



So, a larger and very full edition of the newsletter this time around. Apologies that there has been a longer gap than usual between editions. It has been a really busy time for our small team, and I suppose like everyone else we have experienced pressure linked with the current economic situation worldwide given that we rely on being able to generate income through our training and consultation work.

In reviewing the articles in this edition, there is certainly a truly international feel to many of the items. We have had a number of visits and work placements to our team from people keen to learn from our experiences of developing and implementing services for families. We have continued our long-established links with services in Australia, in particular with mental health services in Ballarat, Victoria. Two of our team, Chris and Julia travelled to deliver further training both to new staff and those who have received training previously. In spite of the time difference we provide regular telephone supervision to those trained, and it is clear that there is a strong commitment in the Ballarat services to ensure that there are services available to families. One of their staff, Carly Johnson spent three months with us experiencing different aspects of family work implementation.

We had a group of visitors who travelled from Japan where the development of services to families is crucial as the majority of those with mental health problems either live with their family or receive most of their support from family members. Community services are as yet poorly developed, although in some areas there are quite strong family associations who advocate for better services for families. Following the visit we have made a couple of videos that have been shown at conferences in Japan, and are in touch with those who visited to draw up long-term plans over a five year period to develop a cascade model similar to what we have used in the West Midlands to ensure that staff are trained in family approaches. The other person we were delighted to welcome on placement with us was Thomas Walunguba from Uganda who is the first person we have trained from the African continent. Thomas was

fortunate enough to obtain a Commonwealth scholarship which funded his visit. His plans to develop family services on his return are inspiring given that he is attempting to do this primarily on his own. Following the success of his visit with us, two of his colleagues have obtained funding for the coming year to join us for a placement. This will obviously make such a daunting task more achievable. Rounding off the international theme, we have an article by Ross White describing an exciting new programme on global mental health that has been developed in Glasgow.

On the home front, we are excited about the launch of a new Carer's Strategy within our own Trust. This followed extensive consultation with carers across the city. We are hoping that this will result in the continued development of comprehensive services for carers in the Birmingham and Solihull areas. Another exciting and productive development for us has been the collaboration between our Programme and our Trust Solicitor around training on the topic of confidentiality and information-sharing. We realised that many staff are fearful about sharing information with families because of concerns about legal issues. It has been refreshing to have Gill join us in this training to clarify for staff what information can be shared legally with families. It is clear that many mental health workers have erroneous views about the legal position in relation to this and unfounded fears about what might happen if they are more open with families.

Finally, we are delighted to launch a self-help manual for carers in collaboration with Rethink Mental Illness. This has been a really productive collaboration and we are hoping that the manual will be of great assistance to carers who find it difficult to access other types of support, or who can use the material in addition to receiving other forms of support. Details of how to access the manual are provided. So, as I said, a very full edition – hope you enjoy it, and have a good summer.

Sharing Information with Family and Friends

A one day training session

By Paula Conneely, Clinical Specialist, Meriden Family Programme

“Confidentiality and the way in which service users, families and services share information has raised debate throughout the history of healthcare. This is perhaps particularly so within mental health care. Families and friends often play an incredibly important role in the lives of service users, and as such can have an important role in maintaining their mental health, safety and well-being. Equally, feeling involved and included can help relatives feel less stressed, help sustain their own health and enable them to better support their loved one.”

(Meriden “Sharing Information with Family & Friends” workbook, 2011)

It was this ethos, coupled with numerous requests for training on the issues surrounding confidentiality, that led the Meriden Family Programme to consider offering specific training on the topic (the topic forms an integral part of the current Behavioural Family Therapy training, but has until now not been delivered as stand-alone training).

Following the success of the Meriden Programme’s first venture “Sharing Information with the Circle of Care” training held in Nova Scotia in the Summer of 2011, it was felt that there was scope for training on the confidentiality issues faced by carers and family members here in the United Kingdom. As such, a training day was devised which enabled participants to think about the meaning of the word “confidentiality” and its influence and impact from both a service user, family and service-provider perspective. The day was designed to promote reflection and provide participants with specific information that would assist them in dealing with the day-to-day issues of confidentiality and information sharing that they encounter in routine practice.

