



Vol 4 Issue 1

June 2014

Once again this time around, there has been quite a gap between newsletters. I hope that our regular readers were not concerned that we might have ceased production of our newsletter. I know how much it means to many people to receive it, even if it is at erratic intervals. We often get feedback that it helps to keep people motivated to press ahead with supporting the implementation of family work.

So here we are again, and the reason for the gap has been that we have been quite busy as usual with our various activities, both locally in Birmingham, the West Midlands, and much further afield. We hope you enjoy the variety of articles reflecting the diverse developments in family work, both in the UK and in various centres worldwide. So as usual, this newsletter is varied, with reports from different areas geographically, accounts from family members who have received family work, articles on different themes, and information about new materials that have become available since our last newsletter was published.

Starting with the development of family work in different centres geographically, we were pleased to welcome for the third year in a row, a group of people funded through a Commonwealth Fellowship Scheme. This year we had four very enthusiastic clinicians from Nigeria who have already started to lay the groundwork for the development of family work in their local area since their return. You can read the item on their experiences and the challenges they face in starting this from scratch. One positive thing that makes it easier for them is that there is already a focus on developing Early Intervention Services in Nigeria, and this facilitates an emphasis on family work.

We have also been very active in a three year initiative to develop family work in the newly developing early psychosis services in Ireland. This has been one of our main areas of work over the last year, with training courses taking place in the different geographical provinces across the Republic of Ireland. We have been so impressed with the enthusiasm of everyone to get this work going, and our plans there continue for the next two years, with a 'Training for Trainers' course being held next year in order to develop local capacity to deliver on-going training and supervision.

Our work in Nova Scotia is also well developed now, and having started in the capital Halifax, for the last two years we have been rolling this out province-wide. Again the work there has really taken off with all of the districts keen to develop family work in their local services with wonderful support from the Department of Health in Nova Scotia. They are doing this in spite of changes to the whole way in which their mental health services are structured.

We also had a social worker with us on an eight week placement from Singapore. Jiat Khee describes her experiences and plans for supporting the development of family work in Singapore.

Finally, three of our team were pleased to travel to Japan in March to begin initial introductory workshops on evidence-based family work as phase one of a plan under the auspices of the family work movement Minna-Net. Their plan is to begin training of mental health staff to deliver family work across Japan. It is wonderful to see such interest in different countries to ensure that family work is available, but also humbling to see the challenges people face in many of these countries and the scale of the work that is required to deliver these services.

Moving on to other themes in this edition, we have a couple of articles on the theme of siblings – a group often neglected in mental health services but whose needs are great. We also have a description of work we are undertaking here in Birmingham to ensure that families receive some skills based training when a relative is admitted to one of our in-patient mental health units. We are continuing with the development of work for families of those with bi-polar disorder linked with Birmingham being a demonstrator site for Improving Access to Psychological Therapies (IAPT). Another initiative is described by Paula and Julia from our team where they have adapted our approach for working with troubled families. The BFT approach lends itself very well to working with people with these kinds of difficulties.

As always, it is good to have stories from family members who have received support, and we have some included in this newsletter, one general, and one from somebody with bi-polar disorder describing their experiences about how family work benefitted them. Alongside this, there is an account of a mental health worker describing how training in family work has helped with her own professional development.

There are numerous other items either on reports that have just been produced, or new publications such as the book of narratives of caregiver experiences, and Adrian Falkov's book on parental mental health. We also have mention of forthcoming conference and events.

So all in all a varied edition of the newsletter which I hope you find interesting and stimulating. As always we are very happy to receive newsletter items from anyone who would like to contribute. So happy reading and I look forward to hearing from anyone who would like to submit an article.

Very best wishes to you all,

**Dr Gráinne Fadden**

# Working with Families within an In-Patient Setting

**A pilot project to evaluate the impact of providing three brief sessions of family work to families while their relative is in hospital**

**Julia Danks, Clinical Specialist – Meriden Family Programme**

*As part of the commitment of Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) to the implementation of the Triangle of Care, involving families and carers in an acute setting has been identified as an area for development for the Trust. With this in mind, a joint working venture was proposed between the Meriden Family Programme and an acute female in-patient ward within the Trust.*

The Acute Care Declaration (2009) includes an important commitment from key stakeholders: **“to work together to encourage the commissioning and provision of high quality care by developing... a service which shows respect for people who use acute mental health services and their families and carers, and to include them as partners in care and provide support to other informal caregivers when needed.”**

Working with families in an acute setting has many benefits (and indeed challenges) for service users, families, staff and services. Family work has been demonstrated to reduce relapse rates and hospitalisation (Pharoah et al 2010) therefore having a positive impact on quality of life for service users and their families and cost reduction/avoidance for services. The content of this pilot is based upon the Behavioural Family Therapy (BFT) model of family work (Falloon et al, 1982).

In an acute setting where service users often have short admissions, it is recognised that a complete BFT intervention during their stay is not feasible. However, acute in-patient staff are ideally placed to engage with family members, to listen to their experiences of what it has been like in the run up to an admission, to find out what they find difficult, what would be helpful to know and to signpost to other services where appropriate. It is also recognised that whilst 70% of service users recognised when they were becoming unwell, 90% of relatives recognised changes in their relative (Herz and Melville, 1980) clearly giving a rationale for involving families in recognising early signs of relapse work. This early conversation with family members will help build relationships where each person feels listened to and involved as a partner in care and are able to be seen as real partners in the care of their loved ones.

The aims of the pilot are to assess the impact of involving families in discharge planning using a brief focussed intervention. The areas looked at will be:

- Impact on service user.
- Impact on family members.

- Length of stay.
- Impact on staff involved and their experience of working with families in this way.

The pilot is designed to build on the current good practice of the ward and complement this with a brief focussed intervention that aims to involve and inform the family in relation to information sharing, recognising early signs and problem solving issues around discharge.

A loose criterion was set for inclusion in the pilot to maximise the number of families that could be involved:

- The service user has had a previous admission prior to the pilot starting (in order to compare length of stay figures).
- The service user is being discharged back to a family home.

Medical staff (Responsible Consultants) involved in the ward were contacted prior to the start date and invited to comment on the proposed intervention. All responses received were positive and encouraging and they were keen to receive the results once they had been collated. Several doctors expressed an interest in this format being used on other wards.

## What does the pilot look like?

This is the format we follow:

- Identify service users who meet the criteria for inclusion.
- Engage service users and families.
- Complete pre-intervention measures and brief assessment with each individual involved.
- Session 1 – Information sharing.
- Session 2 – Recognising early warning signs.
- Session 3 – Problem solving.

- Discharge as appropriate.
- Post-intervention measures.

In addition we will:

- Interview service user, family and staff regarding their experience of being involved with the pilot.
- Collate results:
  - Pre and post measures.
  - Length of stay.
  - Service user experience.
  - Family experience.
  - Staff experience.
- Report results.

## Content of the sessions that are provided to families

Each of the three sessions is designed to last around 20 minutes.

**Session 1 – information sharing.** This session is intended to encourage the family to understand the experience of the service user more, so they will be able to support the person more effectively. It may also help to deal with any misunderstandings the family might have in relation to diagnosis and treatment. The service user is encouraged, prior to the session, to identify information that they would like to share with their family. The family are encouraged to identify what it would be helpful to know at this time.

**Session 2 – recognising early signs and developing a ‘staying well’ plan.** This session is designed to ensure all the family get involved in developing a staying well plan. It is important everyone understands that with a clear ‘staying well’ plan in place, it is much more likely that if the person begins to become unwell in the future, it can be picked up by the family much sooner, hence making it less likely that admission will be required.

**Session 3 – problem-solving.** Service users and/or family members may have concerns about the discharge process for many reasons. It can be helpful to reassure all concerned that their opinions and concerns have been heard and addressed. Staff work with the service user and family to help identify any areas of concern around discharge and work through a six-step problem solving technique.

## Progress so far

The ward manager met with me several times to talk about the pilot, what it would entail, how we would involve the ward staff, training requirements and what the finished product would look like. These meetings were very useful in helping to cement the intervention and I am grateful for the time the manager gave me during some very busy shifts.

I was able to spend time on the ward, getting to understand the ward routine, getting to know the staff a little bit, talking with service users about the pilot and whether they would be interested in their families being more involved in their care whilst on the ward. Of those service users I spoke with, all were happy for their families to be involved.

It was also useful to spend time on the unit to identify any major obstacles we might encounter during the delivery of the intervention. The biggest one I could see was staff time. Could this really happen when the demands on the staff are so high during a shift? Was this pilot too ambitious? Again the ward manager was extremely helpful and positive. She reassured me that once families were identified and nurses assigned to each intervention, they would diary the sessions in and do their utmost to ensure the session went ahead. So with that assurance I was hopeful that this pilot could have a positive outcome for all.

A six month pilot had been agreed for the early part of 2014. Admissions would be included for the purpose of the pilot from January to May 2014 with the remaining two months to complete any work already started. Due to capacity issues, the pilot has now been moved back to run from May to November 2014. This will also allow a second ward to be involved in the piloting of this brief intervention.

Posters and information leaflets for service users and their families have been designed which explain the brief intervention. Staff are geared up to promoting the intervention with people who are newly admitted and their relatives. Now all we are waiting for is the families to work with in this way. Whilst we understand admission can be a stressful time for everyone involved, we hope that involving families more closely during the admission process and in discharge planning will have a beneficial outcome for all.

I look forward to bringing you up to date with the results of the pilot in our next newsletter.

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# Supporting Siblings of Individuals with Psychosis

**Jacqueline Sin, NIHR Research Fellow, King's College London  
Leigh Wallbank, Mental Health Promotion Manager, Rethink Mental Illness,  
and Mark Hardcastle, Professional Head of Psychological Therapies/Consultant Nurse,  
Berkshire Healthcare NHS Foundation Trust**

Despite an increasing awareness of siblings' contribution to their brother or sisters' care and recovery, siblings of people with severe mental illness remain invisible in statutory and voluntary services. The last few years has seen the emergence of some strong campaigns focused on siblings issues and a few innovative services for siblings. These are led by charities across the world. We describe here Rethink Mental Illness' Siblings Network for brothers and sisters of people with mental illness, some best practice examples and the E Sibling Project, before suggesting ways to promote flexible support and services for siblings.

## Background

Nearly 90% of the population has at least one sibling (Milevsky, 2011; Buist et al, 2013). For most of us, our relationships with our brothers and sisters are some of the most significant in our lives, being a great source of mutual support over the course of our lifetimes. For people affected by severe mental illness whose social circle and contacts are often limited, their siblings may well be the only age-appropriate peers and a major source of social and practical support.

Nonetheless, siblings are often overlooked in the service provision of statutory mental health services where the "carers" are largely seen as parents, especially mothers (over 80% across studies and service survey). It is well established that siblings often do a lot to support their unwell brother or sister as well as their parents and the wider family, e.g. giving emotional and practical support to their parents through evening phone calls, taking their unwell brother or sister out for social activities and family gatherings (Sin et al, 2012; 2008). Many siblings also "inherit" the carers' role from their parents as they age or become unable to provide care (Friedrich et al, 2008). However, siblings' need for support and service remain largely un-answered.

## Recent research in understanding siblings' experiences and needs

In addition to the significance of the sibling relationships we discussed above, research over the last two decades has demonstrated that a positive sibling relationship, especially during adolescence, is a predictive factor in the siblings' future involvement in caring for individuals with schizophrenia and also associated with a higher quality of life in the service users. In young people affected by a first episode of psychosis, a positive sibling relationship predicts a more promising recovery trajectory (Sin et al, 2012).

Having a brother or sister affected by psychosis would almost definitely add a new dimension to the sibling relationship. Siblings often experience a range of negative emotions, such as shame, guilt, sorrow, worry, resentment, loss and grief. The challenges of adjustment and coping with the circumstances and emotional responses to having a brother or sister with psychosis in the family is likely to have a significant impact on family relationships. Such circumstances could bring a tremendous burden on the siblings, making them more vulnerable to mental ill-health themselves (Milevsky, 2011; Buist et al, 2013).

Amongst all these negative factors there are some positives. These were identified in a UK-based study which was conducted with siblings aged between 11 to 35, of young people with first episode psychosis (Sin et al, 2012). Some siblings described the experience of coping with psychosis with their brother or sister as "cathartic", that they felt supporting their brother or sister helped them become a better and more understanding sibling and individual and that the experiences they faced had somehow made their family stronger and more cohesive (see Sin et al, 2012 and Sin et al 2013, Cochrane review protocol for more details on recent research on the topic).

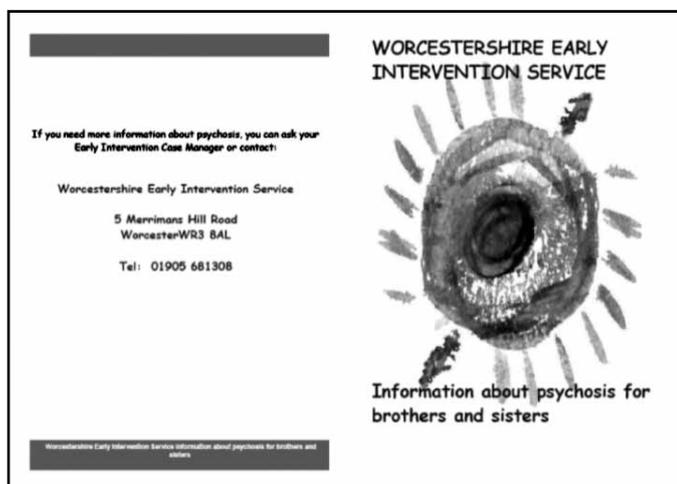
Conventional family and carer support resources (e.g. family work/intervention, carers' education and support group, voluntary carer services) are often under-used by siblings who are in a busy phase of their own lives. Our earlier study identified siblings' needs for information on psychosis and coping strategies coupled with peer (i.e. other siblings) support, delivered using modern information and communication technology, i.e. an internet-based/delivered information and support resource.

