying in schools, the workplace and tertiary education settings can lead to vicious cycles. These include increasing social isolation, anxiety and depression, increasing substance abuse, poor self-esteem, reduced capacity to work or study, and often to extreme states such as psychosis and risk behaviours and diagnoses of “mental illness”. Stigma and discrimination still occur when people receive diagnoses of “mental illness”. At the extreme end of the “mental illness” spectrum, life expectancy for the people we serve is reduced by up to 25 years, for multiple and complex reasons associated with the further vicious cycles that ensue. Despite the fact that we now have evidence that what we need is a paradigm shift in understanding and service provision, cultural and

Figure 4



power-based dynamics prevent the wide-spread uptake of less harmful, more collaborative and effective approaches to mental health care. I believe The Gift Box has a place in this transition, possibly in a similar way to the ethos and practice of the Meriden Family Programme.

The Gift Box resources have been shown in clinical practice and training settings to facilitate and enable a shift in attitudes and values that support greater understanding, compassion, well-being, self-responsibility, empowerment, self-advocacy, education, and a greater sense of purpose and meaning (particularly in making sense of suffering). The “crisis” becomes the opportunity to build hope for ourselves and the people we serve in any setting – particularly for those who have experienced, or are experiencing distressing interactions, but also for their families and health service providers. The Gift Box enables access to an easily understood shared framework and resource kit that can potentially be used in classrooms, lecture theatres, primary care and counselling settings, secondary and tertiary health services and beyond (e.g. in prisons). As these concepts apply to us all and put us all literally and figuratively “on the same page” (see diagrams), when I run workshops, participants practice using the resources personally and this assists in promoting and creating awareness and capacity for self-care.

Thus the “Re-covery Model” and resource kit contained in The Gift Box is normalising and validating, based on research and the lived experiences of its practitioners as well as on evidence-based best practices. It is not a therapy in itself but helps to integrate a range of well-known evidence-based practices such as Cognitive Behavioural Therapy; Dialectical Behaviour Therapy; a Strengths-based approach; solution-focussed care; motivational interviewing; Acceptance and Commitment Therapy; Interpersonal Therapy; psychodynamic approaches; trauma-informed care; mindfulness; compassion and forgiveness-based approaches;

sensory modulation; medication management when required and a dialogical approach compatible with Open Dialogue.

I am now retired from clinical practice but continue to present The Gift Box workshops internationally and I am currently writing a book with my colleague Dr Josephine Stanton which show-cases this approach. My own story has been published in several contexts and I have certainly had many opportunities to “practice what I preach” as I have learned about my own “re-covery” patterns.

I am currently looking into producing The Gift Box commercially as I am passionate about making it available to as many people as possible because I know it helps change lives.

If anyone is interested in learning more please contact me at: patterandal@gmail.com

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Acknowledgments

I would like to acknowledge Auckland District Health Board (ADHB) for its role in supporting the development of the “Re-covery Model” and Dr Deborah Proverbs for contributing the concept of the “victorious” cycle, as well as Joel and many others whose creativity and ideas are embraced within The Gift Box.

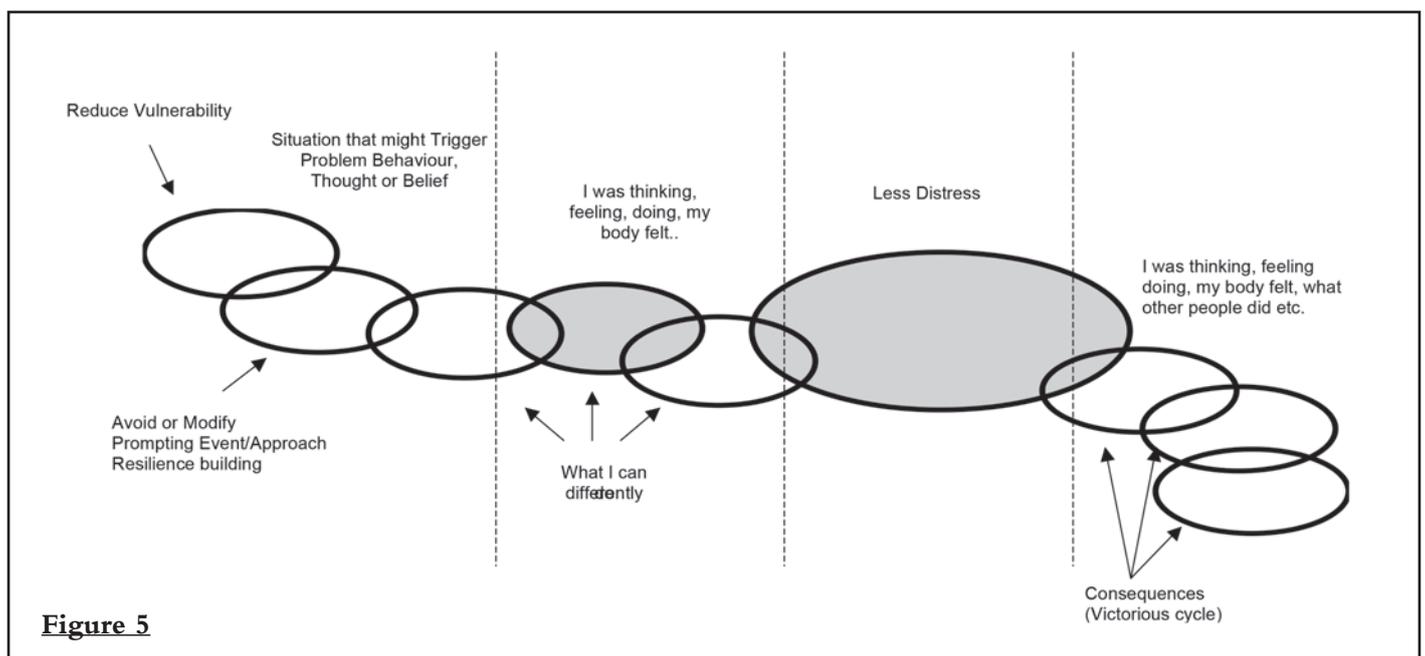


Figure 5

Report on Behavioural Family Therapy (BFT) Awareness Training at Butabika School of Psychiatric Clinical Officers in Kampala, Uganda

**By Thomas Walunguba, Programme Director
Behavioral Family Therapy Programme in Uganda (BFTPU)**

I am indeed very happy to inform you that from 19th-20th March 2018 we were given the opportunity to train and create awareness about Behavioural Family Therapy in Uganda and internationally to 22 Psychiatric Clinical Officer (PCO) final year students at the Butabika School of Psychiatric Clinical Officers in Kampala.

Three members of BFTPU – myself, Irera Charles and Nampijja Robinah facilitated the session voluntarily. I was indeed very happy with the skills that were displayed. The school lecturers were impressed and promised to give us opportunities to provide the same training again.

The major learning outcomes were:

- Participants to be able to develop awareness of the need to deliver family work to families.
- Participants to be able to build on existing skills to be able to deliver evidence-based family work to those families requiring it.

We were able to follow the programme that we had developed including ‘Expectations’ and ‘Ground Rules’.

We went through the highlights of BFT in Uganda and internationally. We also covered background experiences of relatives and carers, individual user perspectives, family intervention studies, policy and guidance related to families and carers, family communication, problem solving skills, engagement of families in family work, information sharing and relapse prevention (Staying Well Planning).



Irera Charles with delegates on the course



Nampijja Robinah facilitating a ‘Staying Well Planning’ session on the course

We used the methods of role-plays, participants practicing and powerpoint presentations. Delegates also watched the videos from the Meriden Family Programme.

Later, on the second day we evaluated the session by asking questions. We received 18 responses:

- 72% reported that the number of sessions were just right
- All 100% reported that presentation methods were useful and the contents of the sessions were appropriate.
- 15 of the group (68%) reported that the amount of information provided was just right.
- 100% reported that they would recommend the training be offered to other Psychiatric Clinical Officer students.

The entire programme evaluated as good/ valuable. Other comments included:

‘The presentation was really good and if time allows, I would request you our presenters to come back again.’