We were extremely fortunate to have contributions from Laurence Gladden, a young man who experienced psychosis in his teenage years who spoke positively regarding “The value of having my family involved”, and Peter Woodhams, Carer Consultant with the Meriden Family Programme who delivered a session entitled “Carers have needs too”. Both sessions received outstanding feedback from those who attended, and really drove home the importance and value of keeping significant others involved, included and informed throughout the care pathway.

During the afternoon session we heard from Gill Harrad, Trust Solicitor for the Birmingham & Solihull Mental

Health NHS Foundation Trust, who spoke at length regarding the legal frameworks surrounding confidentiality. Gill was able to reinforce the importance of sharing information and the fact that relevant and proportionate information sharing is crucial in the provision of quality care. Having a legal expert to hand was extremely beneficial and provided participants with the opportunity to ask specific questions relative to their area of practice. It also reinforced the fact that “hiding behind” a façade of confidentiality is not acceptable and that many more issues/complaints arise from the withholding of information than the sharing of information in an appropriate, proportionate and timely fashion.

Through a series of presentations and small group exercises, this interactive day provided both factual information and the space to reflect upon practice. Given the positive feedback received, Meriden will be offering further training dates throughout the coming year. Please see our website for details.

Comments from delegates....

“Really useful - made you think properly about all of the issues around confidentiality and carers.”

“Necessary and proportionate! Found Peter and Laurence’s input moving and helpful to understand what it is like from a mental health point of view.”

“This training was excellent and should be mandatory. In addition to elements and issues of confidentiality, it encourages more psychological thinking and consideration of wider issues impacting on service users lives and the lives of others in the systems around them.”

Information Sharing

A Legal Perspective

**By Gill Harrad, Trust Solicitor
Birmingham & Solihull Mental Health NHS
Foundation Trust (BSMHFT)**

Confidentiality and information sharing is one of the areas in which the legal team at BSMHFT frequently get asked for advice from staff within the Trust. In running a telephone advice service for staff, this is a subject that crops up time and time again, whether it be sharing information with other healthcare professionals, police or significant others, staff often seem to lack confidence in this particular area.

So I was pleased to be able to contribute to a course being run by Meriden on the topic of confidentiality in terms of adding in the legal framework to the discussion. It is interesting that healthcare staff often feel worried that sharing information without consent is likely to lead to them being 'struck off' their professional registers. However, in many serious inquiries following tragic incidents, problems have often been identified about the failure to share information rather than sharing information in good faith for sound reasons.

One of the really useful elements of the training with Meriden has been the discussion groups that take place, in which practitioners have the opportunity of raising

problem areas and often reaching an answer through a group discussion.

One of the areas that has been highlighted for me through my involvement in this training, has been the concern that staff often have in respect of sharing any information, even though it might not be confidential. This may be something as simple as a parent who is already aware that their son has been diagnosed with schizophrenia and who knows that he has been prescribed particular medication, asking about the nature and duration of that illness or side effects of medication that their son is receiving. This information is not confidential to the patient – it is general information that is available to anyone. It does, of course, become confidential if the parents do not have prior knowledge of the illness or treatment, and ask what the diagnosis is or what medication is being prescribed.

The other area that appears to cause difficulties is when confidentiality is used as a reason not to engage in discussions with significant others in patients' lives. Families have reported that professionals do not always explain why they cannot share information, or whether they have even had a discussion with the patient about sharing information. They say '*we can't talk about that because of confidentiality*'. Discussions around these topics have been useful in sharing practical examples to give people confidence about how they may handle difficult situations.

I hope that by attending the information sharing course, staff feel more confident about handling what can be difficult and sensitive situations.