## Good practice approaches in supporting siblings

Since 2006, Rethink Mental Illness has undertaken research to better understand the needs of siblings. In 2010, the Siblings Network (<http://www.rethink.org/carers-family-friends/brothers-and-sisters-siblings-network>) was launched. The Siblings Network provides information and advice and brings siblings together. The network aims to enable and empower siblings to better cope with the challenges mental illness can bring; and to improve their own health and wellbeing. To achieve these goals, the Rethink Mental Illness Siblings Network offers a dedicated web-space for siblings through which they can get information and resources, join an online forum with other siblings or share their story. Siblings can also join a sibling support group to meet with others and to share experiences and advice.

One of the service providers often highlighted as a leading light and best practice example by the Siblings Network and other commentators in the field is the Worcestershire Early Intervention Service, led by Professor Jo Smith, Consultant Clinical Psychologist and Tony Gillam, Early Intervention Clinical Manager/family work trainer. The service demonstrates how to include siblings in all family-inclusive service provisions (see Smith et al, 2009, 2010 for information on adapting family interventions in order to include siblings). An information booklet for siblings and video presentation from Professor Jo Smith on effectively involving brothers and sisters, are posted on the Rethink Mental Illness Siblings Network website (see <http://www.rethink.org/carers-family-friends/brothers-and-sisters-siblings-network/get-info-and-advice/sibling-advice-videos>).

**Figure I: Cover pages of the information booklet for siblings produced by Worcestershire Early Intervention in Psychosis Service**



## The E Sibling Project

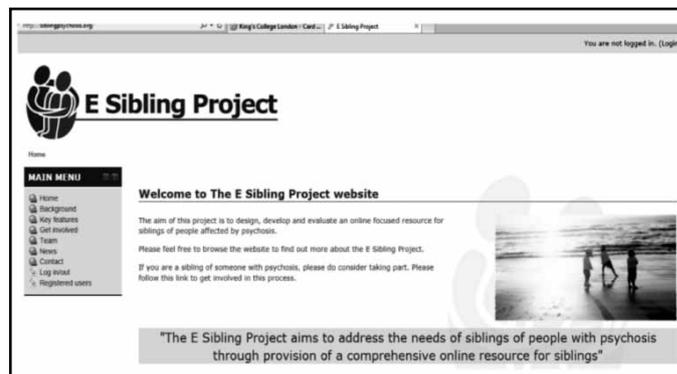
Another exciting development to address the siblings' call for dynamic yet robust information and support resources is the "E Sibling Project" (see <http://siblingpsychosis.org>). Over the last two years, the E Sibling Project online resource for siblings was designed and developed using an iterative process combining mixed research methods (i.e. systematic reviews and focus group study with siblings) to map out the essential ingredients of the desired resource design and content, and on-going consultation with an Expert Advisory Group. The group included siblings, parents, individuals with personal experience of psychosis, mental health professionals, and IT experts. This internet resource has multiple components, such as:

- Information on psychosis.
- Wellbeing promotion.
- Peer forum and siblings' blogs.
- "Ask the Experts" forum.

A prototype of the online resource was tested earlier this year and received a very positive evaluation from siblings. Of all the functions, the "Ask the Experts" forum and Peer Forum were the best used and well-evaluated.

The E Sibling Project online resource is currently being evaluated through an online randomised controlled trial to examine its impact on siblings' wellbeing, knowledge, and experiences of caregiving. We are recruiting 150 siblings of people with first episode psychosis in Greater London and Berkshire in England to try out the resource and give us lots of feedback about their experiences of using it.

**Figure II: Screenshot showing the homepage of the E Sibling Project**



## Future work

Support for siblings is a growing area of interest and development, and the services and projects considered here will be key to the development and future direction of the support offered to siblings. The E Sibling Project online resource will remain exclusively accessible by research participants till the end of 2014. If the resource is proven to be effective and well-received by siblings, there are plans to open its provision to all.

In the meantime, considerations and innovations in collaborative working and service provisions are called for from all clinicians, health and social care workers when working with families and carers. "What can we do?" Think siblings! Signpost siblings to the online resources, campaigns and groups highlighted here.

For further information please contact Jacqueline Sin on:  
Email: [Jacqueline.sin@kcl.ac.uk](mailto:Jacqueline.sin@kcl.ac.uk)

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# Working with Siblings

By **Jacquie Cullen, Family Interventions Co-ordinator**  
**Nottinghamshire Healthcare NHS Trust**

Andrea Emmens (Family Interventions Co-ordinator/BFT trainer), Christine Collinson (Clinical Psychologist/BFT trainer) and I facilitated a workshop focussing on working with siblings late last year. Attendees had all completed the 5 day Behavioural Family Therapy (BFT) training over the previous two years. It was also a rare opportunity for a reunion, reminiscing about role play etc! To date, 43 members of staff from a variety of community teams, residential and in-patient settings have completed the training and attend monthly group supervision available in four venues across the large geographical area we cover in Nottinghamshire, England.

We had a distinctly chilly start to the day, due to a poorly heated venue and exceptionally cold winds. A very warm welcome, however, was extended to Jacqueline Sin, NIHR Research Fellow, Kings College London. We felt extremely lucky that Jacqueline had kindly agreed to attend our event. Sharing her expertise, informing us of her research and her extensive knowledge in relation to working with siblings was truly inspiring for us all.

This was a valuable opportunity to focus on working with siblings and raising awareness of their needs. Also to explore how siblings coping with psychosis are appreciated, understood and respected when we are working with families. Comments from attendees confirmed this was indeed an issue for many in their clinical roles. Some examples of barriers to working with siblings were:

- Lack of routine recording of *whole* family i.e. drawing a family tree.
- Concerns about confidentiality and age, in particular, young people under 16.
- Overcoming parental 'protectiveness' towards their other children becoming involved in services, even in the context of BFT.

Brothers and sisters of the person affected by psychosis all too often say they how they feel 'invisible' within the family. As mental health professionals, we need to acknowledge that when working with families we may unwittingly treat siblings as invisible too.

The value of sustaining the relationship between the person experiencing mental health problems and their siblings is evident. Psychosis can cause profound changes to a sister or brother they have (usually) grown up with. Often our childhood involves shared experiences of special significance with brothers and sisters that continue throughout our lives. It is usually the only relationship spanning our lifetimes, as we would normally expect to outlive our parents.

BFT sessions can be an ideal opportunity to address some of the issues which may be specific to siblings in the family. In my experience, it is often the first time a sibling has been asked about the impact of the situation on them. It has given them a voice within the family to express their feelings and anxieties safely and crucially, to feel acknowledged, valued, and included.

Jacqueline's presentation on working with siblings highlighted the need to identify and actively engage siblings in the process of our work and at the earliest possible stage. Also, we need to have much greater awareness of siblings needs and '**regard siblings as recovery resources**'.

During the latter part of the morning there was time for discussions in small groups, clustering people from similar work areas, for example, Community Mental Health Teams/Early Intervention in Psychosis (EIP), Acute and residential settings. We asked them to consider, '*What would support you and your team to work more with siblings?*'

## **Some of the ideas this generated included:**

- Proactive approach from onset. This would require a culture shift.
- A clear protocol for the involvement of siblings.
- The electronic recording system needs to be more family work friendly.
- More staff trained in BFT.
- Flexibility in working hours and locations.
- Protected time for workers.
- Specific resources that are relevant to siblings easily available.

## **Goals were set by each group to take back to their teams and develop. These included:**

- Designing a leaflet specifically aimed at siblings.
- Always use a standard form to capture *all* social support/network.
- Therapeutic interventions with siblings.
- Teams starting regular family evenings/sessions specific focus on encouraging siblings to attend.
- Establish information base of resources for example the 'E Sibling Project' and Rethink Mental Illness Siblings Network.

## Manager's Perspective

*I was delighted to be invited to the Family Interventions Service away day which focussed on working with siblings and centred around the keynote speaker Jacqueline Sin from Kings College London. A productive series of discussions was generated on the issues of engagement with siblings. These issues included aspects of comparative age of siblings, their own vulnerabilities, needs and emotional maturity. This in turn raised the question of the preparedness of Adult Mental Health workers in addressing the diverse needs of the family and when younger children are involved. The traditional understandings of the 'nuclear family' were challenged and placed into the context of BFT.*

*The energy and enthusiasm of the day was evident to all attendees and as a Clinical Services Manager I was particularly struck by the options that BFT had opened up to service users, carers and therapists as a complementary or alternative to traditional health interventions.*

**Tim Constable (Service Manager)**

## General Feedback

In the current climate of austerity and services under pressure, it was indeed a pleasure to hear the following comments about the day from those who had attended.

*"A great booster session, keeps morale up."*

*"Renewed my motivation for engaging families."*

*"An excellent and positive day has given me more confidence to carry on my work with families."*

*"My awareness of siblings' needs has vastly improved and I will now be focussing on improving our systems for identifying and engaging siblings not just for BFT but routinely in my team."*

CAREIF – Centre for Applied Research and Evaluation  
International Foundation is an International Mental Health Charity



### Careif Essay Prize Competition 2014

#### Careif-Global Suicide and Suicide Prevention Essay Competition

**1st Prize £500 • 2nd Prize £300 • 3rd Prize £100**

Centre for Applied Research and Evaluation International Foundation (Careif) is an international mental health charity with a special focus on protecting and promoting the health and well-being of young people living in culturally diverse societies around the world. Each year, we have held a highly successful essay prize competition to encourage 'state of the art' essays on key mental health themes. These are published on our website and in the lay and academic press. The essays aim to bring together a wide range of disciplinary perspectives, integrating the academic research, theoretical, conceptual, and public health perspectives.

Suicide is a tragic event with far reaching impact on the lives of those touched by it. Initiatives that seek to understand more fully the causes and opportunities for suicide prevention are ever more important as public health experts report increasing rates of mental ill health in the current economic climate. Suicide is complex with psychological, social, biological, cultural and environmental factors involved. Every year, almost one million people worldwide die from suicide; this roughly corresponds to one death every 40 seconds. ([www.who.int](http://www.who.int))

You are invited to submit, in open competition, an essay on Suicide and Suicide Prevention and to explore its socio-religious context, cultural meaning and its association with stigma. The essay should include an incisive and synoptic literature review, focusing on improving knowledge about the ethno-aetiology of suicide together with the policy and practice implications for suicide prevention.

Entries must be no more than 4000 words, should be referenced using the Harvard reference style, and submitted by email to [essay14@careif.org](mailto:essay14@careif.org) by 21st December 2014. Applicants will be notified by 21st January 2015. The judges reserve the right not to award a prize if none of the entries meet the required standards. Authors must include their full name, address, country, email, and occupation on the title page.

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# Improving Access to Psychological Therapies for Bipolar Disorder

**Chris Mansell, Deputy Director – Meriden Family Programme**

The national Improving Access to Psychological Therapies (IAPT) for Severe Mental Illness (SMI) project aims to increase public access to a range of National Institute for Health and Care Excellence (NICE) approved psychological therapies for psychosis, bipolar disorder and personality disorders. The long-term ambition of the IAPT for SMI project is to ensure that all people with psychosis, bipolar disorder and personality disorders who could benefit from evidence based psychological therapies have access to these interventions.

In October 2012 Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) was selected as the only IAPT for SMI national demonstrator site for Bipolar Disorder in the country. Our Trust has been selected to focus on Bipolar Disorder because of the well established evidence based clinical work that is being delivered through the Mood on Track Programme and the Meriden Family Programme. As part of this selection the Trust was asked to develop a formal partnership with an academic research centre at Lancaster University called the Spectrum Centre for Mental Health Research, which specialises in research into the management of Bipolar Disorder.

There are approximately one million people who have been diagnosed with bipolar disorder in the UK. This project aims to increase public access to a range of psychological therapies for bipolar disorder with the long term ambition of ensuring that all people living with this disorder who could benefit from evidence based psychological therapies have access to them.

NICE Guidance for Bipolar Disorder (NICE, 2006) states that healthcare professionals should consider offering a focused family intervention to people with bipolar disorder in regular contact with their families, if a focus for the intervention can be agreed. The guidance recommends that the intervention should take place over 6–9 months and cover psychoeducation about the disorder as well as ways to improve communication and problem solving. This fits with the Behavioural Family Therapy model of family work delivered by the Meriden Programme.

This is an exciting opportunity to focus directly on the benefits of psychological interventions for people living with bipolar disorder and their families. Most people living with this condition only have access to medical treatments and whilst these can play an important role, people are looking for other interventions to support their recovery. Families and carers are still not getting access to support and information.

The IAPT project will run until December this year and will enable the Trust to demonstrate the value of a pathway for people with bipolar disorder that includes psychological interventions.