‘Thank you for choosing to share with us, we have learned a lot of skills.’

‘Thank you for the wonderful job done it was fantastic.’

Generally it was indeed a very successful training. Two commented that there was not enough time.

I would like to thank my co-trainers /family workers and all BFT Ugandan trainers for their time and effort to see that the training was a success.

Good News for Carers in Secure Services

By Sheena Foster, Family and Friends Representative,
Forensic Quality Network, Royal College of Psychiatrists

March saw the launch of “Carer support and involvement in secure mental health services – A Toolkit” hosted by the Royal College of Psychiatrists.

The toolkit has been developed by NHS England in partnership with UCLAN (the University of Central Lancashire), led by Mick McKeown, a researcher who actively involved carers in all aspects of its development. The basic aim of the toolkit is to provide clear information for carers, service users, service providers and commissioners about how carers of people who use secure mental health services should be engaged with, supported, involved and empowered. There is a printed version available and it is available online by logging on to <https://www.england.nhs.uk/publication/carers-support-and-involvement-in-secure-mental-health-services/>. It gives access to a wide range of information and the research findings which were part of the process. Two short films were also produced using participatory methods, led by Flexible Films who are filmmakers with lived experience.

contact details for providers and further resources. It was not easy to find good practice examples as carers in secure services are largely ignored. They are often traumatised by events leading up to the admission of their loved one and their needs rarely addressed.

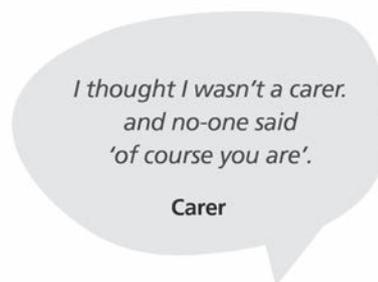
The Toolkit, however offers hope for change as it is useable by all stakeholders. Carers can use the toolkit to understand what services could be doing for them and are given the background information to gently challenge them. For commissioners there is the opportunity to have more informed conversations with carers and reframe the questions they may ask of providers. For providers they can begin to think about the issues faced by carers and how they might be addressed along the care pathway and begin to share good practice with other secure services. Central to this is the Royal College of Psychiatrists’ willingness to adopt the toolkit and share it across secure services through their Quality Network. Finally it’s hoped that service users will use it to give them an understanding of the journey faced by their family and friends and ask for better support and involvement for them.

This is a beginning for carers in secure services. Their stories and experiences are rarely heard and this needs to change. The toolkit is unlikely to have covered all the issues but it’s a start. There is hope for them in the future.



From the start, there was a clear commitment to using the ideas and experiences of carers with NHS England involving carers in writing the bid and reading the proposals. There was a clear working relationship with the researcher with carers refining the questionnaire, being interviewed, scripting and reviewing the films, developing the structure of the toolkit, and writing and reading through draft copies besides providing documents that had been found useful when challenging services. In all, over a 100 carers were involved in the process.

The Toolkit is written in such a way that there is an obvious pathway outlined following the carer’s journey through the system, for example assessment, admission to secure care etc. Each of those sections are then divided into key issues faced by carers, (based on the research finding), what carers should expect from services, good practice examples with





Trainers and delegates on the March 2018 Training Trainers course

Training Trainers Course – Spring 2018

By Chris Mansell – Deputy Director, Meriden Family Programme

We held our 22nd Behavioural Family Therapy (BFT) Training Trainers and Supervisors course in March 2018. Demand for the course remains high with 39 people attending. 562 people worldwide have now completed this course and are able to deliver BFT training and facilitate supervision to support the implementation of family work.

This course had representation from England, Ireland, Scotland, Wales and Japan. We were really pleased to have our first participants from Northern Ireland and they already have a series of training courses and a programme of supervision planned.

The purpose of the course is to provide participants with the skills necessary to train and supervise people in the use of family interventions for those experiencing mental health difficulties including psychosis, depression and bipolar disorder. The course is participative in nature and provides participants with the opportunity to practice skills and to receive feedback from fellow participants and from the facilitators. Participants learn skills for use in straightforward training and supervisory situations relating to family work, and also how to handle unexpected events and awkward questions and situations.

Feedback from the course was very positive and included the following comments:

“Every part of the training was 100% relevant to me in helping me become proficient as a BFT trainer. The modelling by all facilitators was really helpful, the “keeping everything on track”, both content and presentation was excellent and again, really well modelled.”

“Very easy to understand, lots of audience participation which made learning fun.”

“I appreciated having the content provided via different methods e.g. practice, education and prompt sheets. This supported my learning and supported me throughout the process”.

“All the presenters were engaging, encouraging and approachable.”

Because of the continued interest we are holding a second course this year from the 15th – 19th October 2018. The course will take place in Birmingham – venue is yet to be confirmed.

If you would like further details about the next course or a discussion about Training Trainers please contact Sam Farooq on 0121 301 2888 or email samfarooq@nhs.net

Relative Peer Support: A new approach to supporting family members and carers of people with mental health difficulties

By Veronica Burke, Senior Social Worker, Bealach Nua Service,
County Mayo, Republic of Ireland

The involvement of relatives and service users with lived experience as peer supporters is an evolving phenomenon in mental health services. Different terms in different countries are used to describe family members who support other family members who have been affected by mental health difficulties or who advocate for change. Examples of different terms used are Relative Peer Supporter, Family-to-Family Peers, Carer Consultants, Family Peers and Relative Peers. Health Workforce Australia (2014, p. 5) identified 6 different titles used in Australia for the equivalent roles of Family Peer Supporter.

Family Peers have been defined as lay persons “who are experientially similar to the carers they are supporting” (Burnell et al, 2012). For the purpose of this article, I will use the term ‘Relative Peer Supporter’. This term describes family peers or carer supporters who provide one to one support to families, group facilitation or co-facilitation of psycho-education and those who are involved in education or organisational change, as often these functions are part of the same role.

As this relative peer supporter role is new, it is an area where there is little research (Burnell et al, 2012). The literature I reviewed focuses on all these roles mentioned above. It looks at literature on the role in a number of areas such as dementia, child health as well as youth mental health, focusing more specifically where possible on adult mental health. Because of the limited literature available, I refer to studies where the role is paid or voluntary rather than make a distinction between these two.

Different Models of Relative Peer Support

The relative peer support role has evolved and developed in a range of settings to meet the specific needs of families and service. In some instances, relative peer supporters are reimbursed or paid as in youth mental health services in the USA. In other instances they work in a voluntary capacity as in some dementia services in the UK.

Obrochta et al (2011) suggest there are effectively three organisational models of relative peer support. The models are the external models, where peers provide a service to the statutory services but are employed by an external family support agency such as Families Child Advocacy Network. The internal model is where peers are employed within the mental health care organisation such as Hathaway- Sycamores Child and Family Services in Los Angeles County. A third model is a blended model, where the relative peer supporter is employed by an external

agency but trained and supervised by staff in a mental health statutory agency.

Relative Peer Support Role in Ireland

In Mayo, the project I am involved with as a supervisor is called Bealach Nua. This project fits with the blended model of peer support as described by Obrochta et al. (2011). The relative peer supporters are employed by Shine, a voluntary organisation, and supervised and situated within the statutory Health Service Executive (HSE). They are trained in ‘Caring for Carers’, a group approach to supporting carers, provided by the Meriden Family Programme, U.K. (www.meridenfamilyprogramme.com). They also are trained by the Health Service Executive Social Work Mental Health Team and Shine who is their employer.

It is the first relative peer support service working within the Mental Health Service in Ireland to date. A key aspect of the role is providing one to one relative peer support to family members.

An advantage of locating the service within the mental health system but not directly within the multidisciplinary team is that family members whose relative does not consent to their involvement in their treatment and care can still access support for themselves and attend to their own support needs. This group can be particularly vulnerable and isolated. Supporting this group can also help reduce risk when a family member is supported to communicate important information to their relative’s mental health team or GP if their relative poses a risk to themselves or others. All our family members whose relative is involved with the service can refer themselves for support or can be referred by a professional or service user.