Birmingham and Solihull 
Mental Health NHS Foundation Trust

Sharing Information with Family and Friends *A one day training session*

Venue: The Uffculme Centre, Birmingham
**Dates: 11 September 2012,
5 December 2012 and 27 February 2013**

The issue of confidentiality is complex. Confidence around what information can/cannot be shared freely can sometimes be low and the issues compounded if the service user does not give consent. This interactive training day aims to reflect upon these issues and introduce good practice strategies for working with service users, their families, friends and significant others.

Learning objectives for the day will be:

- To clarify what is meant by confidentiality, information-sharing, and the different types of information.
- To encourage participants to reflect on issues relating to confidentiality and information-sharing.
- To explore the benefits of sharing information and of establishing more collaborative patterns of working.
- To reflect upon good practice strategies for sharing information with carers
- To discuss common scenarios and dilemmas that can arise in relation to information sharing, and how these can be addressed.

**If you are interested in attending please complete the attached booking form and return to
Sam Farooq on: Fax: 0121 301 2891, Email sam.farooq@bsmhft.nhs.uk, Telephone: 0121 301 2896**

Launching the Triangle of Care West Midlands

**By Peter Woodhams, Carer Consultant and Julia Danks, Clinical Specialist
Meriden Family Programme**

In early December, Meriden hosted an event to formally launch the Triangle of Care in the West Midlands. Both the new mental health strategy 'No Health without Mental Health' and the new carers' strategy 'Recognised, Valued and Supported' quote the Triangle of Care as an example of good practice as it promotes a therapeutic alliance between service user, professional and carer that supports recovery and sustains well-being.

The development of this framework was funded through the National Mental Health Development Unit but since the demise of that unit in 2010, really important initiatives such as this have relied on organisations coming forward voluntarily to promote and support them. Fortunately, in the case of the Triangle of Care, The Carers Trust formerly known as The Princess Royal Trust for Carers has maintained the momentum by hosting and supporting a national Triangle of Care group but it needs more localised organisations to carry on this work 'on the ground'.

Despite extensive advertising of the West Midlands launch event, which was free, through our own networks, the attendance was disappointing. Our own trust Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) was well represented and the only other localities present were Coventry and Warwickshire, Dudley, South Staffordshire, Walsall and Hereford.

The delegates fully participated in the event and made it a lively and very beneficial day. After an introduction by our own Director, Dr Gráinne Fadden, Alan Worthington

outlined the background and content of the framework and how its formal introduction into services can benefit service users, professionals and carers. Alan is a carer himself and the co-author of the Triangle of Care with Paul Rooney who, until his recent retirement, spent many years with this trust here in Birmingham.

Julia Danks, Clinical Specialist with Meriden, and Elaine Herlihy, a Ward Manager at BSMHFT then talked about the work that is being done on the Triangle of Care in Birmingham, through the undertaking of self-assessments, issuing of feedback questionnaires to carers and the steady increase in the number of staff appointed as Carer Leads in teams across the Trust. Following this, delegates looked at the challenges and solutions of implementation and commented on how they might take this forward in their own settings.

In conclusion, Ruth Hannan of the Carers Trust outlined the support that her organisation was able provide to the promotion of the framework through the national group. She was keen to establish a Regional Triangle of Care Group in the West Midlands and was looking for people to join this group from across the region including Worcestershire, North and South Staffordshire, Dudley and Walsall, Wolverhampton and Sandwell. If anyone is interested please contact us at Meriden on 0121 301 2896 or email peter.woodhams@bsmhft.nhs.uk.

Meriden also organised the East Midlands Triangle of Care launch earlier this year. This was hosted by Nottinghamshire Healthcare Trust and a report on this event is below.

East Midlands

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

Health, social care professionals and carers from Nottinghamshire, Leicestershire and Derbyshire came together in February for the East Midlands' Launch of the Triangle of Care. The seminar was organised by the Meriden Family Programme and hosted by Nottinghamshire Healthcare with the support of Carers Trust (formerly known as The Princess Royal Trust for Carers). The speakers included Alan Worthington, lead author of

the document, and Ruth Hannan, Mental Health Lead at Carers Trust, which is leading the Triangle of Care project nationally.