The project objectives are:

1. To describe a best practice pathway for people with Bipolar Disorder to ensure appropriate and timely access to evidence based psychological therapies.
2. To develop a suite of outcome measures (a minimum data set) that can be used nationally to support and evaluate clinical pathways and services for people with this condition.
3. To extend the best practice pathway (objective 1 above) to include a population based systems analysis.
4. To develop proposals for a national clinical network for Bipolar Disorder which could be initially hosted by BSMHFT beyond the life of this project.

## **The ‘Mood on Track’ Programme**

The ‘Mood on Track’ course is a ten week group programme that aims to help people with a diagnosis of Bipolar Disorder learn more about their condition and develop successful ways of managing it. The programme is evidenced based, and follows a therapeutic approach called Cognitive Behaviour Therapy (CBT). The course consists of 10 weekly sessions, each lasting 2 hours with breaks for refreshments. These sessions are dedicated to delivering the following: information about the condition, what it is and how it is diagnosed, ways to manage the lows and the highs, spotting early signs of a problem mood swing, with plans to manage these. Also the role of medication and problem substances to avoid, plus ways of improving well being, etc. Included in these sessions are Mind and Body stimulation control techniques which provide people with an opportunity to try out a range of practical skills to quieten and calm both mind and body processes. All of these sessions take place in a group format of about 8–10 people.

The group is facilitated by at least 2 members of staff so there is always someone on hand to help if there is something people do not understand or if people need further support.

At the end of the course those attending meet with a member of the team on their own for between 4 – 6 sessions to develop a personalised ‘Early Signs Signature’ and ‘Action Plan’. These will then be incorporated into an ‘On Track’ relapse pack. This pack contains key information and guidelines to help people ‘Stay on Track’ and reduce the risk in the future of the need for home treatment or inpatient care.

More information about Mood on Track can be obtained by contacting Dr Jayne Eaton [jayne.eaton@bsmhft.nhs.uk](mailto:jayne.eaton@bsmhft.nhs.uk)

## **References:**

National Institute for Health and Clinical Excellence (2006) CG38 Bipolar Disorder – the management of bipolar disorder in adults, children and adolescents in primary and secondary care.

## **The following is an account of the experience of someone accessing both the Mood on Track Programme and Meriden family work**

*I am a 54 year old man who has suffered with Bipolar for approximately 19 years. I do become severely depressed, agitated and suicidal very quickly once my mood has significantly deteriorated. The common characteristics of my depression are tearfulness, lack of motivation to undertake any tasks within or outside my home and the inability to fight off the desire to lay down.*

*After my first bout of depression, my GP referred me to the North Birmingham Mental Health Team. The main down side of the support I was receiving at the time, was the fact that there did not seem to be any continuity in terms of consultants that I saw. Eventually the team moved and at some point I started to be seen by one consultant who thankfully has remained my consultant and has been a source of support not only to myself, but also to my wife.*

*The consultant was responsible for putting me in touch with Jayne, a Consultant Clinical Psychologist who I believe is in charge of the 'Mood on Track Course'.*

*At the time I attended the course I was not in a depression, but the benefits of the course soon became apparent:*

- *It was good to actually meet other people who suffered with a mental illness.*
- *It was good that we met on a weekly basis.*
- *The fact that the course covered a number of different topics was useful.*
- *The handouts we worked through and were able to build a folder with, has proved very useful when you feel you might be approaching a relapse.*
- *There is on-going support with a monthly newsletter and meetings open to anybody who had attended the course, which gives one the chance to keep in touch with people.*

*To date I have attempted suicide four times, which shows the depth of depression one can suffer. Although I have been labeled as having Bipolar, I usually get extremely low very quickly, but I do not feel I really suffer with the highs associated with Bipolar. During my most recent bout of depression which started in October 2012, I was referred to the psychology department at the where I was being seen by a student psychologist, under the supervision of Jayne.*

*Throughout the many years of my suffering with Bipolar, this was the first time I was given this type of support which was meant to be on a one to one basis, but because of how low my moods were, my wife was in attendance at some of the sessions. It became apparent in these sessions how bad my depression was and the impact it was having on us as a couple. It was whilst I was having these sessions that I had my last suicide attempt which was linked to a planned return to work. I knew that my work at the time contributed to my illness and the fear of going back into that environment was just too daunting.*

*It was suggested that both myself and my wife were seen by the 'Family Therapy Team'. After giving this much consideration we*

*agreed that we needed to try this extra support as we were both at breaking point. After a few weeks we were contacted by the family therapy team and arrangements were made for a home assessment.*

*On our first meeting with Martin and Lizzy we were still a little apprehensive as to how they could help us. However, their approach was sensitive and it was clear that they had knowledge and experience of the issues relating to my problems. This made us comfortable in speaking about various issues and working with them on the different techniques they introduced. The sessions lasted for 12 weeks which included helping us to achieve individual goals, problem solving, decision making, positive communication etc. Whilst all the sessions were beneficial, the 'Relapse Plan' that I was encouraged to draw up proved to be extremely useful as it highlighted the benefits of the sessions and more importantly it allowed me to identify the different stages of my depression and how to respond.*

*Overall our experience of both the Mood on Track course and the Family Therapy Team have been positive. We are not sure where we would be today had we not had the intervention of the Family Therapy Team and the information that was made available from the Mood on Track course. My wife has benefited greatly from both services and would recommend them to anyone who has found themselves in a position where they feel isolated as a result of their partners mental ill health.*

If you would like further information on family work and bipolar please contact Chris Mansell [chris.mansell@bsmhft.nhs.uk](mailto:chris.mansell@bsmhft.nhs.uk)

### **The Spectrum Centre for Mental Health Research**

The Spectrum Centre conducts translational research into the understanding and psychological treatment of bipolar disorder and other related conditions.

It achieves its purpose both by obtaining significant grant funding and by working collaboratively with third sector organisations and service users, regionally and nationally. <http://www.lancs.ac.uk/shm/research/spectrum/>

### **Improving Access to Psychological Therapies (IAPT)**

The IAPT programme supports the frontline NHS in implementing NICE guidelines for people suffering from depression and anxiety disorders.

It was created to offer patients a realistic and routine first-line treatment, combined with medication where appropriate, which traditionally had been the only treatment available.

IAPT for SMI project aims to increase public access to a range of NICE approved psychological therapies for psychosis, bipolar disorder and personality disorders. <http://www.iapt.nhs.uk/smi-/>

# The value of having my family involved and how they got me through!

By Jo Twiss

My family were already known to the mental health service as both my mother and elder sister had experienced mental health difficulties. Both had made good progress by the time I became unwell with a bipolar disorder subsequently amended to a schizo-affective disorder. This experience enabled my family to be at the core of my care, alongside the continuity of care provided by mental health professionals. An individual's mental illness is a family illness because all members of the family are affected in some way. They are after all the people who know the individual best and at times become the voice of the illness itself. The family have always been that vital foundation in maintaining my own mental health to a consistent healthy level. But, this very foundation can break down in the midst of crisis and when not thinking clearly because of mental health difficulties. The family can be seen as negative, and the individual can refuse to engage in the early stages of acute illness.



The Twiss family on the day Jo was presented with her degree in Solihull in October 2013. A proud day for the whole family.

Behavioural Family Therapy (BFT) was the starting point by which a solid relationship was developed with all four members of my family. This communication and interaction within the family home eventually led to the decision to develop my independence through supported accommodation. This independence has enabled growth and development in fulfilling my true potential, but with my family still very much involved.

It has been really important to me that the mental health service along with my family have provided me with the safety net to catch me when I have fallen. The approach of the team has been to consider the individual and the family in order to achieve recovery and wellbeing for us all.

Having reached a point where I felt I could take life on again, as a stepping stone I took on a voluntary placement at the Birmingham Disability Resource Centre and at the same time obtained an NVQ level 3 in Business Administration in 2009.

My psychiatrist sowed the seed by giving me the belief and confidence that studying at degree level was a possibility for me. Taking this on board, I embarked on a Fine Art degree in 2010 which was the biggest challenge I had taken on in my life. Once again the family was at the heart of picking up the pieces of the tears and tantrums that come with the mountain of stress and strain of academic study. However with the total support and encouragement of my family I managed to complete the three years of study and obtained a 2:1 Bachelor of Arts with honours degree (validated through Birmingham City University) and I received my degree at a graduation ceremony in October 2013.

Art, spirituality and mental illness fused together in attaining the process of 'individuation'. Jung speaks of the Self as our life's goal; for it is the most complete expression of that fateful combination we call individuality. When an individual acquires sufficient maturity with life experiences, it can be a difficult and even painful process.

On becoming a graduate, the next step for me was to move out of supported housing and I now reside in an independent flat. The family are still a constant presence for me in continuing to support the healing process.

Mental illness will always be part of the whole picture of my life but I have realised that it is now only 20%, leaving me with 80% to get on with doing other things in my life. I would not be here today without my family or mental health services. My endeavour now is to give something back by being a voice of hope in helping others and doing what I can to help improve services.

Amongst the things I now do is to help deliver the 'Caring for Carers' programme as part of Birmingham & Solihull Mental Health Services. This is a carer support and education programme that staff at one of the Trust's clinic run for friends and family over eight sessions. They do this 2 or 3 times a year. My parents and I share our experiences at the very last session of the programme which is entitled 'Recovery and Hope', and I understand that the carers find this particularly helpful. This has been a liberating and confidence-building experience for me, empowering me as a service user to feel an equal by working alongside professionals.

Also I am a regular speaker on the 'Sharing Information' workshop – a training day aimed at addressing confidentiality issues between professionals, service users and family members which is run several times a year by the Meriden Programme. My talk is called 'The value of having my family involved' and in this, I explain how it was important for me for professionals to talk to my family throughout the periods when I was unwell.

It has been helpful to me in making these contributions to have undertaken two Meriden run courses: the intensive five day Behavioural Family Therapy course and also the three day 'Caring for Carers' course which has been particularly useful for my role when delivering on the course.

I'm currently helping to co-author a chapter for the third edition of 'Craft of Caring', a psychiatric and mental health nursing book, by providing narratives on family involvement and support networks. I have also been involved in two research projects through the Social Work team at Birmingham University.

I feel now that my calling is to encourage others, including mental health professionals, to provide care not just to the person who is unwell but to all members of the family and those providing unpaid care and to promote the importance of the quality of life for everyone concerned.



## Conference Announcement

**The World Association  
of Cultural Psychiatry with careif  
announces 4th World Congress  
of Cultural Psychiatry**

**Place: Puerto Vallarta, Jalisco, Mexico  
Dates: 29 October to 2 November 2015**

**Theme: "Global challenges & cultural  
psychiatry: Natural Disasters, Conflict,  
Insecurity, Migration, and Spirituality"**

**For more information log on to:  
<http://www.4wacpcongress.org>**

## New Reports from Rethink Mental Illness

Rethink Mental Illness has recently published two very important reports:

**Investing in Recovery** was produced by Rethink in conjunction with the London School of Economics and it outlines the economic case for investing in services which support recovery *including family therapy* and this can be accessed on; <https://www.rethink.org/diagnosis-treatment/investing-in-recovery>

**Lost Generation** was produced by Rethink Mental Illness in conjunction with The IRIS Network (Initiative to Reduce the Impact of Schizophrenia) and it highlights that many Early Intervention in Psychosis (EIP) Services are struggling to maintain high levels of care and are facing uncertain futures due to funding cuts. The areas highlighted are:

- 50% of EIP services say their budget has decreased in the past year, some by as much as 20%.
- 58% of EIP services have lost staff over the last 12 months.
- 53% say the quality of their service has decreased in the past year.
- Many young people face unacceptable delays in accessing EIP services, greatly reducing their chances of recovery.

It expresses concerns that young people with psychosis are in danger of being left behind and suggests what needs to change. The recommendations are:

- Young people experiencing psychosis need guaranteed access to EIP support. The government must introduce a maximum waiting time of 28 days for accessing EIP services from the point of referral.
- NHS England must make provision of EIP services a key priority for commissioners. To achieve this, it should design Commissioning for Quality and Innovation (CQUIN)s and other incentives to ensure local commissioners reward good quality EIP services.
- Clinical commissioning groups must ensure that they commission the full EIP model, including specialist employment and physical health care support.

This can be accessed on the following weblink:  
<http://www.rethink.org/media/973932/LOST%20GENERATION%20-%20Rethink%20Mental%20Illness%20report.pdf>

# Visit by the Standing Commission on Carers

**Peter Woodhams, Carer Consultant – Meriden Family Programme**

*The Standing Commission on Carers is an independent advisory body providing expert advice to government ministers (notably the Minister for Care and Support) and the Department of Health on progress in delivering the national Carers Strategy. It also seeks to identify strategic challenges and opportunities associated with caring. Its Chair is Dame Philippa Russell who wrote to Meriden's Director, Dr Gráinne Fadden, towards the end of last year asking if Meriden would host a visit from the Standing Commission.*

Dame Philippa said that such a visit would be part of a programme of fact-finding visits requested by Norman Lamb, the Minister concerned, and would be looking at positive practice that might be identified in supporting family carers of people with mental health conditions. The request to Meriden came because Dame Philippa was aware of the 'impressive work developed at Meriden'. The two day visit took place at the end of November 2013 and Dame Philippa was joined by two of her colleagues from the Standing Commission, Anne Smyth and Katie Tempest.

A busy programme of meetings and visits was arranged for the group which started with a positive meeting with John Short, Chief Executive of Birmingham and Solihull Mental Health Foundation Trust. The models of the Meriden Programme, including Behavioural Family

Therapy and Caring for Carers, were then explained and an outline was given of Meriden's work both within the Trust and externally. Later meetings covered how families and carers were being involved in a developing project in the Early Intervention Service. The Standing Commission team met a number of Birmingham carers during the day and also the Chair of the Solihull Carers Forum, Georgina Dix.