Our relative peer supporters are trained by Meriden to engage with families from a strengths-based, solution focused perspective. Grounded in the Meriden ‘Caring

for Carers' framework, the relative peer supporters role encourages relatives to focus on their own recovery. It also supports them to use practical strengths based skills and tools such as self care, communication skills, goal achievement, problem solving and staying well planning. Underpinning this approach is a focus on recovery principles and processes and a willingness to meet relatives where they are at in their own journey of recovery by supporting them to identify their needs.

Our relative peer supporters also facilitate opportunities for family members to network with other family members through wellness and education days. We know from evidence that family members who are able to reach out for support and talk to others do better in moving on with their own recovery. Relative peers also have a role in changing organisational culture and educating staff. The advantage of positioning the relative peer supporter's role within the service is that relative peer supporters can be involved in training staff and can involve themselves in policy and other committees internally in the organisation to promote organisational change from within.

Our evaluation by Dr Mark Garavan in the Galway Mayo Institute of Technology demonstrated as a result of family members' engagement with the project that:

- Families ability to cope increased almost two-fold
- Families had increased levels of satisfaction with the level of information provided around responding to their relatives needs
- The peer support model offered something unique in terms of relational empathy
- Bealach Nua also provided families with the opportunity to network with other families and share experiences and build resilience

Relative peer supporters also more recently took part as paid employees of Shine in a pilot project in Limerick and in South Dublin as volunteers in the early intervention in psychosis DETECT service. In Kilkenny and Carlow they work as volunteers under the Carers' Association of Ireland. Clearly in Ireland the role is evolving. However, in the case of Bealach Nua, the role is located in the Mental Health Service which facilitates relative peer supporters taking on a change agent role within the mental health system and ease of access for family members whose relatives are engaged with the services.

Evidence for Relative Peer Support

The relative peer support role in the USA originated predominantly in the child health area. Ireys et al (2010) conducted three randomised controlled studies over a 10 year period of parent to parent support programmes for families with children with a chronic illness and found that the mothers of the children benefited from information, affirmation and emotional support as a result

of the intervention provided. Rodriguez et al (2011) in their study of youth mental health found that professional relative peer support involvement with families showed an increase in family empowerment, skills and self-efficacy as a result of the intervention.

Geraghty et al (2011) in their evaluation of the paid consumer consultant role in a youth mental health inpatient unit in Brisbane suggest that the carer consultant has a dual benefit in terms of education of staff and in empowering families in acute distress. Leggatt & Woodhead (2015, p.5) outline the role of the paid relative peer supporter in the Orygen Youth Early Intervention mental health services in Australia and explain its strength lies in the partnership it builds between teams and families so that families can be offered a better range of interventions.

Relative Peers Facilitators of Psycho-Education Programmes

Evidence of the effectiveness of relative peer support role has focused mainly in the area of family psycho-education. Peer support programmes for carers of people with mental health difficulties have been reported to improve carers' knowledge, increase confidence and reduce stress (Dixon et al, 2004). Chien et al (2005, p. 605) in their study of Chinese families of a relative with schizophrenia reported that those in the mutual support group showed a statistically significant improvement in patient and families' level of functioning when compared with psycho-education delivered by professionals or standard care. Kluge & Kissling (2008) reported that peer-led family support produced short-term gains in knowledge and understanding of the illness similar or even better than courses run by professionals.

Benefits of Relative Peer Support Role

1) Engagement of Families with Mental Health Services

The Health Workforce Australia (2014, p.12) identifies engagement as a key benefit of the relative peer support role. Olin et al (2015) report that relative peer supporters had a role engaging parents who were angry and alienated from services. Burnell et al (2012) explain this in terms of the McPherson's (2001) "homophily theory" which suggests people find it easier to bond and connect with people who have been through similar experiences, as they feel they can better understand them.

They argue that the authentic nature of the engagement makes it more likely that the relative peer supporters can act as a role model and thereby encourage changes in behaviour, emotions and thoughts.

2) Empowerment, Emotional Support, Social Support and Education

Chien et al (2004, p. 605) argue that relative peer led supporters' role is an empowerment oriented model that gives participants more opportunities for information sharing and emotional and social support from others in a similar situation, which reduces stress and self-

blame. Obrochta et al (2011, p. 2) point to a “decrease in internalised blame and a strong focus on self-care”. Lucksted et al (2008) suggest that the self help model works for families because it gives families coping skills, it provides an opportunity to process the trauma and it links participants with a network of support.

This is reinforced by Health Workforce Australia (2014) study on relative peer support, which outlines that relative peer support can empower families and educate them, improve family relationships and provide links for families to a valuable network of social support. Geraghty et al (2011) explain the stigma of mental illness isolates families during a time of great trauma and difficulties around dealing with services. Families reported that they valued the support for their own needs from consumer consultants who had experienced mental health difficulties in their own family.

3) Identification of Carers Who Are Acutely Distressed

Looking more specifically at the role of relative peer support and what it provides, Olin et al (2015) in their study of parent depression and anger in peer-delivered parent support programmes in New York suggested relative peer supporters have a role in identifying carers at risk of depression. They identified that 64% of parents who engaged with relative peer supporters reported clinically significant depression. Supporting these parents to seek assistance for their own needs will undoubtedly benefit their children. Leggett & Woodhead (2015) noted that support for distress was a common theme in their study of early intervention services. Mothers were those most commonly engaged by the relative peer supporters, with a range of strong emotions including shock, exhaustion and sadness identified as prevalent themes.

4) Changing Organisational Culture

Leggett & Woodhead (2014) outline the role the relative peer supporter has in terms of organisational change. This organisational change role of relative peer support is also mentioned in the Health Workforce Australia (2014). Geraghty et al (2011) point to the valuable resource that consumer advocates with self experience can be to staff by widening their understanding of relatives’ experiences so they can better empower staff and families to collaborate more. Consumer consultants also have a role in recommending changes in the organisation to improve the quality of the service for families and service users. They also noted a change in how staff behaved in dealing with families who were linked with the consumer consultant. In particular staff work in a more collaborative manner with the families supported by the consumer consultant.

Positioning the relative peer support role within the mental health service allows greater access on a daily basis to staff which in our experience in Bealach Nua increases opportunities for changing the organisational culture. We have had a role every year in training health care staff, nurses and medical staff as well as authorised officers to broaden their understanding of how families can be impacted by health difficulties.

Challenges of Relative Peer Support Role

As the role is a new and evolving role in a mental health system that is traditionally medical and hierarchical, it is not surprising that it presents both the organisation and the relative peer support role with challenges. Rodriguez et al (2011) call for research to focus on the organisational issues that act as barriers to provision of a quality family advocacy service. Other issues identified were poorly paid jobs, role confusion and conflict, negative staff attitudes, issues around confidentiality and poor opportunities for support and networking as barriers faced by peer support workers in Australia.

Demands of the Role

One of the difficulties with the relative peer support role is that it encompasses a range of different functions Bell et al (2014, p. 13). The role of relative peer support includes family peer support and advocacy and sometimes these roles will be performed separately. Watson (2013 in Bell et al (2014, p. 109) argues that the peer support and advocacy roles should be separate because they call for a distinctly different skill set. Eastern Health Adult Mental Health Service (2009) also pointed to the challenges of the relative peer supporter taking on dual roles as a carer consultant and a family peer due to the limited time available in the role.

Role Boundaries

Clear boundaries around the service provided is important as often relative peer supporters come in contact with a lot of unmet needs in families and therefore need to be assertive with families and service providers around their role. In some settings, the powerless nature of their role can leave relative peer supporters vulnerable.

Wisdon et al (2011) reported that some families reported a lack of confidence in the relative peer support, when they failed to respond immediately to the parents concerns. This was noted by Wisdon et al (2011), who reported in their study of the process, content and context of family to family support services that in some instances family peers overstepped their role by asking to take on a parental or therapeutic role, working directly with the child or in some instances the relative peers shared their own experiences in an unhelpful way.

Recruitment and Training

Health Workforce Australia (2014) identified poorly paid jobs as a barrier to retaining staff. The need for core competencies and certified training for relative peer

supporters was outlined in a number of reviews and studies (Eastern Health Adult Mental Health Service, 2009). Rodriguez et al (2011) point to the lack of research done into the background, work experience and context in which relative peer supporters are employed. In their study, they found that the more experienced relative peer supporters demonstrated more effectiveness in their role.