Julia Danks from the Meriden Family Programme explained how the Triangle of Care was being implemented in Birmingham and Solihull Mental Health Foundation Trust, and gave examples of how the

Trust had introduced Carer Leads, established a Carer Leads Network, undertaken Self Assessments by services on how well they respond to carers' issues and conducted Carers' Surveys.

The Triangle of Care model identifies six key elements of best practice, including identifying a carer as early as possible, and staff understanding what it means to be a carer, and training being provided to support carers. These elements offer a framework for adoption, with worked examples of good practice and a self-assessment tool to allow evaluation of the current methods of carer engagement within services.

The event was opened by Simon Smith, Nottinghamshire Healthcare's Executive Director of Local Services, who emphasised the Trust's commitment to supporting the families and carers of service users. This includes the development of a family intervention service that provides individual family work and peer to peer support from people with lived experience of mental distress for both service users and carers. He commented that the Triangle of Care approach is making a major contribution.

Judith Machin, a Carer Peer Support worker employed by Nottinghamshire Healthcare as part of the 'Closing the Gap' project funded by the Health Foundation said:

“Today is the start of something I have felt passionately about for the past twenty years, since a family member first experienced mental distress.”

The Department of Health's new mental health strategy, 'No Health Without Mental Health' (DoH, 2011), and its policy document 'Recognised, valued and supported: next steps for the Carers' Strategy' (DoH 2010), both quote the Triangle of Care as an example of best practice. This event enabled delegates to learn more about its key principles, how to evaluate current practice, and how to modify or augment current practice to achieve desired standards. There was enthusiastic participation by all present at an event which was both challenging and inspiring.

The event was a first step in bringing the project to the East Midlands and following this, the Carers Trust will seek to bring together key representatives from relevant organisations and carers to work together in implementing the Triangle of Care across health trusts in the East Midlands. This follows the same initiative that was launched in the West Midlands at the event organised and hosted by the Meriden Programme.

Note: Information about the 'Closing the Gap' project can be found by accessing: <http://www.ucl.ac.uk/clinical-psychology/EBPU/news/files/2.%20SDM%20Project%20information%20Pack.pdf>

References

Department of Health (2011). No Health Without Mental Health. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

Department of Health (2010). Recognised, valued and supported: next steps for the Carers' Strategy. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077



From left to right: Peter Woodhams, Carer Consultant (Meriden Family Programme), Julia Danks, Clinical Specialist (Meriden Family Programme), Ruth Hannan, Policy Development Manager (Carers Trust), Jacqui Cullen, Family Interventions Co-ordinator (Nottinghamshire Healthcare NHS Trust) Alan Worthington, Lead Author – 'Triangle of Care', and Judith Machin, Carer Peer Support Worker (Nottinghamshire Healthcare NHS Trust)

The Triangle of Care

Putting it All Together

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

For some time now Carer Leads from the in-patient wards have been meeting regularly to share best practice and develop skills and knowledge around working with families and creating family friendly environments in their places of work. Recently, in line with the ethos of the Triangle of Care operating across the acute care pathway, Carer Leads have been developed within all Home Treatment Teams in Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) and have joined the renamed Acute Care Carer Lead Network. This also encompasses acute day services.

A short focussed pilot at an in-patient unit

Working closely with Nurse Consultant, Shameemara Rajpar, we looked at the benefits of working with families for service users, their family and friends, staff and the service as a whole. Following this, a series of small, focussed initiatives were undertaken, largely at the Zinnia Centre, an in-patient unit, to try and understand the experiences of carers, family members and staff on the unit.

1. Carer drop-in sessions

Carers were invited to drop in to four sessions that were arranged and advertised at the Zinnia Centre to share their experiences of using the services at the centre. The Zinnia was picked initially as all the acute services are based under one roof and we hoped we would be able to access carers whose loved ones were using a variety of the services on offer there.