The second day began with a very interesting visit to the Chinese Community Centre where Meriden has delivered an education and support programme for Chinese carers. The other support that was provided for carers was explained by Anna Yin, Chief Executive of the Centre and her colleague Ben Chan after which an introduction to the services provided to carers by Stonham Carers Support was given by Sarah Williams and Kieran Jones. The group then returned to the Uffculme Centre for the final session which involved meeting Sandra Pinnock and carers Ann Fitzgerald, Pat Fleetwood-Walker and Helen Robinson who explained some of the ways carers were supported and involved in the Trust.

Dame Philippa has subsequently written to say they found the visit very rewarding and informative and that it was encouraging to see an effective family programme for carers. They had been impressed by the way carers had become strategic partners in the Trust and that an invitation would be forthcoming to attend a 'thematic' day at Westminster this year. It was an interesting visit for all in the Meriden team and thanks go to all the staff, carers and services in Birmingham and Solihull who contributed so effectively to the day and helped raise the flag for carers.



Left to right: Dame Philippa Russell, Ms Katie Tempest and Mr John Short.

## News from UK Parliament Care Act 2014

**The Care Bill received royal assent, becoming law, on Wednesday 14 May 2014.**

**Read More by logging on to:  
<http://www.parliament.uk/business/news/2013/may/lords-care-bill/>**

# My Experience with the Meriden Family Programme

By Jiat Khee Chang – Senior Medical Social Worker, Institute of Mental Health, Singapore



Jiat Khee (centre front) with the Meriden team.

*I am a Senior Medical Social Worker with the Institute of Mental Health, Singapore's only tertiary psychiatric hospital. The Institute of Mental Health (IMH) is a 2,000 bed acute tertiary psychiatric hospital situated on a 25 hectare campus at Buangkok Green Medical Park. I have been a social worker for the last eleven years, with six years in the psychiatric setting.*

*My key role is to work with adult psychiatric service users and their family members in the outpatient clinic, conducting casework, counseling and group work. I am in charge of enhancing the carers' services in the outpatient clinic and coordinating the carers' services in the Medical Social Work Department.*

*I provide training and clinical supervision to fellow professionals.*

I was attached to Meriden Family Programme from 13th October to 22nd November 2013 to learn about carers' services in Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT). It was an enriching experience, fulfilling my purpose in learning how to enhance the carers' services in our outpatient clinic in Singapore.

It was enlightening to learn how Behavioural Family Therapy (BFT) could be applied from direct work with the psychiatric service users and their family members, all the way to the management level of planning for caregivers' programmes. BFT has provided an excellent structure in working with the family. Moreover the passion that the Meriden staff has about BFT inspires me to be creative in the way I work with families. I also have the benefit of seeing how the various teams in BSMHFT such as Assertive Outreach, Community Mental Health, Early Intervention and the Bipolar Service implemented BFT in their daily work.

On top of that, I had the opportunity to see how different carers' centres such as Solihull Carers Centre and Stonham Home Group work closely with carers and provide them with in-depth support. I saw how Peter Woodhams, Carer

Consultant, is a good resource when it comes to advising on carer related matters, from policy level to the running of carers' groups. The perseverance and wisdom exhibited by Meriden staff in guiding the various staff in BSMHFT in maximising the potential in family work was truly admirable.

The skills attachment has definitely enhanced the way I work with carers and service users in Singapore. It definitely brings a different dimension and perspective in reaching out to carers in Singapore, especially using the Behavioural Family Therapy model. Since returning from Birmingham, we have come up with different strategies to outreach to caregivers, such as giving out the caregivers' package as part of the orientation to the outpatient clinic and providing carers' assessments. On top of that, we work closely with the hospital management and external agencies in ensuring that our carers receive the optimum level of care, based on the Triangle of Care. We have also incorporated the BFT model into our weekly family psychoeducation programme in our outpatient clinic. The improvements yet to be made are non-exhaustive and I definitely look forward to implementing more changes to enhance the experience of carers in our hospital.

# Taking Family Work to Nigeria

Having provided training in family work and carer support to 3 professionals from Uganda in 2011 and 2012 as Professional Fellows under the Commonwealth Scholarship Scheme, Meriden was delighted to be able to offer similar training to a group of professionals from Nigeria in early 2014. The programme was set up in conjunction with Dr Sunday Osasu Olotu, Medical Director of The Federal Neuropsychiatric Hospital in Benin City in Edo State, Southern Nigeria who was introduced to Meriden by Professor Jo Smith of the Worcestershire Early Intervention Service.

As well as attending Meriden's three core courses, the Fellows were able to visit a number of inpatient and community services across the Trust and learn about some of the services that are available to support carers in Birmingham and Solihull. Such services don't exist in Nigeria so the plan is that as a result of this training, the Fellows will be able to offer family work and support carers in Edo State.

The four Fellows submitted the article below shortly after they returned to Nigeria. It is followed by an article submitted by the Worcestershire Early Intervention Service who hosted the Fellows for a very informative and relevant day as part of the training programme.

Peter Woodhams

## Our Training with the Meriden Family Programme

**Dr Nosa Igbinomwanhia, Dr Felicia Thomas, Dr Blessing Uteh and Mrs Nkechi Igbinigie**

The Federal Neuropsychiatric Hospital, Uselu, Benin City is a 230 bed referral specialist mental health facility located in the Southern part of Nigeria. Weekly patient attendees range from 600 – 900 with extensive opportunity for interactions between mental health professionals, patients and carers.

Up to now, substantial proportion of our care to patients has been medication oriented, with relatively little done in the domain of psychological and social approaches. Virtually all aspects of care are directed to the patient, with little or no attention to carers, particularly families who form the major social support to patients in Nigeria.

However, a more holistic approach to care of our patients demanded an improvement in our knowledge, skills and attitudes as mental health professionals. When we received



Delegates on the Behavioural Family Therapy training course January 2014.



The Meriden team with Nosa, Blessing, Felicia and Nkechi.

information about family work and the training courses to acquire the skills, we saw it as an opportunity to acquire knowledge and skills as part of manpower development which would eventually translate to enhanced patient care.

The team from Nigeria comprised of three trainee psychiatrists and a senior mental health nurse. Our stay in Birmingham, UK with the Meriden Family Programme was from January 13th to February 28th, 2014. We had a one-week intensive course on Behavioural Family Therapy, a 3-day "Caring for Carers" course and a one-week "Training the Trainers" course. These courses exposed us to needed knowledge in helping patients and carers optimise their interpersonal relationships and their relationships with professionals through information sharing, enhanced communication skills and an improved approach to problem-



The Fellows and Peter Woodhams (centre back) with staff from the Solihull Carers Centre.

solving. Our presentation skills as professionals were also enhanced during the 'Training the Trainers' course.

We were given the opportunity to visit a number of services and groups within Birmingham and Solihull. All members of the Meriden Family Programme whom we met were very warm and friendly, including Peter Woodhams who received us on arrival at Birmingham International Airport and Martin Atchison who supervised our training courses, Gráinne Fadden the Programme Director, Chris Mansell, Sam Farooq, Maria Albanese, Paula Conneely, Julia Danks, Nadine Berry, Alison Lee, and Rubina Jhadray.

### Achievements

We were able to acquire much needed knowledge and skills in family work, with a view to utilising these as part of our care approaches to patients in our centre back home in Nigeria.

- We acquired training on how we could train colleagues and other mental health professionals in family work.
- We also experienced the workings of carer groups, and left with a resolve to set up carer groups in Nigeria, starting with our centre as these had not been available previously.

### Implementation

Our plan is to implement Behavioural Family Therapy in Nigeria starting in our own area. However we also plan to train other mental health professionals, work with families and of course, facilitate and support the development of carer groups. We would also like to keep an open line of communication with the Meriden Family Programme for continued supervision.

### Challenges

Inevitably, in order to achieve this we have some challenges to face such as:

- Funding the training.
- Modification and adaptation of training to suit our institutional and cultural peculiarities.
- Inadequate manpower.
- Few mental health professionals.

### Update

Since returning back home our proposal has been sent to the management of our hospital and we are at the stage of conducting a survey amongst carers with a view to setting up our first carers group.



Meriden is very grateful to the staff at the Solihull Carers Centre for making the visit so informative and friendly.

## A visit by Commonwealth Fellows from Nigeria to the Worcestershire Early intervention Service

**By Dr Ruth Sheen, Behavioural Family Therapy (BFT) Co-ordinator  
Worcestershire Early Intervention Service (EIS)**

Worcestershire Early Intervention Service was delighted to host the delegation of mental health professionals from Nigeria in January 2014 while on placement with the Meriden Programme. They had chosen to visit our service as a model of how family interventions can be integrated within an Early Intervention Service as this was to be their goal on returning to Nigeria. This very committed group of professionals are part of the first and only Early Intervention Service in Nigeria, and they hope to generate the research which will allow these services to expand.

Africa as a continent has a young population where more than 50% are less than 25 years of age, and a total population which is about 12% of the global population. In Nigeria, the average life expectancy is 45 years and for individuals with psychosis it is much less. These individuals frequently suffer a very long 'Duration of Untreated Psychosis' (DUP), often because the family cannot access or afford treatment or because their symptoms are attributed to demonic possession. Many have been taken to traditional healers where they have experienced alternative forms of treatment. The increased morbidity and mortality from

infections and malnutrition coupled with the adverse effects of a long DUP makes these individuals with severe mental illness some of the most disadvantaged people on earth. The challenge for the Fellows is to develop Early Intervention Services which treat patients early and also to work with families to share information and support them in their caring role.

The whole Early Psychosis team contributed to the day with some doing presentations and others organising equipment, lunch and transport. Tony Gillam (Early Intervention Clinical Manager) started the day with an overview of Worcestershire Early Intervention Service and our experience of implementing BFT within the service.



Back Row (Left to Right) – Nosa Igbinomwanhia, Matthew Lammas and Vicky Wormleighton.  
Front Row (Left to Right) – Felicia Thomas, Ruth Sheen, Nkechi Igbinigie, Blessing Uteh and Jo Smith.



Back Row (Left to Right) Alan Farmer and Tony Gillam.  
Front Row (Left to Right) Martin Leeder with the four Fellows.

Alan Farmer, Matthew Lammas and Vicky Wormleighton followed with presentations on different aspects of the Early Intervention service and the day finished with Professor Jo Smith describing the development of Early Intervention services in the UK.

The visitors left full of enthusiasm and gratitude for what they had learnt and we were proud that they had chosen to visit Worcestershire EIS. Our service always welcomes the opportunity to share our experience and expertise in working with vulnerable young people, wherever they might live.

## Exciting Times in Japan

**Chris Mansell, Deputy Director and Peter Woodhams, Carer Consultant  
Meriden Family Programme**

It was a great privilege to be invited to speak at three conferences in Japan in March 2014 alongside our Director, Dr Gráinne Fadden. This was the first stage in a project to introduce family work to Japan that Meriden hopes to undertake over the next few years. This initiative is being led by a voluntary sector organisation based in Tokyo called Minna-Net. A number of Directors from this organisation

had visited Meriden in the U.K. last year as reported in the June 2013 Meriden newsletter (available on the Meriden Programme website). Minna-Net had organised two major full day conferences for us to speak at, one in Kyoto and one in Tokyo at which our task was to launch the concept of family sensitive practice, engaging in collaborative practice and evidence based family interventions.



The Meriden team being received at Tokyo Airport by members of Minna-Net.

The overall plan is for The Meriden Family Programme to deliver Behavioural Family Therapy (BFT) training in Japan in 2015. Meriden will then support those people trained to implement BFT by providing regular clinical supervision and consultation via teleconference. Some of those trained in BFT will then travel to Birmingham in 2016 to access the BFT Training Trainers course. They will then be able to train and supervise people locally in Japan with on-going support and consultation from Meriden which will greatly increase the availability of family work locally.

It was clear that many family members agreed with Minna-Net that families needed more support and involvement in Japan. Minna-Net had identified from a survey that in Japan

'there is no support for the family when the need arises', that the 'family is still the support staff' and that 'there is no place for the family to find knowledge and information'. It was as a result of this survey that Minna-Net decided to launch this project to seek to develop the family support system and they identified Meriden as the organisation they wanted to help to achieve this through its BFT cascade model. The project aims to spread family work across Japan and in seeking to achieve this, Minna-Net is working very closely with Professor Atsushi Sato, a Psychiatric Social Worker who is an Associate Professor at Notre Dame University, Kyoto. He is very passionate about the importance of families when a family member has mental health problems and he also has an extensive knowledge of family interventions, particularly as applied in the UK. He has also visited the Meriden Family Programme previously.

At each of the conferences, Professor Sato introduced the concept of working with families and the service structures required to support this. He made comparisons between



The Meriden team in Tokyo.

current service provision in Japan and other parts of the world to highlight the developments required. Dr Fadden introduced the concept of family sensitive practice and service developments required to achieve this. She then focussed on caregiver stress literature, the experiences of caring for someone with mental health issues and the impact of this on people's lives. She described different levels of support and intervention and the evidence base for psycho-educational family work. Chris then introduced the Behavioural Family Therapy model of family work, exploring the different components in detail. He then described the cascade model of training highlighting how this will support services to build up a critical mass of people trained in the BFT model of family work and so enabling mental health teams in Japan to become independent in developing and maintaining family work.