Core competencies were also mentioned as essential and have already been developed in America by The National Federation of Families for Children in Mental Health (Obrochta et al, 2011) who provide a national certificate for peer workers. In Australia, Mind Australia run five day relative peer work courses as well as a more advanced course as a basic requirement. A peer must have a Certificate IV as a minimum entry requirement for employment in the Mental Health Services (Bell et al 2014).

Supervision

Obrochta et al (2011) argue that staff need regular individual supervision, peer supervision and team days to facilitate connecting with other family peers so that they can support each other in their role. They also argue that it is important to provide relative peer supporters with an opportunity for advancement and further training so they can develop skills and enhance their opportunities for advancement. Copes (Bell et al, 2014) provided staff mentors and champions for their relative peer supporters as a way of supporting their integration into the mental health clinical teams. They also provided individual and peer support supervision (Eastern Health Adult Mental Health Service 2009). Olin et al (2015) argue that more attention needs to be paid to the psychological impact of the role.

Evaluation

Obrochta et al (2011) argue for the need to evaluate Family Peer Advocacy in terms of outcomes for families and service users. They look in particular at a number of areas that could be focused on such as improvements in empowerment, self-efficiency, carer well-being and satisfaction. Rodriguez et al (2011) point to the need to developing quality indicators to standardise and quality approve relative peer supporter service provision. This study suggests that agreeing clear goals and outcomes measures are crucial to judging success of the relative peer supporter role.

Leadership

Copes found that the project was sustained as a result of the combined efforts of a number of different agencies which helped build and establish the project both internally in the adult mental health service and externally in the community. Bell et al (2014, p. 16) point to the key role played in preparation of the service for relative peer supporters

through consultation and engaging stakeholders. Without this work, the burden on the peer is much greater. Obrochta et al (2011, p3) talk about the need to address organisational culture and the importance of relative peer supporters working in a family friendly environment with a leadership team committed to working in partnership with families.

Summary

This article outlines the available research evidence that the relative peer supporter role can be beneficial in terms of engagement of angry and distressed carers as well as providing valuable information, emotional and social support to family members and carers. The relative peer supporter role can also assist in building a more collaborative and family-friendly culture in mental health services. The challenges include having clear boundaries for the role as well as ensuring relative peer supporters get adequate support, supervision and training. It is also crucial that relative peer supporters work in an environment that is supportive and promotes quality assurance. The need for clear guidelines around the competencies necessary for the role, training and accreditation need also to be examined further.

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Training Carer Peer Support Workers – a new initiative in Birmingham and Solihull Mental Health Trust

Gráinne Fadden (Director), Peter Woodhams (Carer Consultant) and Sana Rana (Psychology Research Assistant), The Meriden Family Programme

Background

Peer support and peer-delivered services are a relatively recent addition to mental health services but have quickly become an integral part of the system. Peer Support Workers (PSW) are those with lived experience, either as someone who has experienced a mental health condition, or someone who has cared for a friend or relative with a mental health difficulty. Peer support workers are becoming part of the professional multi-disciplinary team and support care and recovery by sharing their own stories and experiences with their peers. McPherson and colleagues (2001) suggest that people often find it easier to talk with others when they share similar experiences, as they feel better understood. To date, most of the initiatives in this area involve service user peers (Pitt et al, 2013), and carer peer support is less well developed (Burnell et al, 2012). The literature on peer support in services in general is developing (Repper and Carter, 2011, Chinman et al, 2014 and Johnson et al, 2014).

Development of carer peer support training in Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)

BSMHFT have recently trained and employed service users as peer support workers. In parallel with this development, we developed a training curriculum for carer peers and have trialled it with a group of carers and family members



Shelagh Musgrave receiving her certificate from Sue Hartley, Executive Director of Nursing, BSMHFT

who were interested in offering support to other carers either in a paid or voluntary capacity. The initiative was approved by management in the Trust and we began the process of co-producing the initiative and curriculum with carers. Family members were involved right from the outset.

Our first step was to promote the idea with carers. The proposed training was advertised



Left to right: Gráinne Fadden, Les Bloom, Shelagh Musgrave and Peter Woodhams

across the BSMHFT area by email, through the trust website and flyers were displayed across trust sites. Information was also distributed by word of mouth, through Trust staff and through our partner organisations such as the Home Group. Following this, five consultation meetings were held at various sites, to accommodate carers from across the city.

The purpose of these meetings was to give carers the opportunity to voice their views on the training programme and the Carer PSW initiative; the contents of the training curriculum, the role of a Carer Peer Support Worker, benefits and limitations of the role, and potential employment opportunities. Thirty-two carers attended the focus groups.

Topics discussed included:

- Characteristics of a Carer Peer Support Worker
- Potential roles
- Training curriculum
- Benefits
- Selection and recruitment to training
- Support to be provided to carer peers following training
- Expenses and payment
- General comments

The focus groups provided rich and detailed views on all of these topics, facilitating the development of a training curriculum.

Recruitment and selection for the training

Following the focus groups, any carers who were interested in applying for the training were asked to submit an application. Although initially, 30 carers expressed their interest, only ten applied. The reasons for not pursuing it included:

- Timing unsuitable due to other commitments
- Unable to invest the time
- Carer responsibilities
- Unable to get time off work

Ten carers were invited to an individual interview, nine were offered a place on the training and 8 attended the training, five female and three male.

Training curriculum

The training was held one day a week, with a total of ten sessions. The training curriculum was designed to cover a broad range of essential topic areas. Carers were consulted again before the programme was finalised.

Topic areas to be covered in the training programme included:

- Co-production
- Recovery
- Individual learning styles
- Confidentiality
- Problem-solving
- Encouraging hope
- Risk management
- Listening, showing empathy and communication skills
- Sharing own journey and personal stories
- Signposting to resources and services
- Diversity and difference
- Boundaries
- Ending contact
- Supervision and self-care

The style of the training was experiential, with participants being asked to participate in exercises in pairs, group exercises as well as individual learning tasks. Reading material relevant to each week's topic was provided at the end of each session and carers were encouraged to read this between the sessions. Trainees were encouraged to keep a reflective journal from the start of the training. Each week there was a 'guest speaker' either from the Trust or from partner organisations on a topic relevant to families and carers or linked with opportunities to work or volunteer within the Trust.

On one of the days a carer peer worker (Maria McGoldrick) and a social worker (Veronica Burke) from Ireland who have been involved in carer peer support work for the past

three years following training delivered through the Meriden Family Programme came to speak about their experiences with this type of work. Attendance at the training was excellent, although on occasion caring responsibilities meant that some participants had to miss some of the sessions.



Les Bloom receiving his certificate from Sue Hartley, Executive Director of Nursing, BSMHFT

Next steps

Following the training, we are now in the process of establishing e m p l o y m e n t

opportunities for those who have been trained, either in volunteer roles or in paid employment. Establishing these new roles requires the establishment of posts, job descriptions and role profiles. Those taking up these posts will also have to complete the mandatory training required by the Trust and undergo the usual checks required for employment.

Conclusion

This initiative has demonstrated that carers are interested in training as carer peer support workers. Like any new initiative, developing new roles in services presents challenges, and some of these have already been articulated (Berry et al, 2011, Repper & Watson, 2011; Kemp et al, 2012).

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A Model of Care for Forensic Families

By Dr Francesca Mantia-Conaty, Clinical Psychologist,
Secure and Complex Care, Birmingham and Solihull Mental Health NHS Foundation Trust

This article discusses the support we are putting in place for families in secure units in Birmingham and Solihull Mental Health NHS Foundation Trust. Firstly, it explores how caring for individuals with mental health needs and a history of offending behaviour affects families. Secondly, it presents our support plan for families.

Introduction

Several recent recommendations have been made regarding the support offered to the families and carers of service-users accessing mental health services in the UK. A recurring message is that carers require more support than they are currently being offered (Fish, 2016; Littlechild, 2015). These recommendations are largely based on findings from research exploring family or carer experience, with a key finding being that the majority of carers feel that healthcare staff do not do enough to directly provide, or signpost to relevant information and support (NHS England, 2014).