Despite the posters around the building being in place for a couple of weeks and dates put into team/ward diaries it was difficult to access the carers. We had to resort to hovering near reception and asking carers if they could spare a few minutes after their visit. Perhaps not the best way to engage carers but the results were encouraging and without a doubt all of the carers we did manage to speak to were grateful someone had taken the time to talk to them.

Feedback

On the whole, families' experiences of using the Zinnia Centre were very positive. Carers were generally contacted soon if not immediately after admission

and were helped to try and understand their relative's condition. Staff were deemed polite, helpful and friendly. Many carers were visiting for the first time and were reassured by the building, the staff and the service. It was difficult for them to think about themselves when they were so worried about their relatives.

A small number of carers felt excluded by language barriers, e.g. their relative might speak some English but they didn't. Others felt excluded by confidentiality issues.

Disappointingly, few carers were directed to the Carer Lead on the ward/team, were informed of their right to a Carer's Assessment, given a carer pack or introduced to the idea of family work. This might be an area of development for the unit.

2. Family work focussed supervision

In order to try and understand the challenges for Home Treatment Team (HTT) staff a series of supervision sessions were provided.

The main issue to arise from supervision sessions, despite the enthusiasm amongst many staff members to collaborate with families, was the issue of engagement. Not just from the perspective of how to engage families but when families only want to engage with one team member, e.g. if they have connected with a particular individual, or if only that member of staff can speak their language or dialect, this can bring difficulties for the rest of the team.

3. Back on the beat

A member of the Meriden team also worked some shifts with a couple of different Home Treatment Teams. The purpose of this was to see what was working well from a family work perspective and identify areas that further training might enhance.

The different teams had different approaches, and in teams where families were more involved and valued, there was a family friendly ethos from frontline staff to team manager and Consultant.

The culmination of these initiatives and working towards closing the Triangle of Care was an **Acute Care Focussed**

Family Work Course delivered to staff over 4 days, one day a week, across the acute care pathway. It was delivered in this way to encourage staff to reflect between sessions and to try out new techniques and skills. Staff were then encouraged at the start of each training day to share their experiences of using their new skills.

A range of staff took part in the training:

- Consultant Psychiatrist (HTT)
- Community Psychiatric Nurse (HTT)
- Occupational Therapist (Day Service)
- Health Care Support Worker (Forensic, HTT)
- In-patient Staff
- Activity Workers
- ST4 Doctor

The content of the course was similar to a general Behavioural Family Therapy (BFT) course but consideration was given to the information/issues gathered beforehand.

As it was felt that staff in an acute setting were less likely to complete a whole BFT intervention due to the shorter contact with service users and families, priority was given to the areas that the acute care staff could reasonably be expected to deliver. Time was therefore spent looking at engagement issues, confidentiality and information sharing with the whole family, early warning signs work/staying well plans with families, issues for siblings, working across cultures and young carers.

Problem solving was another topic that the group spent time on, particularly with regard to exploring concerns that families may have regarding discharge from either the ward or home treatment.

One of the doctors shared their experience of trying out the problem solving technique in review and very quickly could see benefits of using it with families. It had helped with one particular family to think and reflect on different solutions and consider the advantages and disadvantages of each suggestion. This was not only beneficial to the family in that they felt involved in the decision making process, but it also helped the team move forward with an issue that had been holding up progress.

Less emphasis was placed on communication skills although an introduction was given to all of the four skills and delegates were able to explore and practice how to deliver one communication skill to a family by the use of various teaching methods; introducing the skill and generating discussion; watching a clip of DVD where a family worker delivers the skill to a 'family' and then having a practice within a facilitated role play group.

A service user and carer also came along to speak to the group about their many experiences of home treatment and in-patient admission prior to having BFT and what

life had been like since. It was a powerful session where the couple were able to share the benefits of having the family intervention, even though they admitted it was hard work at the time. One delegate remarked in their feedback ***“service user/carer session – great, inspiring, made it appear worthwhile.”***

Time was then given to plan the next steps. What would implementation look like and what support would staff need from their managers and colleagues? The Nurse Consultant had spoken to the group on Day One of the training and bravely pledged she would do all she could to facilitate staff being able to put into practice the learning gained from this bespoke training.