Following these talks, Peter spoke about how BFT had helped his own family so that the many family members who attended the conferences were able to gain an understanding of what BFT is from a family perspective and of the real benefits it can bring. A large number of family members attended each of the conferences and they were keen to learn more and to find out when BFT might be available to them. They also asked many questions at the end of each conference. The conferences were also attended



The Meriden team in Kobe with members of the City Assembly.

by people with lived experience, third sector organisations, mental health professionals and government ministers.

Prior to the first conference in Kyoto we were invited to present at an evening conference in Kobe. Ministers from Kobe City had visited Europe in December last year exploring a range of health and social care provisions to develop and support community care. They requested a meeting with Meriden as part of this visit to find out more about family sensitive practice and the evidence base for family work. Following this visit they invited us to talk with carers, ministers and other key people in Kobe at a small conference which was very well received with many questions. The people in Kobe are very keen to be involved in the developments of family work.

Throughout the duration of our visit to Japan we were treated to wonderful Japanese hospitality and warmth. We are very grateful to Noriyoshi Suzuki, Yuko Takamura and Yuki Izuka from the Minna-Net team for making all the arrangements so efficiently as well as to the Chair of Minna-Net, Youko Kawasaki and her successor Yoshikaxun Honjo for driving the initiative forward alongside Professor Sato. Thanks also to Masaru Matsuzawa and Waka Matsushita for being our guides in Tokyo and Kyoto respectively.

It was a truly memorable trip for all of us and one which we hope will result in the development of family work in Japan, thus bringing real benefits for all members of families affected by mental health problems.



The Meriden team in Kyoto with members of Minna-Net.

# Continuing the Development of Family Work and Collaborative Practice in Nova Scotia

**Chris Mansell, Deputy Director – The Meriden Family Programme**



Donna Methot, Family Member from Nova Scotia described the development of family work in her article 'Realising a Canadian Dream' (Meriden Newsletter issue 2013) and this report highlights the continuing developments and achievements across the province.

The development of family sensitive practice continues to be supported and facilitated by the Mental Health Foundation of Nova Scotia and the Nova Scotia Department of Health and Wellness. This work is a key action in the Nova Scotia Mental Health and Addictions Strategy – 'Together We Can,' which highlights the need for support to be offered to families. The document states that families play a key role in the care and recovery of people with mental health problems and addictions, and has a specific action to offer skills based interventions to families across the province who need help through the work of the Meriden Programme and Community Reinforcement and Family Training (CRAFT).

Staff from the Programme supported by Cheryl Billard from Capital District Mental Health Services and Donna Methot visited a further four districts within Nova Scotia. In June 2013 consultation visits took place with Mental Health Services in Pictou County and Cape Breton and in September 2013 with Cumberland and Guysborough & Antigonish Strait.

During each individual service visit, meetings were held with groups of local people who use services, their family members, clinical staff, service leaders and associated organisations, with a focus on collaborative working and family sensitive practice. This enabled the identification of good practice, barriers and areas for development. This information has been used by each area to develop action plans to support family sensitive and collaborative practice.

During each visit the team also facilitated a day focusing on supporting services with sharing information with families and carers. The events were attended by people with lived experience of mental health, their families and mental health professionals. The aim of the day was to help services focus on the benefits of sharing information with the individual and their family, focusing on the guidance to support staff and develop actions to overcome potential barriers to information sharing and the issues of confidentiality. This event also prepared teams made up of mental health staff, people with lived experience and family members to roll out this training to teams within their services in a cascade model enabling organisations to ensure that these changes can be sustained and developed.

Throughout these visits the team were met by extremely motivated and enthusiastic people who were keen to support and develop family sensitive practice.

In March 2013 five staff members from Capital District Mental Health Services who were previously trained in Behavioural

Family Therapy (BFT) travelled to the UK and completed the Training Trainers course. Following completion of the course they have been busy facilitating a programme of supervision across their service and have delivered two BFT courses. They have managed the time difference between Nova Scotia and the UK and are accessing regular telephone supervision from the Meriden Programme to support them in this work.



Gillian Harris and Christiana MacDougall-Flemming

Three staff from the Meriden Programme travelled to Truro in Nova Scotia in June 2013 and with the support of two BFT Trainers from Capital Health facilitated the first province-wide BFT course for 25 participants. Capital Health facilitated another province-wide course and there are now 68 people trained in BFT across Nova Scotia. The BFT trainers and supervisors from Capital Health have been facilitating supervision to support these people following training.

In September, a province-wide Caring for Carers course was held, which prepared teams of family members and mental health staff to jointly facilitate structured psychoeducational support programmes for carers. This was the second of these courses and there are now 28 family members and staff trained to facilitate these programmes. Several districts have already rolled out the programmes and others have plans in place.



Four people who were trained in BFT previously: Donna Methot, Dani Himmelman, Gillian Harris and Christiana MacDougall-Flemming, attended the Training Trainers course in February this year, taking the number of BFT trainers and supervisors up to nine across the province. This was also important because two of these people are family members. This has been an excellent opportunity to use the skills and experience of family members in the role of trainers but this also gives an extremely important message about collaborative practice.

Plans are in place for five more consultation visits in July to continue this work across the province, and a 5-day BFT course with a specific focus on Acute Care which will take place later this year.

We will continue to keep you updated on the developments in Nova Scotia.

**References:** Nova Scotia Department of Health and Wellness. *Together we can: The plan to improve mental health and addictions care for Nova Scotians*. Halifax, Canada: Nova Scotia Department of Health and Wellness; 2012.



Meriden's exciting and rewarding work in Nova Scotia continued in September 2013 with a further 4 day Caring for Carers course which is called 'Families Matter' training in Nova Scotia. This was the second such course run by Meriden in Nova Scotia. The course was held at a conference centre on an interesting old military camp in Debert, near Truro which is some 70 miles due north of Halifax, the capital city of Nova Scotia. On this occasion the Meriden delivery team of Martin Atchison, Paula Conneely and Peter Woodhams was ably supported by Angela Naugle, an Occupational Therapist and Trainer with Capital District Health Authority and Danni Himmelman, an influential local caregiver.

Thirty four delegates completed the course and they came from across the province from areas including Cumberland, Pictou, Annapolis Valley, Antigonish, Cape Breton, Halifax and Colchester. It was very helpful that the delegates included six caregivers and also that there was representation from the Confederacy of Mainland Mi'Kinaq, which represents the First Nations community in Nova Scotia.

The impact of the Caring for Carers/Families Matter initiative in Nova Scotia has been really positive and most importantly, caregivers are really benefitting from attending local roll outs. Not only have the two foundation courses been well received, but they have led to at least twelve roll out's across the province covering Truro, Amherst, Pictou, Kentville, Antigonish, Sydney, Cole Harbour as well as the Halifax/Dartmouth area. A four session roll out is being piloted in acute units and further training is planned in Cape Breton.

This is some of the feedback received from local roll-outs:

*"This course has been the most helpful experience I have had for a very long time and has been so timely for me."*

***"It has saved my sanity these last couple of months. I looked forward to each Tuesday night."***

*"I really did enjoy these meetings. It was really nice to know that our family is not the only one going through these things."*

This really is excellent progress in Nova Scotia so very well done to all concerned.

## Meriden and the Mental Health Innovation Network

Earlier this year, the Meriden Family Programme was delighted to have the opportunity to contribute to a new initiative hosted by the Mental Health Innovation Network.

The Mental Health Innovation Network (MHIN) originated in June 2013. It is an international group which seeks to improve the lives of those affected by mental health issues globally by facilitating the development and uptake of effective innovations.

Their activities are supported by a team of researchers and policy makers from the London School of Hygiene & Tropical Medicine's Centre for Global Mental Health and the World Health Organisation's Department for Mental Health and Substance Abuse. It is funded by Grand Challenges Canada. The key aims for MHIN are to:

- Enable learning.
- Build partnerships.
- Synthesise and disseminate knowledge.

As such, the MHIN now hosts and maintains an online repository of innovations in global mental health. Providing an overview of each innovation and its impact, the repository is designed to link users directly to tools, publications, and other materials developed by the innovators. Currently, the repository highlights innovations in both the treatment and care of those experiencing mental health issues. In time, the MHIN hope the repository will be expanded to include a whole range of innovations in global mental health. Innovations are not endorsed by MHIN, but rather shared in the interest of open access to information and ideas.

The online repository of is just one of many tools that MHIN is developing to help promote collaboration and knowledge exchange among mental health innovators from around the globe.

The Meriden input can be accessed through the following links: [www.mhinnovation.net](http://www.mhinnovation.net)  
<http://mhinnovation.net/innovation/meriden/>



Delegates on a BFT course in Ireland.

# Developing Family Work in Ireland

**Dr Gráinne Fadden, Director – Meriden Family Programme**

We are delighted to be playing a key role in the exciting new developments in mental health care in the Irish Republic. The Health Service Executive (HSE) in Ireland has launched an initiative to support the development of early psychosis services across the country, similar to what happened in England a number of years ago. Up to now, services for young people with psychosis have been limited to a small number of services such as the Detect Service in Dublin addressing this need. The new plan is ambitious with an aim of having services provided in the cities and also across the vast rural areas. Because of the demographic and geographical diversity, it was decided that no single model of providing services would be stipulated, but that each area would develop services appropriate to their needs, for example, having core teams, in areas with large populations, or ‘hub and spoke’ services in geographically dispersed centres of population.

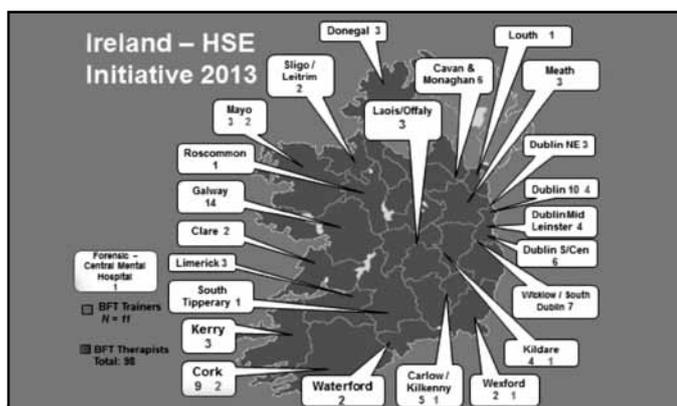
Sometimes it can be an advantage to develop services a little later than in other countries in that the lessons learned by innovators can be adopted and mistakes avoided. The HSE in Ireland have decided to take an evidence-based approach from the start, and plan to have staff in the new services trained in the three main evidence based approaches – family interventions, Cognitive Behavioural Therapy (CBT), and supporting young people in obtaining employment. These are in addition to pharmacological treatments and addressing physical health needs.

The Meriden Family Programme was approached to draw up a three year plan for training up the workforce in the skills needed to offer family work to young people and their families. The Meriden cascade approach was felt to be appropriate for the task of ensuring that mental health staff around the country could be trained in these skills in a relatively short space of time, and that the necessary support would be in place to ensure implementation.

Having provided some introductory workshops and presentations to managers in Spring 2013, the main thrust of our work in Year 1 of the plan was to train up staff in the four geographical HSE areas across the country. In Autumn 2013, four training courses were held – in Dublin, Cork, Galway and Kells, resulting in 98 staff being trained. We were joined in the training by three Irish trainers who had previously trained with us. Supervision was provided following the training, with attendance of supervision ranging from 75% to 100% which in our experience is exceptional. The majority of those trained identified families to begin working with immediately after training. It is interesting that in terms of those trained a high proportion, 46%, have been social workers.

In Phase 2 which began in 2014 we trained up a small group of trainers to join the existing trainers. Six clinicians attended our February Training Trainers course – two from Castlebar, one from Dublin, one from Cork, and two from South East area – Wexford and Kilkenny. Along with a Meriden trainer on each course and the three experienced Irish trainers, these new trainers are running their first course in their own areas in May/June 2014. This will result in a further 65 people trained in family work skills. Further courses will be held in Autumn 2014 and Spring 2015.

The third phase in 2015 will be to hold a ‘Training Trainers’ course in Dublin for 26 experienced family workers from across the country, so that each local area will have its own trainers and supervisors, thus ensuring that local areas have sufficient trained staff. Supervision will continue for all of those trained, and Meriden will offer supervision to the trainers and supervisors.



Details of people trained in family work in Ireland.

For the Meriden team, it has been fulfilling and a delight to offer this training. From a travel point of view, we can reach Ireland from Birmingham faster than many places we have delivered training in the UK. The enthusiasm for the training has been amazing with all the courses oversubscribed. Many of the delegates arrive an hour before the course is due to start, and stay to discuss issues at the end of each day. Attendance at supervision has been higher than in most other places we have delivered training. And of course, the Irish hospitality has been great, with delegates offering lifts back to our accommodation, and the usual freshly baked scones for everyone on Day 1 of courses, acknowledging that people have typically travelled long distances to get to the course.

We are very much looking forward to continuing with the training, and seeing the delivery of family work flourish across the country.



Delegates on a BFT course in Ireland.

## NHS must care for the carers, says new NHS England CEO

We were delighted to hear that the new chief executive of NHS England has paid tribute to carers for their “immense contribution” as he pledged to do more to help them.

Simon Stevens launched NHS England’s Commitment to Carers to coincide with the Carers UK State of Caring Conference in London. He has committed his organisation to do more to support the millions of people providing unpaid care, their number having grown by 600,000 over the past decade. NHS England has for the first time asked carers on a national basis what support they would like from the NHS.