Families have reported a range of profound consequences to assuming a caring role in a forensic context; these effects could relate to their relationship with their relative, relations with services, or the effects of stigma. For many, this had implications for their personal sense of well-being and resulted in, at different times, experiencing a variety of intense emotions including sadness, intense grief, frustration, anger, shame, fear and anxiety.

The National Institute for Health and Care Excellence (NICE) provides national guidelines to improve health and social care. NICE has recently developed several evidence-based publications detailing the support that ought to be available to the carers of service users accessing mental health services (NHS England, 2017). In addition to this, the most recent set of NHS commissioning intentions make it clear that increasing levels of support ought to be offered to the carers of service users using NHS mental health services. Our project aims at supporting families and using their knowledge and experience to increase the effectiveness of mental health care and treatment. The support includes but is not limited to, informal support and advice to families and carers on issues such as mental health diagnosis, information and advice, support groups, and more formal family therapy including Behavioural Family Therapy (BFT) and systemic therapy.

Needs of carers in a forensic context

A number of the studies have explicitly sought to define the needs, experiences or concerns of relatives associated with being a carer for a detained person or their interaction with services (McKeown et al, 1995; McCann et al, 1996; Ferriter et al, 2003; MacInnes et al, 2013) and there is one published literature review (Tsang et al, 2002).

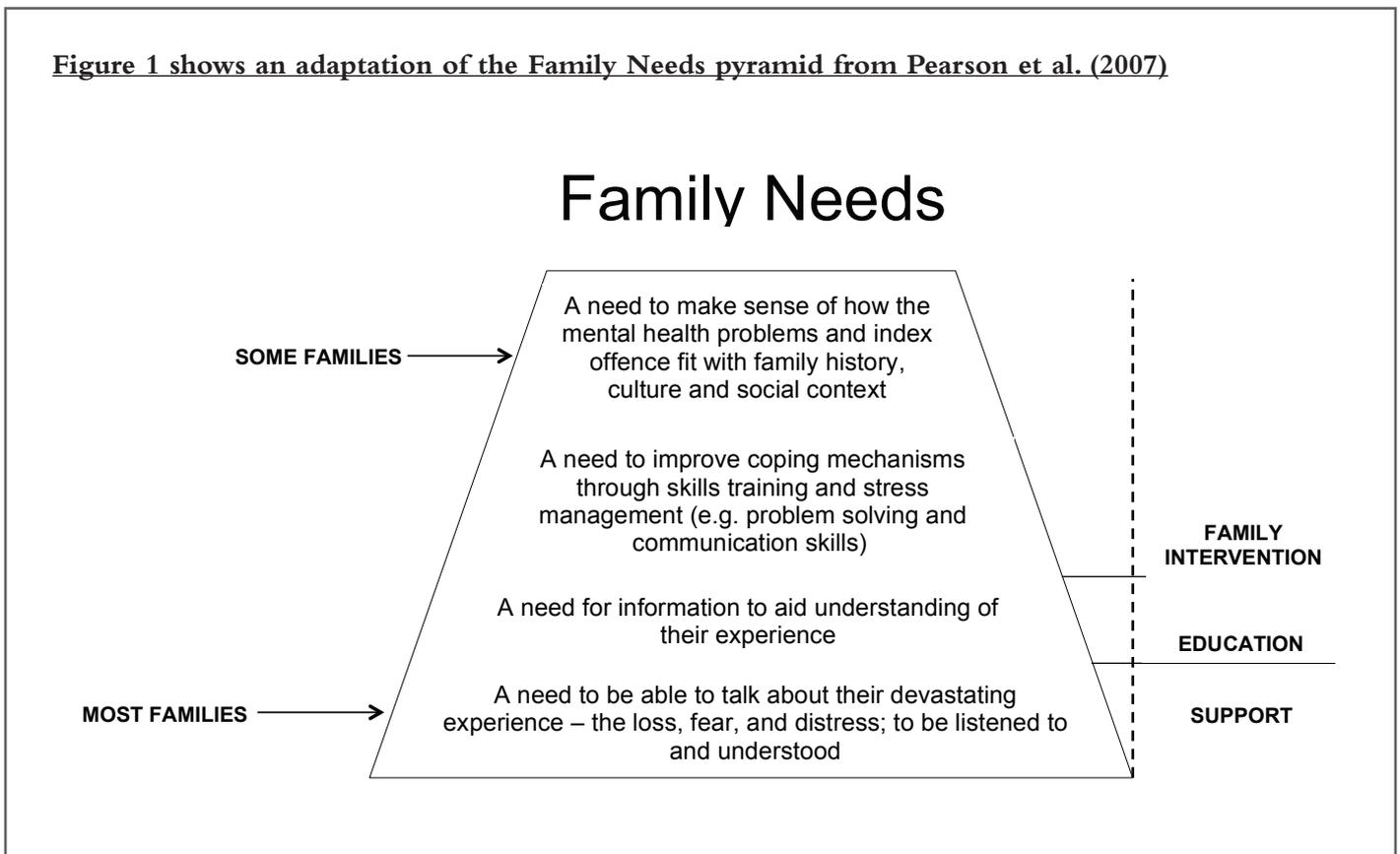
Taken together, these studies describe key issues for carers that include:

- The physical separation involved in visiting institutions away from home, which can weaken levels of support and contact.
- Increased stress or burden of care compared with carers of non-forensic service users, including fear of experiencing violence.
- Stress in their dealings with services, including the forbidding nature of security regimes.
- Stress resulting from experiences relating to the actual index offence and treatment by the police or the courts, or anxieties associated with negative media coverage of forensic services.
- The double stigma of mental health in the family along with offending, sometimes including hostility from neighbours or in the media.
- Specialist and general information needs, complicated by the use of confidentiality issues by services to effectively exclude relatives from information or involvement.
- Practical and emotional support needs.
- Uncertainties around how to deal with their relative's mental health problems.
- Some families experience feelings of guilt and self-blame; they might feel responsible for the development of a mental illness.
- Some families highlight lack of involvement in the care plan and this can be a cause of stress and feed into anxieties for the future.

Our model of care for forensic families

This model takes into account the vast and heterogeneous needs families might have both in the inpatient and community forensic settings. We have found that a helpful way was to consider families' needs in terms of hierarchy (Mottaghipour et al, 2005; Pearson et al, 2007), although families' needs will not necessarily present in single categories and will not necessarily develop in a step-wise manner. We have adapted the Pyramid of Family Care framework developed by Dr Mottaghipour & Bickerton (2005) to support families in an Early Intervention for Psychosis setting.

Figure 1 shows an adaptation of the Family Needs pyramid from Pearson et al. (2007)



This framework is based on the same conceptual work as Maslow’s Hierarchy of Needs. The bottom levels include the family’s basic needs for information about the illness and orientation to the mental health service. The top level represents complex needs for interventions such as intensive family therapy.

The model describes four types of interventions described below.

SUPPORT. When first involved with services, all families would benefit from having the opportunity to talk about their (traumatic) experiences. This commonly includes a need to discuss their experiences related to the development of mental health problems, their difficulties in accessing appropriate help and feelings of fear, anger, loss and grief.

EDUCATION. When first involved with services, most families tend to require information about mental health issues, treatment options and how services work.

FAMILY INTERVENTIONS (level 1). A need to improve coping mechanisms through skills training and stress management. Many families will also welcome help with solving problems (e.g. about roles, responsibilities and achieving goals) and improving communication, and some will seek more in-depth exploration of issues.