Carers, charities and partner organisations have worked with NHS England to draw up eight priorities – and 37 commitments – that will help the NHS to deliver the care and support carers have said they need. These include a national event for young carers, a carers’ champion on the board of NHS England, and promoting carers’ interests through, for example, work on personalised care planning, end of life care and dementia.

**Simon Stevens, who met with carers during a visit to Manchester said:** “Carers are hugely important to our society, their contribution is immense. Over 1.4 million people provide 50 or more hours of unpaid care per week for a partner, friend or family member.

In terms of providing care, they are often doing most of the work so it is vital that we in the NHS give them the recognition and help they need. We also need to remember how the demands of caring can take its toll on people’s own health. We need to care for the carers.”

Simon Stevens pointed to research from Carers UK which shows:

- Full-time carers are over twice as likely to be in bad health as non-carers (*Census, 2011*) and in the 2014 *State of Caring Survey*, 80 per cent of carers surveyed said caring has had a negative impact on their health.
- As well as the physical strain of caring, the pressure of providing care to a loved one can have a serious impact on mental well-being. 73 per cent of carers surveyed reported increased anxiety and 82 per cent increased stress (*State of Caring Survey, 2014*).
- Across the population an estimated 2.3 million people have given up work to care and 3 million have reduced working hours at some point, to provide care for a loved one (*Caring & Family Finances Inquiry UK report, Carers UK, 2014*).

NHS England’s eight priorities in its Commitment to Carers publication are:

- Raising the profile of carers among staff, stakeholders and partners, making them aware of what carers do and how they can be helped.
- Improving education, training and information for staff, stakeholders and partners, increasing awareness of what it means to be a carer.
- Developing services, with NHS England investigating how carers are involved and where initiatives may be developed to make their role easier.
- Providing person-centred, well co-ordinated care – this includes providing better information, involving carers and patients and giving them more control.

- Considering how carers may be helped through primary care, working with our partners to identify, measure and share best practice.
- Evaluating commissioning support, assessing the impact of services and policies on the role of carers.
- Helping to build, sustain and develop links between health, social services, charities and other key partners that will support carers.
- Continuing to offer policies on flexible working, leave and employment to support the carers among NHS England staff.

term conditions and delivering high quality care which is person-centred and well co-ordinated.”

**NHS England’s board champion for carers, Jane Cummings, Chief Nursing Officer for England says:**

“Millions of people offer a lifeline to help and support their loved ones. My family and I have personal experience of caring for loved ones and I understand the impact this can have. “After listening to carers came NHS England’s Commitment to Carers which recognises the invaluable contribution carers are making every single day to those that need it the most. We are dedicated to making sure we provide the support, care and guidance they need, for themselves as well as those they care for. Providing that support to people is a huge privilege which I feel really passionate about.”

**Dame Philippa Russell, Chair of the Standing Commission on Carers says:**

“As a family carer who has just completed half a century of caring, I warmly welcome the NHS’s commitment to carers. “Like the National Carers Strategy for care and support, the NHS Commitment to Carers both recognises and celebrates the contribution of carers to the well-being of many of our most vulnerable citizens.

“It also acknowledges and sets out the challenge for carers and their partners in health and social care as they start out on a new journey where the contribution of carers is respected, supported and valued as integral to the health and well-being of the nation.”

**Neil Churchill, NHS England’s Director for Improving Patient Experience says:**

“While carers should receive consistently great experiences of care, they have told us that they can hit a crisis point when it is difficult or impossible to cope. “The recognition and support our commitments will offer, can prevent that from happening and help carers continue to look after themselves and their loved ones.”

**Martin McShane, NHS England’s Director for People with Long-Term Conditions says:**

“Personally and from previous work as a GP, I know at first hand the benefits that unpaid carers – parents, partners, children, friends and neighbours – have for the people for whom they care as well as the challenges that they face on a daily basis. “As health and care professionals, we need to recognise and support the contribution that carers make and the expertise that they bring. This is particularly important in helping us all meet the growing challenge from long-

## Warm congratulations to Jo Smith!



We are delighted to offer our congratulations to Jo Smith on her appointment as a Visiting Professor in Early Intervention and Psychosis with University of Worcester, Worcester, UK. Jo has long been an ally of the Meriden Programme, and a consistent and ardent supporter of the development of services for families. She is well known nationally and internationally for her work in the area of early psychosis. It is fitting that the wonderful contribution she has made has been recognised in this way, and from all of her friends at the Meriden Programme, we offer her our warmest congratulations.

For those of you who don’t know her, Jo is a Consultant Clinical Psychologist and Early Intervention Clinical Development Lead with Worcestershire Health and Care NHS Trust. She was Joint National Early Intervention Programme Lead for NMHDU (National Mental Health Development Unit) with Dr David Shiers supporting Early Intervention development and implementation across England. She was also previously Chairperson of IRIS (Initiative to reduce the impact of psychosis) which published ‘Clinical Guidelines and service frameworks for Early Intervention in Psychosis’ (IRIS, 2000) which later formed the basis for the ‘Department of Health Early Intervention Policy Information Guide’ (DH, 2001).

Jo was also a member of the UK Department of Health Taskforce for Early Intervention. Her clinical work has largely focused on the development, evaluation and delivery of psychosocial interventions to individuals with psychosis and their families. She has been involved in a number of research and service developments including psycho-educational initiatives, early signs monitoring and family intervention.

# The Benefits of Behavioural Family Therapy (BFT) – A Family Experience

*This family wished to share their experiences, but to remain anonymous – the account is written by the father*

## **Brief background**

Our family consists of four members, two boys with an age difference of 14 months and us, the parents. At the age of 18 the older of the boys suffered an acute psychotic episode and ended up in the local accident and emergency department due to his uncontrollable behaviour. He owned up to hearing voices since the age of 15 and that they got progressively louder and more aggressive. He also self-harmed. Prior to this acute illness we noticed that his behaviour was becoming unpredictable and he was also physically and verbally aggressive, especially towards us. He was initially medicated and managed by the local crisis team with daily visits from a team member and weekly visits to the out-patient clinic where he saw a consultant psychiatrist. He was unable to attend secondary school and he spent most of his time asleep. After three months, he was deemed to be stable enough on his medication to be transferred to the local Early Intervention Team.

This experience was obviously very traumatic for all of us. My wife and I were both off work with stress for three months. In addition we were obviously the carers, but we had no idea of what mental illness was. Clearly a lot of our attention became focused on the older one. The verbally aggressive behaviour continued, and we found ourselves arguing about even the most minor of disagreements. This was clearly having a negative effect on us all with escalating tension, especially between us the parents. We are not sure what effect if any this tension had on the younger sibling, but he appeared to just let it flow over him – he carried on at school and his weekend rugby games.

## **Behavioural Family Therapy (BFT)**

At times we (the parents) were invited to speak to the consultant psychiatrist at the early intervention clinics to discuss medications and voice any concerns. We repeatedly discussed our home situation regarding the disruption in our family dynamics, but it was only after fourteen months that we were offered BFT. We had weekly evening visits (to accommodate the fact we were both back in full time employment) by two members of the Meriden Team. Each visit lasted approximately an hour but on occasions it went on for longer. We were trained in the various techniques and practiced them in the presence of the team members. Through the techniques of BFT we were provided with a forum in which we became more aware of each other's feelings and discussed what went on in our lives during the week. We learned to have structured family meetings using the suggested formal approach of keeping to agreed ground rules, have an elected chairperson and a note taker. We were required to report back to the team the following week and discuss the outcomes of the meeting. Obviously initially it felt strange to adopt such a formal approach to communication but eventually it took away most of the

tension that had built up over the months. Further on in the programme, we were also coached on how to approach difficult issues through problem solving and to express unpleasant feelings, using a technique that was recognised by all of us. Also rather than focusing on the unpleasant things, we learned how to recognise pleasant situations and express our thanks to each other in a manner understood by all.

It is perhaps good to mention that we went on our annual family summer holiday abroad towards the end of the sessions and on return we reflected on the fact that we had a more relaxing time. We even had a family meeting while in the sea to plan a day out. This was a pleasant change to previous holiday experiences where arguments still happened that were sometimes totally unnecessary.

On further reflection we have come to realise that BFT gave our younger son his due importance within the family (he proved to have good listening and leadership skills and ensured that family meetings ran smoothly) as opposed to all the attention being focused on our older son. In addition through BFT, the older son was able to hear what was going on in the lives of the rest of the family and how they felt they were walking on 'eggshells' as at times he was unapproachable. By the end of the course he said that prior to the course he had felt frustrated because *'my parents did not know enough about my condition and so I was always having to explain myself'*. BFT radically altered the way we behaved with each other.

Mental health problems do not just affect the individual but all the other family members in one way or another. Dysfunctional communication affects relationships and we (the parents) found ourselves blaming each other for what happened. We wish that BFT was offered much earlier as we could have addressed some of the stress associated with our son's problems. Short conversations in a busy clinic are not sufficient to deal with deep-seated problems of communication and aggressive behaviour. We all agree that BFT was fundamental in our lives as it allowed each of us to have a voice and provided us with the confidence to re-establish bonds of family friendship and love. It is now four years since all this started and we still have disagreements but not in the same intense manner as before the commencement of BFT. I suppose we have learned to safeguard what we have achieved and none of us want to go back to the old days! The boys have come a long way. The older still takes his medication but started to reduce one of his doses and is at the end of the first year at university. He is now under the care of the community mental health team. The younger one is doing his commando training. We the parents have moved further into the 'accepting' phase of our grieving and feel more positive in general.

# Troubled Families

Supporting a local team to deliver a consistent model to families – Families First Solihull

Julia Danks, Clinical Specialist, Meriden Family Programme



## Background

The Troubled Families Programme was launched by the Prime Minister in 2011. Government data collected in October and November 2011 estimated that £9 billion is spent annually on troubled families – an average of £75,000 per family each year. Of this, an estimated £8 billion is spent reacting to the problems caused by these families with just £1 billion being spent on helping families to solve and prevent problems in the longer term.

## Issue

Troubled families are those who have problems and who cause problems within the community around them, putting high costs on the public sector. The government is committed to working with local authorities and their partners to help 120,000 troubled families in England turn their lives around by 2015 (DCLG, 2014).

## Actions

As part of the Troubled Families Programme, the government set national objectives:

- Get children back into school.
- Reduce youth crime and anti-social behaviour.
- Put adults on a path back to work.
- Reduce the high costs these families place on the public sector each year.

The plan to achieve the outcomes was to work more effectively by:

- Joining up local services.
- Dealing with each family's problems as a whole rather than responding to each problem, or person, separately.
- Appointing a single key worker to get to grips with the family's issues and work intensively with them to change their lives for the better for the long term.
- Using a mix of methods that support families and challenge behaviour.

## Planning

It was with the above in mind that a senior worker in the Solihull Families First team invited two members of the Meriden Team along to their team away day to share our experiences of working with families in a structured way. The team wanted to consider if they thought this approach

would be valuable for the families they come in contact with. Following the away day, we were subsequently invited to deliver training to 9 members of the 11 strong team. Training the majority of the team was of real benefit as there was a shared understanding of what they were trying to achieve and for the first time since the team was formed, they had a consistent and structured way of working.

## Training

The training was adapted slightly as there is no evidence base for teams working with families where there is no diagnosed mental health issue. The team generally felt there were low level undiagnosed mental health issues and a high level of substance misuse. We included sessions on common mental health issues, how stress affects us all, stress vulnerability, family stress and illness, mental health and cannabis use, the evidence for using Behavioural Family Therapy (BFT) with families, information sharing, communication skills and problem solving.

The training was delivered over five days, two days one week and three the next. This allowed the team to process the learning, talk through as a team how it might fit and to start talking to their families about working in this way. At the end of the training there was a real sense of optimism and hope that working collaboratively in this way would effect positive changes with the families the team were in contact with. They held a meeting post training and took the decision that *'this is our way of working now'*.

It is fair to say that even though the staff were motivated in changing their practice, there was a certain amount of trepidation about how the families would receive it. The families had been described as *'abusive'*, *'chaotic'*, *'always fighting and swearing at each other'* and *'there is no way this family will sit together'*.

## Supervision

It was felt from the outset that supervision would be integral to the success of the investment in training. It was such a radical change in the way the team offered their service that supervision was essential to embed any changes, keep the momentum and work through any difficulties encountered. It was also a great way for the team to get together and reflect on their successes.

Where there had been concern that families would reject the BFT model, the staff encountered quite the opposite. Yes, families might behave chaotically, but often this was because they didn't know what else to do. Life had always

been like this but that didn't necessarily mean that's how they liked it. Working with a structure enabled the families to increase their skills and build better relationships with each other. Obviously this is a work in progress and will take time to see the longer term outcomes change.

### A family worker's experience

The following is a report by one of the people who attended the training.