FAMILY INTERVENTIONS (level 2). A need to make sense of how the mental health problems and the offences fit with family history, culture and social context. Some families will benefit from engaging in a more intense family

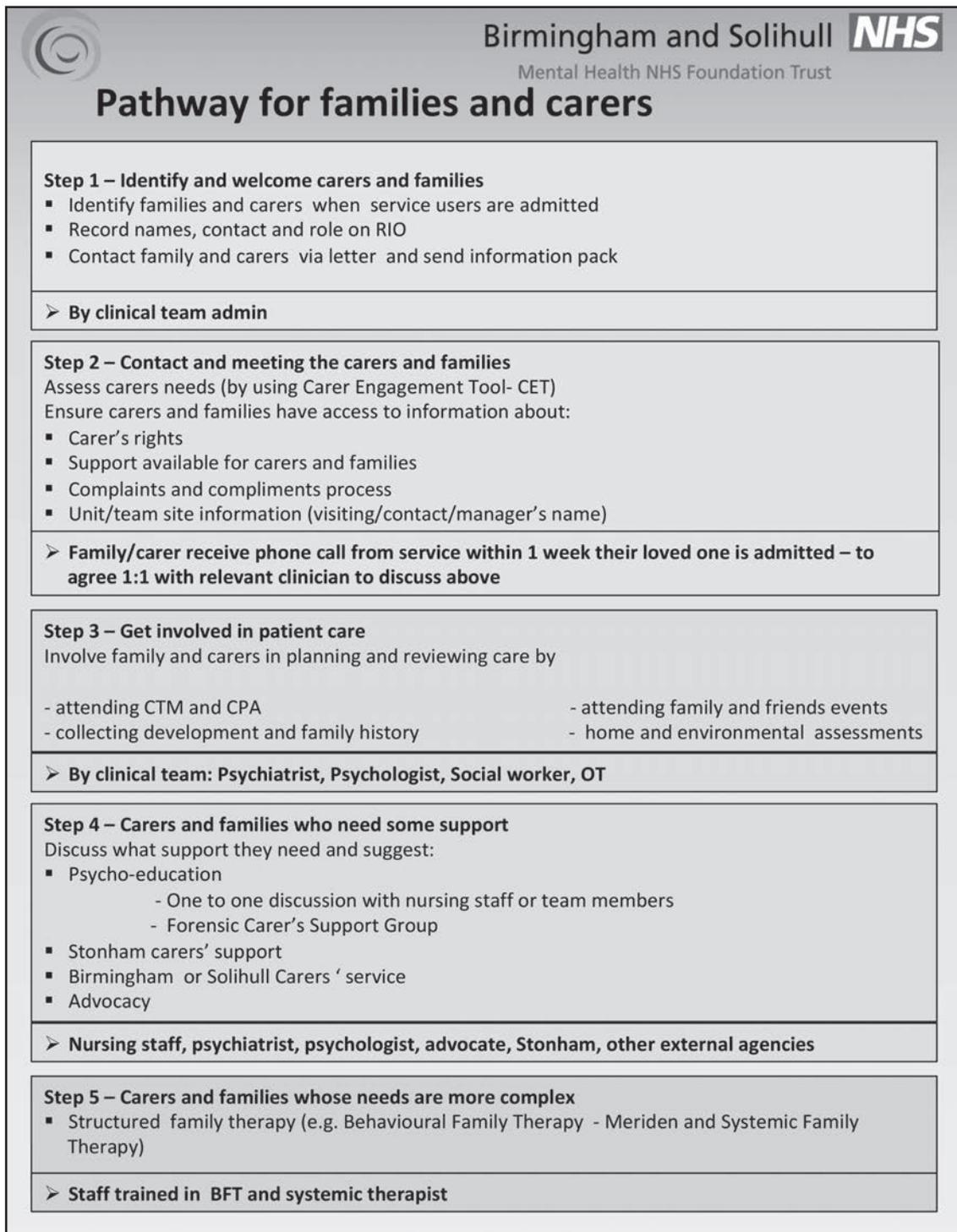
therapy which explores early trauma, adverse experiences and emotional and social attachment processes in childhood in order to understand the development of mental health problems, personality disorder and criminal behaviour.

Carers’ needs survey

A survey was conducted to explore multidisciplinary views in relation to family and carers’ psychological needs and level of support required. The survey was disseminated via Survey Monkey© to team psychologists and Community Psychiatric Nurses (CPNs) for a period of two weeks. Psychologists answered for inpatients and CPNs for outpatients. Respondents were asked to consider the families of service users in their teams, then indicate how many of their service users’ families required each intervention of the adapted Pearson’s model. An adapted version of the questionnaire was also distributed to service users’ families at the “Family and Friends Day” at Reaside Clinic and at the Tamarind Centre (both secure units).

Eleven clinicians responded to the questionnaire, representing ten clinical teams. Eight of the respondents were psychologists, and three CPNs. The respondents answered for a total of 142 service users, 105 were inpatients and 37 outpatients. Each team had an average of 13 inpatients, and 12 outpatients. While there was relatively little difference between most interventions, marginally more families were indicated as requiring psychoeducation (44%) and family interventions (45%) than requiring basic support (36%). A minority of service users’ families required intensive family therapy (22%).

Figure 2: Pathway for families and carers



Regarding the family and carers' responses, we had 28 questionnaires (15 from Reaside Clinic and 13 from the Tamarind Centre).

Of the respondents, 36% felt that they did not need any psychological interventions; 57% felt that they needed basic support; and psycho-education and, both levels of family interventions were similarly desired with 50%, 53% and 53%, respectively.

Overall, the responses emphasised the need to offer support to families and carers of service users accessing forensic services.

Service evaluation

The aims of this service evaluation were two-fold. Firstly we wanted to identify the support currently available to families and carers at the Tamarind Centre, Reaside Clinic and Ardenleigh secure services. Secondly, we wanted to hear staff perspectives on barriers preventing families and carers from engaging with the services.

For the first aim, we collected data from RIO records (our electronic recording system) using a structured data collection tool. For the second aim, we conducted a semi-structured interview with staff on each of the wards at the Tamarind, Reaside and Ardenleigh hospitals.

Our analysis found that telephone contacts accounted for the majority of interactions with the services (circa 70%). Nursing staff (circa 65%) were most often involved, followed by psychiatrists (circa 16%) and social workers (circa 10%). We observed three main types of contacts. Around half of all contacts (circa 50%) were initiated by families in search of practical information e.g. to book visits, to ask about contraband items. The second type of contact was initiated by staff in order to provide psychoeducation (circa 20%). The third type involved gathering information from families (20% circa).

We identified three main kinds of barriers preventing families and carers from engaging with the services: 1) barriers by families e.g. resolving engagement issues, trusting clinical teams, difficult past experiences with professionals; 2) barriers by staff e.g. staff capacity, further training required, lack of confidence; and 3) physical barriers e.g. time, money, distance.

Pathway for families and carers

The data available to us and the model of care discussed above (adapted from Pearson, 2007) have supported the development of our pathway for families and carers. This includes the following five steps (see figure 2).

Step 1 – Identify and welcome carers and families. This involves sending welcome letter and information pack to families and carers soon after their loved ones are admitted to the hospital.

Step 2 – Contact and meeting the carers and families. This involves contacting the families and offers a face to face appointment in order to give them the opportunity to ask staff questions, to hear their experiences and also assess their needs.

Step 3 – Get involved in patient care. This means involving family and carers in planning and reviewing care, understanding and respecting service user views by attending Clinical and Care Programme Approach meetings, family and friends events etc.

Step 4 – Carers and families who need some support. This involves discussing what support families might need including psycho-education (individual or group support).

Step 5 – Carers and families whose needs are more complex. This involves offering structured family therapy including Behavioural Family Therapy and Systemic Family Therapy.

Conclusion

Family work is essential to the wellbeing of our service users and carers. Our goal is to engage with families “from the beginning” (from the admission into our services) and to use their knowledge and experience to improve mental health care and treatment.

We know that working with families can be challenging. However, by offering a structured approach, we can assess the strengths and needs of families and enhance the effectiveness of our interventions.