*“My experience of completing the Meriden Training in Behavioural Family Therapy was positive and insightful. I felt that the training was accommodated to our needs in terms of relating the approach accordingly to the client group which we would be delivering the work to.*

*The trainers took into consideration the difficult circumstances and dynamics which we would have to face throughout delivery of the work, and helped us to understand how the approach would be appropriate and helpful for some of our families as well as how to demonstrate these points to families and engaging them with family work sessions.*

*I am in the process of delivering the sessions to two of my families, which has been challenging due to the additional difficulties which they present with, which often requires crisis intervention support. The main challenge which I have been faced with for delivering the work overall is maintaining the momentum of family work with the families in terms of reminding them why adhering to the sessions is important and will be effective in the long term*

*in relation to the current pressing issues and demands that they present with.*

*However, due to the approach not being rigid and somewhat adaptable according to the family's needs, it does enable us to take this into account when delivering the work. Families, although initially expressing reluctance to engage with family work have expressed enthusiasm, interest and reflection throughout the sessions. They have all identified the need for better communication and how this could help improve their functioning as a family and relationships within the family.*

*Receiving supervision from the trainers has been helpful, particularly for reflection purposes as to how our delivery of the work may impact the response from families about family work. The trainers have offered advice and strategies around how to manage the challenges which we face on delivering the approach to the particular families which we work with. Supervision also assists with maintaining our confidence in and adherence to the model as well as identifying and reflecting on what has worked well.”*

*Toni-Anne, Family Worker*

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#### References

Department for Communities and Local Government (2014) *Helping troubled families turn their lives around*. London: Department for Communities and Local Government.

**ISPS UK Residential Conference – Save the Date!**

## **FROM DIAGNOSIS TO DIALOGUE**

**17-18 September 2014**

**Stamford Court Conference Centre,  
University of Leicester,  
Manor Road, Oadby, Leicester LE2 2LH**

An international conference for people with personal experience of psychosis, their family, friends and anyone who works to support them (including mental health professionals, therapists etc)

**For more information please visit  
[www.ispsuk.org](http://www.ispsuk.org) or email [admin@ispsuk.org](mailto:admin@ispsuk.org)**

**ISPS UK**  
THE INTERNATIONAL SOCIETY FOR PSYCHOLOGICAL AND SOCIAL APPROACHES TO PSYCHOSIS

ISPS UK Charity No: 1098909

## Look out for our new web link – Recovery for Carers

We are in the process of developing a significant new section to our website ([www.meridenfamilyprogramme.com](http://www.meridenfamilyprogramme.com)) on Recovery for Carers. The plan is for this to be launched on World Mental Health Day which is Friday 10<sup>th</sup> October 2014. This will provide a wide range of information that might be helpful to carers in their own recovery journey.

It will also be of interest to professionals who work directly or indirectly with carers and to those with an interest in carers who work in the academic world. Amongst the carer related topics to be covered are rights, benefits, wellbeing, carers assessments, carer education, family work, helpful services, recovery, confidentiality and references to access literature and research papers.

# My Journey from Theory to Practice

**Emma Rich, Assistant Psychologist  
Bipolar Service, Birmingham & Solihull Mental Health NHS Foundation Trust**

## Discovering Meriden

My attention was first drawn to the Meriden Family Programme during the Trust Induction and due to previous positive experience of family work I was immediately interested. I sought to find out what the Programme had to offer and was encouraged by the positive response my interest elicited from the Meriden staff. I was informed that they offered training in Behavioural Family Therapy (affectionately known as BFT), enabling those trained to offer BFT to their clients across the Trust. I returned to my base having only recently taken up the post of Assistant Psychologist within the Bipolar Service and requested permission to undertake the Meriden BFT training course.

Happily, my request was positively received by my manager and I immediately contacted the Meriden team to find out how soon I could start. I was offered the opportunity to join the BFT Acute Services training course, which was conducted one day per week over five weeks. I was excited by the prospect of undertaking the course, but unsure what to expect. I had some previous experience of family work, through involvement in parenting programmes and systemic family therapy, from which I had developed a keen interest in working with families. However, I knew that this course was based around a different model of family therapy to those I had previously encountered and wondered how it would ‘fit in’ with these alternative models.

## BFT Training

The training cohort turned out to be as diverse as it was probably possible to find, representing a wide range of professions. However, the majority of participants were female with only one male. The information was presented using a variety of different techniques including presentations, discussions, video clips and role plays. The course proved to be particularly interactive and we were encouraged to reflect on our own experiences of being part of a family, which promoted the idea that BFT is not just about families in crisis, or families struggling with mental health difficulties, but applicable to all families.

In general, the course focussed on helping us to learn how to work collaboratively with families to help them recognise their current strengths, develop their communication and problem solving skills, share information and put together a relapse prevention plan. At each stage of training, an emphasis was placed on developing our understanding of the rationale behind each of the elements of the intervention. This in turn helped to build our confidence in ourselves as practitioners.

## Role Plays

Admittedly the first time I heard the facilitators mention the phrase “role play”, I wanted the ground to open up and swallow me whole. In a manner that seems traditional in these situations, the facilitators requested volunteers. A noticeable number of the group visibly sank into their chairs and all eyes immediately hit the floor...but clearly used to such reticence and well-practiced in the art of delivering training, the facilitators were unperturbed. They informed us, not unkindly, that role plays were a key element to training and all trainees would be required to participate. I admit that part of me wanted to run screaming from the room never to return. However, their argument that the intervention was best delivered by those with some experience of the process was difficult to argue with. I swallowed hard and acknowledged that my confidence was going to be tested during the course of the training.

When my turn came, I was slightly panic stricken, however with the aid of some cognitive anxiety management techniques (positive self-talk, deep breathing, etc.) and the benefit of seeing other people survive the process, I dived in...sink or swim. It wasn't graceful or pretty, but on reflection, it was less painful than I had anticipated, became easier over time and more importantly, proved to be a valuable learning experience. Most significantly the role play experience encouraged me to reflect on the problems families face when a loved one becomes unwell and how family dynamics impact upon a service user's recovery. I became especially aware of the central role ‘the family’ play in helping people recover and stay well.

## My First Family

All too soon the course was completed and I was looking for my first family. Elated by the prospect of being able to go out and “do” family work, but somewhat nervous about the reality of that, I sought advice from the course facilitators. Again the Meriden team could not have been more helpful and suggested that I co-work with one of their team to help me get started. I gratefully accepted their offer and so it came to be that I was helping facilitate an engagement session on Christmas Eve 2012.

The work with my “first family” is now all but completed and it was every bit as interesting and rewarding as I had hoped it would be. After some initial scepticism the family really seemed to take to the approach and the style of delivery. At times the emotion within the room escalated and heated debates were sparked, but by sticking to the model and focusing on the process and not the content, the session progressed as planned.

I have to admit after my previous experience of Systemic Family Therapy I found it difficult not to get ‘pulled’ by the content of the family’s discussions, especially in more emotive moments. Initially, I also wondered how the family would respond to having the content of their interactions being so neatly side stepped. However I was reassured to find that by sticking to the model and bringing the family’s focus back to the process they were able to contain any issues/emotions that had been raised (if only temporarily) and focus on the current objective e.g. learning a new skill. Throughout the sessions, when problems arose, we highlighted the skills that the family could use to help find a resolution, but avoided becoming embroiled in analysis of the issue itself. This enabled the family to think about when and how they could realistically hope to utilise the skills they had learned.

Working alongside a seasoned professional proved to be a very valuable experience helping to consolidate the BFT training. I was able to try out my newly developed skills with confidence and listen and learn when I was less sure how to proceed. Ultimately I learned that if I stick to the structure and format I will give both myself and the family with whom I am working the best chance at success. I gained a great deal of confidence from co-working in this manner and discovered that the only way to get a feel for family work is to get out there and work with a family.

### **Family Work within the Bipolar Team**

Recently the Meriden team have been working alongside the Bipolar Team as they strive to develop a care pathway for people with a diagnosis of Bipolar Disorder. As stipulated in the NICE guidelines the best intervention for people with this diagnosis is medication, psycho-education and family work. To this end, there is now a family engagement session included within the Bipolar Service’s “Mood on Track” course which is hosted by a member of the Meriden Team. In light of the collaboration between the two teams, it seemed pertinent that my role working with families should be utilised where possible with Bipolar Service clients and their families. To this end, earlier this year, I began work with my second family.

The composition of my second family contrasted that of my first family, in particular with regard to the ages of the children, the roles of the service user, and their diagnosis. Despite their differences, it soon became clear that many of the issues and concerns were the same; a lack of information, a lack of understanding and a lack of a plan to help people know what to do and when. Further exploration, however, revealed a difference in how each family wished to tackle their objectively similar difficulties. The first family seemed to find the protected time of the session itself particularly useful and the communication skills training constructive. In contrast, the second family were more interested in the information sharing aspect of the work and helping everybody develop a common understanding of the issues and how they could be managed. Reflecting on the

differences and similarities between the two families has served to highlight the expertise families bring to family work and their ability to help themselves given the right support.

### **How does BFT fit in with my previous experiences of family work?**

On reflection, I feel that BFT sits comfortably alongside my experience of other models of family work as it is practical in its focus and application. BFT does not seek to analyse a family’s situation or difficulties, but instead strives to help families develop skills that they can use together to manage their situation as effectively as possible. This is not to say that service users and their families will no longer require input from other services, but it is likely that with the benefit of BFT, they will be able to manage more effectively together as a family, recognising when additional support is needed and accessing services before reaching crisis point. Furthermore, it seems likely that due to the non-analytical nature of the intervention, it would not impact upon any other therapies that may be being offered.

### **Supervision**

As with all clinical work, the question of supervision is an important one. Fortunately the Meriden team have it covered, offering monthly supervision with the other members of the training cohort. I have found the supervision provided especially helpful as it offers the opportunity to discuss the general progress of any family work as well as any difficulties that have arisen. Furthermore, it enables me to benefit from the experiences of others in the group and to share ideas and suggestions alike.

### **Conclusion**

BFT from training through to practice has been a rich learning experience. It has tested my confidence and challenged my thinking. It has keyed me into looking beyond the service user as an individual, to seeing them as a member of a family network and viewing the family as a key part of a holistic intervention. I believe BFT teaches skills to service users and their families to help them find their own way of managing, and in doing so, families automatically develop ideas that take into account the reality of their lives. I believe the intervention is therefore pragmatic and in turn likely to be of benefit to the majority of service users and their families with additional benefits for other services.

I feel I have benefitted greatly from the training both personally and professionally. I have successfully utilised the skills with my own family and found practicing family work has diversified my job role thus enhancing my job satisfaction. Training in BFT has added a new dimension to my ambitions for the future. I am now looking to build up a family work case load and hope to be able to continue practicing family work throughout my career.

# Training the Trainers Course 10th-14th February 2014

**Martin Atchison, Clinical Specialist –  
Meriden Family Programme**



The annual Meriden Training the Trainers course was attended this year by 44 people, the largest group that has attended the course since the Meriden Family Programme began in 1998. This was very encouraging for the team, as it demonstrates that family work and the training of professionals in family work continues to be valued by organisations. With so many people on the course, the team was eager to ensure that everyone attending had a positive experience and were fully prepared to take on a training role. All of the team were involved in delivering the training throughout the week and colleagues who had previously worked for the Programme, and experienced trainers from Birmingham and Solihull Mental Health Foundation Trust, and Worcestershire Mental Health Partnership NHS Trust were also involved in delivering the course.

Equipped with a roving microphone and speaker system to ensure that everyone in the room could hear, the Programme Director, Dr Gráinne Fadden welcomed people from various organisations across England and Scotland, and people from Ireland who were to begin training clinicians in the emerging Early Intervention services. There were also four people from Nigeria, again who were going to go back and develop Early Intervention services, and four people from Nova Scotia, Canada, including two family members who have been significant in motivating the development of services for families in the province.

As usual, the background of the participants was from across all professions in mental health, and a variety of service areas were represented also. Attendees worked in settings including early intervention, inpatient community services, and learning disabilities services.

The atmosphere throughout the week was very positive. People attending the course would be going back to organisations that were at different stages of the implementation of training, some who would be joining an established group of trainers, and others who would be setting up and developing training programmes

from scratch. Everyone spent time during breaks to network with each other and learn from each other's experiences. From our perspective it was a really motivating week, and we feel confident that the people attending the course will continue to have a positive impact on families' lives across the world.

Some quotes from the feedback that participants provided included the following:

*"It was really relevant, well structured, accessible and thought through. It's helped me feel less anxious about presenting which is no mean feat."*

***"Excellent, very appropriate. Built up my confidence, enthusiasm and commitment. Excellent learning environment created, and fun."***

*"Absolutely fabulous course. My goal was to improve my observation/feedback skills and I have done that. I am very confident these will continue to improve."*

***"Intensive, exhausting but extremely well put together. Thank you!"***

*"Facilitators have clearly worked hard to ensure it appears that it is not hard work at all"*

***"The skills and spirit of BFT have been modelled throughout. Excellent organisation. Excellent team work. Thanks"***

*"Brilliant course, best one I have ever been to! It has really helped to overcome anxieties re: presentations. Very constructive feedback. The sessions were very well thought through and I appreciate the time and effort put into it."*

***"I like the fact that emphasis was placed on the process of teaching, not on the content. I have been to other training trainers' courses that assumed we all had presentation/facilitating skills – mistake!"***

*"Found this week inspirational – adding to my BFT skills/presentation - and enhancing my confidence to facilitate in groups. Amazing presenters. Fabulous colleagues. Ready to go. Thank you."*



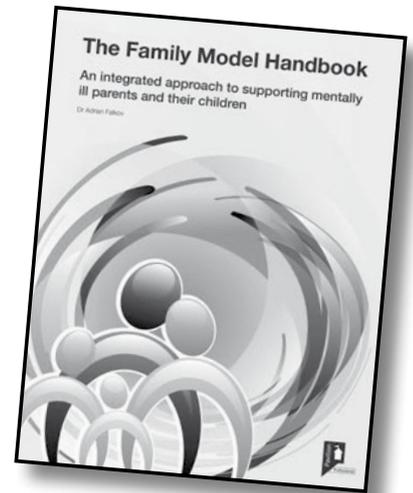
All photos show delegates on the Training Trainers course 2014 in Birmingham.

# The Family Model Handbook

**Author: Dr Adrian Falkov**

**Reviewed by Paula Conneely, Clinical Specialist –  
Meriden Family Programme**

*“All individuals who experience mental illness are, or have at some point been, part of a family. Families play a vital role in everybody’s experience of mental illness, and ill health in turn has a critical and enduring influence on family life” (Falkov, 2012)*



The Family Model is a conceptual approach to practice devised by Dr Adrian Falkov, a child and adolescent psychiatrist who trained and practiced in London before moving to Sydney, Australia. The Family Model handbook is an extension of the *Crossing Bridges* programme co-developed and managed by Dr Falkov in the late 1990s. The handbook builds on the principles and practice of his *Crossing Bridges* work, while integrating more recent approaches to whole family working.

The focus of the handbook is Falkov’s “Family Model” concept. In brief, during its conception this model consisted of four elements/domains, with *Crossing Bridges* exploring how they interacted, influenced and impacted upon one another. The original domains were:

- Parental mental health.
- Child mental health and wellbeing.
- Parenting and family relationships.
- Risk and protective factors.

Within the revised manual, Falkov has now enhanced the model by adding further principles which take into account:

- Services (To ensure that both adult and children’s service provision is explicitly considered in the context of relationships).
- Culture and Community (To ensure that broader influences on family life are also considered).

Within the text, Falkov provides an overview of current thinking and literature from an international perspective, interspaced with stories and quotes from those who have experienced the impact of mental ill health first hand. The writings of Heide Lloyd are particularly poignant and insightful and really add a sense of reality and relevance.

The individual domains are discussed in detail, with Falkov exploring their relationships and linkages in a clear and easily read manner. Again, the text is interspaced with a number of tables and diagrams which help the reader visualise how each aspect/domain relates back to the conceptual model.

The latter chapters address approaches to practice and how the model can be used to assist engagement and form part of the assessment and care planning process, with further text considering service frameworks and examples of good practice (referencing the Meriden Family Programme as a successful UK initiative).

In addition to the handbook, there is a useful disc enclosed which provides a helpful way of exploring the model. It contains sections of the manual in electronic format, copies of the Family Focussed Assessment sheet (taken from the New South Wales mental health clinical documentation suite, NSW Department of Health, 2010) and a CD-rom which enables the user to explore the full-colour diagrams in a more interactive manner, linking the visual elements of the model to the respective chapters in the text.

In summary, this is a detailed handbook which helps the reader think about and reflect upon the interconnected relationships between family members, parents and children and how these unique relationships may influence the onset, course and prognosis of illness. It will help any reader, regardless of professional background or service setting, think about how best to engage and work with whole families.

Indeed, “a key principle in the achievement of greater family-focused care is the explicit recognition that parenting is a mental health issue and that investment in families as a whole brings benefits beyond the well-being and recovery of the affected adult as an individual”. (Falkov, 2012)

## References

Falkov A (Ed) (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children; an evidence based Reader*. Brighton: Pavilion Publishing.

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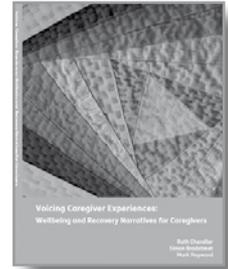
**ISBN: 9781908066619. Price: £35.00**

**Publisher: Pavilion Publishing and Media Ltd**

**Publication: 01 July 2013**

# Voicing Caregiver Experiences Wellbeing and Recovery Narratives for Carers

**Authors: Ruth Chandler, Simon Bradstreet and Mark Hayward**



**Reviewed by Peter Woodhams, Carer Consultant – Meriden Family Programme**

This is a fascinating and unusual book that has a number of different dimensions to it and will be of interest to caregivers and staff who work with caregivers alike. In my review, I use the word caregiver as this term is consistently used by the book editors. It will also be relevant for those who are interested in developing the concept of recovery for caregivers.

The three editors are professionals, although in one case the person has experience of being both a user of services and a caregiver. Ten of the chapters are narratives written by ten different caregivers based in either Scotland or Sussex. These ten authors contributed on a voluntary basis and were free to say entirely what they wished. Sometimes their own commitments to caregiving and other unpredictable factors affected timescales and priorities but their main brief was to put their own recovery first in their writing – as opposed to the recovery of the person they cared for, which I am sure was sometimes difficult for them. The editors took a ‘stepped-back’ approach but provided support when necessary which sounds a really nice style. This means that the ten chapters written by caregivers are of varying length and structure but each has its own ‘personality’ and story.

The editors have written a brief summary of each of the caregiver chapters at the beginning of the book which is helpful if the book is used in a reference or selective way. For example, caregiver readers may wish to read a story that they can relate to most easily or that might be helpful at a particular stage in their own caregiving journey. Interestingly, the editors have introduced a ‘Pause for Thought’ chapter between caregiver narratives five and six, in which they reflect on the importance of hope and recovery for caregivers aided by the use of scenarios and exercises. These are the some of the features of each of the ten narratives:

## **Chapter 2 – Recovery... a strange word for me**

A mother’s account of caregiving for a daughter with a psychotic illness – how it was with and without support from services; the emotional difficulties of not being listened to; also that by being involved and made to feel valued, the process of ‘recovering’ can be helpful to caregivers.

## **Chapter 3 – The silver lining**

An uplifting account of how a husband and wife overcame confusion and stress after their son developed a psychotic illness. How seeking out information and improving understanding helped their relationships with professionals and their own recovery journey.

## **Chapter 4 – So you love someone with a mental illness?**

Both social and personal recovery started for this wife when she

joined Al-Anon (the sister group of Alcoholics Anonymous) after her husband with a bipolar disorder turned to alcohol. The tools she gained helped her support her husband to sobriety and manage her own recovery.

## **Chapter 5 – My story... so far**

A strong narrative by a mother whose son developed both physical disabilities and psychotic symptoms in which she explains that her own recovery was helped by taking up voluntary work and becoming a magistrate as well as managing the current reality.

## **Chapter 6 – Love is my first ingredient**

An interview with an Asian mother of a daughter with mental health problems which the family have found difficult to talk about. Her own recovery has been helped by joining carers’ groups, and by contributing to training while maintaining a close bond with her daughter and supporting her recovery.

## **Chapter 8 – Every pebble counts**

The husband of a wife suffering from depression talks about personal pain and hope and through understanding recovery as regaining what has been lost, he has developed strategies to help maintain wellbeing.

## **Chapter 9 – Recovery – or simply acceptance?**

An emotional account about the meaninglessness of recovery for a mother whilst her daughter is not free from a psychotic illness. She outlines in her ‘diary of despair’ her pain at watching her daughter lose everything, but also how poetry and literature have helped her to express and cope with her loss.

## **Chapter 10 – I wish I could go back and give myself a hug**

How national and international training initiatives around recovery for caregivers have helped this mother better support the recovery of her son after her distress at the poor provision for her son.

## **Chapter 11 – Hearing the music and remembering to dance**

In this chapter the author offers an uplifting narrative about the power a recovery based approach has to improve caregivers’ lives and service delivery. On the other hand she reflects on the life opportunities she has missed as a caregiver and calls for real choice in supporting wellbeing.

## **Chapter 12 – Recovery together**

A detailed account written by a caregiver who came to the UK as a young Iranian girl and grew up with a brother who was diagnosed with schizophrenia. She talks about the lack of cultural awareness shown by services and the difficulties faced in this country by her mother. She explains how starting a

carers' group and training as a psychotherapist has helped her own recovery and ends with ten 'practical tips to support recovery together'.

In the final chapter '*Making sense of it all*', the editors have drawn out their own learning from the narratives both collectively and individually. I found this a very helpful chapter and feel that it is worth highlighting just four of the many points made about recovery for caregivers:

1. The importance of 'care for the self' in recovery and wellbeing.
2. The importance of early support and information for caregivers.
3. The importance of relationships with caregivers.
4. A sense of shared humanity.

This is a compelling book which should be a 'must read' for those who work with and support caregivers, to help them appreciate the depth of the emotional experience of caregiving, and to think about how they can help caregivers with their own recovery. Many caregivers will also be drawn to it as well because they will associate with many of the stories but it may also help them in their own recovery. Certainly the book makes a major contribution to the evolving concept of recovery for caregivers.

**A 2013 joint publication from:** Sussex Partnership NHS Foundation Trust, Sussex and Scottish Recovery Network, Glasgow. To download chapters from the book please log on to: <http://www.scottishrecovery.net/Latest-News/voicing-caregiver-experiences-10-new-stories-of-recovery-and-wellbeing.html>

## Consideration for Carers in New NICE Guideline

**Peter Woodhams, Carer Consultant – Meriden Family Programme**

February 2014 brought the publication of the National Institute for Health and Care Excellence (NICE) Guideline on Psychosis and Schizophrenia in Adults (Update) which is the 3rd guideline I have worked on as the only designated Carer Representative.

This particular guideline proved to be a positive experience for me as the evidence reinforced recommendations related to family interventions made in the 2002-2009 guidelines, and it also introduced recommendations regarding information and support for families and carers.

Family interventions are again recommended as a treatment for people with psychosis or schizophrenia, particularly where families live with or are in close proximity to the service user. Attention is drawn once again to the fact that they might be particularly helpful where there is recent or potential relapse or when symptoms are persistent.

The guideline also re-emphasises that amongst other features, a family intervention should include the service user, last for 3-12 months, have a minimum of 10 sessions and have a specific supportive, educational or treatment function and include negotiated problem-solving or crisis management work.

The support for carers element introduced into the guideline this time was for me particularly pleasing and I hope it will prove to be really helpful for all carers and families. These are some of the recommendations covered in section 1.1.5 of the new guideline:

- Mental health services should offer carers an assessment of their needs and develop a care plan which should be copied to the carer's GP.
- Provide carers with written and verbal information about the diagnosis and management of psychosis and schizophrenia, positive outcomes and recovery, types of support for carers, the role of teams and services and getting help in a crisis.
- Negotiate with service user and carers as early as possible about how information will be shared.
- Regularly review how information is shared.
- Include carers in decision-making if service user agrees.
- Offer a carer-focused education and support programme, which may be part of a family intervention, as early as possible.
- This programme should be available as needed and have a positive message about recovery.

Speaking as a carer it is sad that recommendations such as these are just there as a 'gold standard' but nevertheless they represent really good practice which can be attained. Family interventions and effective carer support which may also help in the management and possible reduction in relapse of course has cost implications.

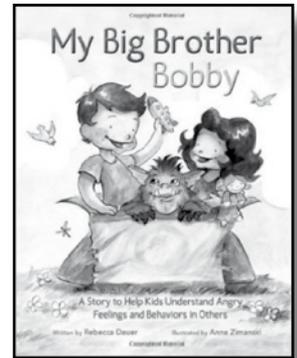
Meriden's Behavioural Family Therapy training does of course enable staff to deliver a family intervention that complies with these recommendations as does the Caring for Carers course in the context of carer support.

# My Big Brother Bobby:

## A Story to Help Kids Understand Angry Feelings and Behaviors in Others

Written by Rebecca Dauer and illustrated by Anne Zimanski

*A new book from the United States which may be of interest to anyone working with families where one of the children presents challenging behaviour.*



*My Big Brother Bobby* is written from the perspective of a little girl growing up with an older brother with an unspecified condition. She loves to play with her brother but feels upset when the ‘monster living in his belly’ emerges and his behaviour changes. In the course of the story the girl learns strategies to manage her feelings, just as her brother learns strategies to ‘tame the monster’ within.

This is a lively picture book that will appeal to younger siblings. The story of the sibling relationship is told honestly with charming illustrations. There are also some useful activities for siblings to help them name their feelings, manage difficult situations and calm down.

*“What a wonderful conversation starter for parents to share with their young children. This book is a welcome addition to the literature that helps to empower children to manage their fears and worries when growing up with a child who has difficult behaviors, and should be in the ‘toolbox’ of all health professionals and educators.”* Kate Strohm, Author of *Being the Other One* (Shambhala Press).

*“Like parents, sibling of kids with special needs benefit from opportunities to have their experiences described and*

*confirmed. My Big Brother Bobby is wonderfully validating to young siblings of kids with challenging behaviors.”* Don Meyer, Director of the Sibling Support Project; Senior Author of *Sibshops: Workshops for Siblings of Children with Special Needs*.

*“My Big Brother Bobby, provides an excellent opportunity to address children’s feelings, in a non-threatening manner, about an out-of-control sibling. Many children are not only fearful, but feel neglected and resentful when the adults in charge spend so much time focusing on the out-of-control child. The child, with such a sibling or playmate, learns that these feelings are not only normal, but that they can learn strategies to handle them in times of stress. This book should be in every child therapist’s book collection.”*

Dorothy H. Rawley, Ph.D. Psychologist

Paperback: 32 pages.

Publisher: Lime Blossom Publishing (6 Dec 2013).

ISBN-10: 0615909450.

ISBN-13: 978-0615909455.

For more information on this book please visit [www.mybigbrotherbobby.com](http://www.mybigbrotherbobby.com)

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

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