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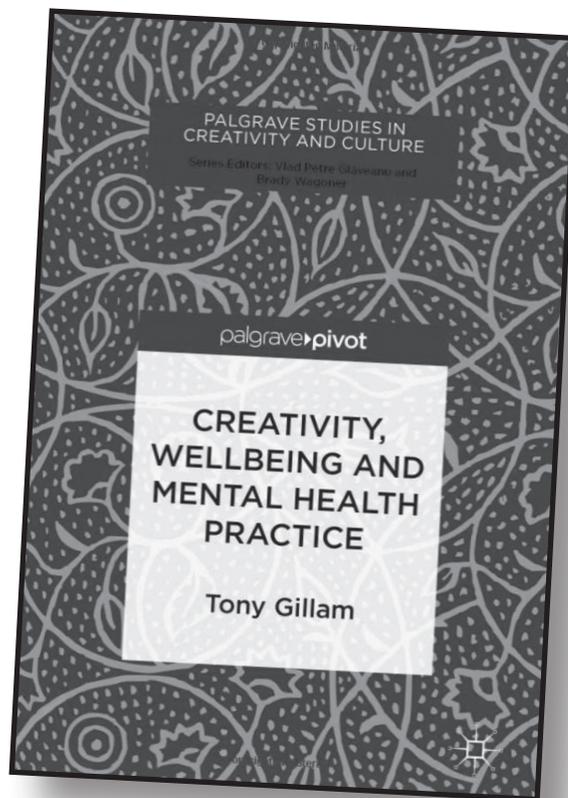
Creativity, Wellbeing and Mental Health Practice by Tony Gillam

Reviewed by Martin Atchison, Deputy Director, Meriden Family Programme

Tony Gillam will be a familiar face to anyone that has completed the Behavioural Family Therapy training over recent years. He is, of course, the family worker for Family 1 on our 'Family Work in Early Psychosis' set of training DVDs. He is also a musician, award-winning mental health nurse and author of both fiction and non-fiction. After working in mental health services in Worcestershire for many years, he is currently Senior Lecturer in Mental Health Nursing at the University of Wolverhampton.

Tony has produced a thought provoking book about creativity and wellbeing, writing about how they fit within mental health practice. Tony acknowledges throughout that these 'buzz words' are fuzzy, nebulous concepts, but that their applicability within mental health (often writing about mental health nursing specifically) is an important issue to consider.

Tony mentions early on that mental health nursing can be seen as a craft, a combination of skill (art) and knowledge (science). This is based on the Tidal Model, a model that argues that therapeutic nursing is interactive and about helping people to develop. Tony argues that creativity is a significant factor in this and that the mental health nurse will help to craft wellbeing through interacting with others.



Chapter 2 helps the reader to understand the concept of creativity, with Tony referencing and combining a number of definitions of this term. Some of the terms used include:

- An ability to produce work that is novel and appropriate
- A creative response to a problem that is good and relevant
- Novelty, effectiveness, ethicality

He argues that in order to be an effective mental health practitioner who is committed to the job, that person should utilise creativity in their work. He writes that it would be difficult to do your job without a sense of imagination, inventiveness and critical thinking.

Creativity can also be seen as a life affirming activity, not only for mental health practitioners, but for everyone. Creative people enjoy greater health, and becoming involved in creative activities has long been acknowledged to have benefits for people in terms of self-esteem, and physical and mental health. This was acknowledged by

the 2004 U.K. government's Social Inclusion Programme, which advocated increased access to arts, leisure and sports. This has been part of mental health care for a long time, with social activities playing a role in the old asylums. It was interesting to note that when the Meriden Programme were in Ireland delivering training for the new Early Intervention services, there were a couple of the older hospitals that we trained in that still had a nine-hole golf course within the grounds.

Tony discusses how organisations can sometimes stifle creativity, with clinicians feeling that there is a safety first, tick box culture, with the increase in paperwork being a factor.

The book moves on defining wellbeing, a word that has become very fashionable over recent years. Tony offers several definitions of the term which again is hard to pin down. The terms include:

- Positive emotion
- Meaning
- Engagement
- Accomplishment
- Relationships

Interestingly, he mentions how the shift from the term psychiatric nursing (concerned with mental illness) to mental health nursing (concerned with mental health) created a shift in how the role was seen. He wonders if there will be a shift to the term wellbeing nursing in the future, with the role being more concerned with helping people to flourish, to be more resilient, and to have a positive lifestyle.

The reader then learns about two initiatives that Tony has been involved in around being creative, the award-winning music workshop that ran in Worcestershire for a number of years, and a creative writing workshop. These two chapters discuss the benefits of service users attending a creative group, with some discussion about how efforts to seek the evidence of the benefits of these groups can be stifling and hard to specify.

Tony continues to outline how wellbeing is part of the code of conduct for nursing, that the promotion of wellbeing is a statutory duty for local authorities, and that five ways to wellbeing (similar to the five-a-day guidelines for healthy eating) have been proposed by the New Economics Foundation. These are:

- Connect
- Be active
- Take notice
- Keep learning
- Give

We then learn about creativity in leadership, and the natural place for creativity is in leadership rather than management, which is more focussed on tasks. Creative leadership is about enabling the right culture to develop to allow creativity to emerge.

While reading this book I was reminded of the book by Robert M. Pirsig, 'Zen and the Art of Motorcycle Maintenance', which I read many years ago. This is 418 pages of a road trip in which the author tries to define the concept of *quality*. Another thought provoking book that makes the reader think about things in a new and different way. Tony's book certainly makes the reader think about the world of mental health in a different way and is highly recommended.



Behavioural Family Therapy (BFT) Training Trainers Five Day Training Course in Birmingham

Dates: 15-19 October 2018 and 4-8 March 2019
Venues: To be confirmed

Our annual Training Trainers courses have been oversubscribed for the last few years so this year we have again decided to run two courses so please make a note in your diaries of the dates now!

The first course will take place this Autumn from 15–19 October 2018, and the second will take place in the Spring from 4–8 March 2019. Both will take place in Birmingham. Venues to be confirmed.

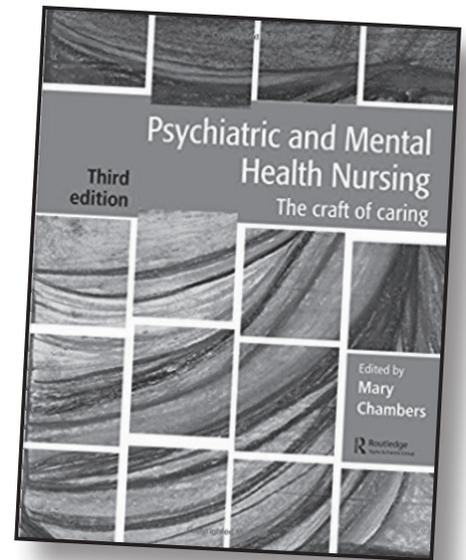
We are now taking bookings, and as places are limited please get in touch as soon as you can if you would like to confirm your attendance on either course. Remember, you need to be trained in Behavioural Family Therapy to be eligible to train as a trainer.

Please contact Sam Farooq on samfarooq@nhs.net or telephone 0121 301 2888 for further information.

More details of what the training involves can be found on our website
www.meridenfamilyprogramme.com

‘Family Involvement and Support Networks’ Chapter in *‘Psychiatric and Mental Health Nursing’ Book*

By Jeanette Partridge, Carer Consultant,
Meriden Family Programme



When the second edition of Psychiatric and Mental Health Nursing was published by Hodder and Arnold in 2003, Chapter 52, quite rightly in our opinion, stated **‘within mental health services there is an emphasis on the service user in isolation, and that ‘Consequently there is a lack of attention to the perspective of other people’**. Here we are in 2018, fifteen years later, and whilst some mental health nurses currently work well with families, we often hear from families who talk about their struggles to be involved in their relative’s care. Since the whole focus of the Meriden team is working with families, Martin Atchison, Jo Twiss and myself undertook the responsibility of rewriting the chapter entitled Family Involvement and Support Networks for the third edition of this book.

The three of us wanted to make it clear from the very start what the learning outcomes should be. Each key point we listed in the opening summary contained the word ‘family’ to direct the readers attention to that being the focus. The introduction pulls no punches in stating that working with families can be challenging compared with just working with the service user. However, in whatever setting a mental health nurse works they are in a prime position to positively influence a family’s response to their loved one becoming unwell.

We then provided an outline of the chapter that included families’ real experiences of mental health, what they find helpful and how the sharing of accurate information is so important to families. This paragraph concludes by stating that those mental health nurses who succeeded in **crafting a relationship between themselves, the service user and the family** would create a win, win, win situation!

The first two sections of the chapter take on a practical approach and are divided into reflective exercises plus both the service user and carer perspective.

Mental health nurses are asked to think about a time when a member of their own family was unwell (physically or mentally) and what affect that had on them. This exercise

has been used the world over and has proved to promote an understanding of what emotions are felt and how families behave as a result. It is a sad fact that families can be labelled as ‘dysfunctional’ or other such terms because they display these raw emotions when they are at their most stressed. From a family’s perspective, they are feeling bad enough without being labelled a problem. Far better the clinician tells the family it is definitely not their fault.

The next reflective exercise asks the reader to think of what services did well and what could have been done differently when a family member of their own was unwell. We would hope that typical responses to the first part of the question include being given information or being listened to. This is about the family being valued and that their attempts to come to terms with their relative’s ill health are recognised. Hopefully the reader will see that, in doing this, everyone benefits.

The next section talks about High Expressed Emotion (HEE) within families and how this term can be used in a negative context. The narrative links back to the first reflection exercise and encourages the reader to view HEE as a **normal response to a stressful situation** which results in better working relationships with families. The carer’s perspective explores the reasons behind WHY families show HEE to support the fact that families do not choose to be critical and hostile. They want their feelings understood.

A lengthy section follows on the much debated and complex subject of confidentiality. It recognises the difficulties for the mental health nurse to work with families and those that are mindful of breaking confidentiality. It also lists the potential anxieties felt by service users for information to be shared with their families. One way for a mental health nurse to be clearer is by reading the **Partners in Care leaflet on Confidentiality** together with colleagues. It also asks that assumptions should not be made that the service user does not want their family to be involved, or that confidentiality is used as a reason for

not listening or not giving information so the family can support their relative. From one service user's perspective, it illustrates how when acutely unwell '*I had abhorrent thoughts of my mother and a distorted view of family life. Yet my family's involvement was my only contact with the outside world*'. And the carer's perspective comment made it clear that the family are in a better position to cope and be more confident in supporting their loved one having been given generic information. The summary reassures the mental health nurse that families don't want to know the sensitive personal details of their relative, but that they need information in order to play a part in their relative's recovery.

The next section is entitled Services for Carers and is divided into the sub headings: carer's assessment, carers' groups and carer support worker. A carer's assessment and care plan, it points out, is a good starting point to involve families and it is something they are entitled to have and so should not be denied by mental health services. A carers' group, whether one that has an open format or an educational one, can be a lifeline for families. It is a place to gain peer support, to learn new ways of supporting their relative and to start looking after themselves. Carer support workers can also provide support in this way.

Readers are then introduced to The Triangle of Care, a document which came about in 2010 originally for mental health staff in acute services and subsequently adapted across all fields of mental health care in 2013. Its creation was the work of Alan Worthington who talks about how it came into being. It has six key elements including a self-assessment tool in order to improve partnership working between mental health services and families. The fact that it has a wealth of good practice examples must surely enthrall the reader to take this guidance into their practice.

We now get treated to a mention of Behavioural Family Therapy (BFT) a means to engaging with families consistently. Core principles of BFT are listed as follows:

- 1) The approach to the family should be positive.
- 2) The expertise and skill of the family is recognised.
- 3) The actions of the family are seen as their best efforts.
- 4) Distinguish between the actions of the family and their intentions.
- 5) Every family has its own culture.

Later in the chapter the key elements of BFT are explained as **Individual Assessments, Information Sharing, Staying Well Plans, Communication Skills, Problem Solving and Family Meetings**.

Mental health nurses would do well to remember if nothing else how this kind of family work sits perfectly with the **craft of caring**. And if they follow the recommendation of familiarising themselves with the model they will have a good chance of seeing how this evidence based approach can be adapted to suit every family. The carer's perspective reiterates what a positive effect BFT can have on a family.

A short paragraph then, makes it clear that **it is vital for mental health nurses to take time in involving siblings** as they can be the keepers of vital information that the rest of the family are not privy to.

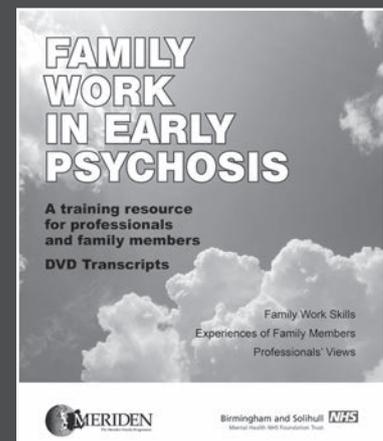
The concluding paragraph of the chapter includes a very important message. Mental health nurses may have a view that involving families takes too much time, and time away from working with the service user. However, involving families at an early stage can save time in the long term and families are an important resource that can help the mental health nurse with their role.

Family Work in Early Psychosis DVDs Now Available with Subtitles and Transcripts

Our updated 'Family Work in Early Psychosis' DVDs are now available to purchase.

The DVDs have English and Japanese subtitles on them and also have an accompanying transcript which makes it easier for those who struggle with regional accents or for those with hearing difficulties.

Please get in touch with Maria Albanese on maria.albanese1@nhs.net or call 0121 301 2895 if you would like further information about these.



Happy 20th Anniversary, Meriden!

I know it sounds like a bit of a cliché to talk about where the time goes, but it really doesn't feel like ten years since we were celebrating our 10th anniversary. At the time, we were pleased that the Programme had survived the vagaries of health service systems, methods of funding and changes in the structure and management of organisations.

The first ten years of the Programme were focussed primarily around the West Midlands area of England which to us seemed a large area at the time – a population of over 5 million – when compared with implementing an approach in a single organisation. It meant we were dealing with many different management styles and organisational cultures which at times were a challenge to navigate.

Over the past ten years, our focus has been much broader, first nationally, then more widely in the UK, and in recent years providing training, supervision and consultation in other European countries. We worked over a number of years in Australia, Republic of Ireland, Nova Scotia in Canada and with colleagues in Japan. Through the Commonwealth Fellowship Scheme, we have been able to influence the development of services for families in Nigeria and Uganda. What has stuck with us through all these ventures is how similar the issues are, whatever the country.

We have been pleased to take part in large developments such as the Health Education England initiative to ensure that staff in Early Psychosis Services are trained to deliver evidence-based family interventions.



In a service area where many programmes do not survive beyond the 'project' stage, we are delighted to be celebrating twenty years of influencing the types of services that are delivered to families. Any tips to pass on to others? Well, being able to adapt and change in the constantly shifting environment we're in, and to take all opportunities that come along. The communication and problem-solving skills that are central to our model have helped in our relationships with others. Believe in what you're doing. And most of all, engage with families every step of the way to ensure they are heard and listened to.

THE MERIDEN FAMILY PROGRAMME CONTACT DETAILS

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

Gráinne Fadden , Director	Tel: 0121 301 2711	Email: grainne.fadden1@nhs.net
Martin Atchison , Deputy Director	Tel: 0121 301 2889	Email: martin.atchison2@nhs.net
Chris Mansell , Deputy Director	Tel: 0121 301 2894	Email: chris.mansell1@nhs.net
Alison Lee , Clinical Specialist	Tel: 0121 301 2892	Email: alison.lee12@nhs.net
Paula Conneely , Clinical Specialist	Tel: 0121 301 2710	Email: paula.conneely1@nhs.net
Julia Danks , Clinical Specialist	Tel: 0121 301 2893	Email: julia.danks@nhs.net
Peter Woodhams , Carer Consultant	Tel: 0121 301 2708	Email: peterwoodhams@nhs.net
Jeanette Partridge , Carer Consultant	Tel: 0121 301 2896	Email: jeanette.partridge@nhs.net
Sam Farooq , Business Manager/PA to Dr Fadden	Tel: 0121 301 2888	Email: samfarooq@nhs.net
Nadine Berry , Team Administrator	Tel: 0121 301 2896	Email: nadine.berry@nhs.net
Maria Albanese , Team Administrator	Tel: 0121 301 2895	Email: maria.albanese1@nhs.net

Fax Number: 0121 301 2891 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: samfarooq@nhs.net or telephone on 0121 301 2888.