Staff were asked to feedback their personal action plans and examples of those are:

- Influence organisational commitment, model skills to team by using the skills with families.
- Sell the approach to other staff members, start working with a family and build a resource package for families.
- Take time to co-work with community teams.
- Negotiate protected time to work with families.
- Link with other carer leads, adapt model to home treatment.
- I have already started working with a family using the BFT model!

General feedback about the course included:

“Content of training was appropriately paced & informative. It was possible to get an understanding of what the therapy contains & how to facilitate it. Very useful and comforting to have the folder provided – to reflect on areas and use as a tool for the therapy.”

“The content of the course has given me a structured approach to implementing pre-existing skills. It also gives me tools/aids to explain the process to clients.”

“Very enjoyable and applicable to clinical area. Helped after practical ideas to make model flexible to working area and client group. Trainers knowledgeable and approachable. Unexpectedly enjoyed the role play.”

“I feel the way the course has been structured has given me a chance to practice skills learned and to bring back the experience to the group. For me this is better than 5 continuous days.”

“Trainers generated enthusiasm about the model and I feel very positive about applying this to my area. I enjoyed the weekly sessions as it allowed time to put skills to good use and seek feedback. Thank you!”

“This is a useful course, will need more practitioners to be trained and course should be run again.”

From the Midlands to Melbourne

Working with parents experiencing mental health difficulties and their children

By Anna Aherne, Family Worker
Building Family Skills Together – MIND Australia



I began working for Mind Australia in May 2008 for a pilot service called Building Family Skills Together. The service works with families in the North and North West of Metropolitan Melbourne using the Behavioural Family Therapy model delivered by the Meriden Family Programme. Prior to employment with Mind Australia, I worked for Birmingham Children’s Hospital as a Staff Nurse on the Ashfield Unit, Parkview Clinic, working with teenagers experiencing mental health difficulties. With this experience behind me I was keen to integrate the skills I had gained working with teenagers, their siblings and families into the family work in the Building Family Skills Together service in Melbourne.

I began thinking about how to make the family work appeal to young people. How can I make it fun? How do I present the information and skills so they will be viewed as important, not a ‘chore’ and something else they have to do as well as go to school?

I’ve decided to write about a few of my favourite ideas that have been used to discuss mental health and develop communication and problem solving skills. I also provide feedback from families I have worked with on what they found helpful, what they would like to have been presented differently, what they have learnt from the family work and how they would describe the family work to others as part of the article.

After the assessments have been completed with family members I often use the “Would you rather…” game as a warm up – family are asked to stand in a line, one behind each other, and asked questions, for example: Would you rather be an apple or a banana? Would you rather go on a beach holiday or mountain holiday? Would you rather be taller or shorter? This provides the family worker and family members with an opportunity to get to know each other and encourage different ideas and opinions that can be used as examples and rationale as to why effective problem solving and communication skills are important.

During the family work, younger children often request to play this game at the end of sessions and come up with their own questions.

To begin exploring ideas around mental health, I have used words and phrases cut out from magazines. This provides an opportunity to ask the young people and their parents what words they associate with mental health. This can be about symptoms, stigma and treatment. I am often surprised how conversation is generated from the words or phrases the young people choose and how comfortably

questions are asked about mental health – these questions are often directed to the parent from the young person instead of asking the family worker for the answers. This provides a great opportunity for parents to describe their own experience rather than the textbook answers young people may be provided with at school and by health professionals.

Using stress as a topic has provided opportunities for all family members to explore and discuss their own stressors. This can lead into exploration of the impact stress can have on mental health symptoms. I have used a ‘stress o meter’ to look at different situations and events which may be stressful and the family all have a turn at placing these on the ‘stress o meter’. This can then be used as a starting point to examine how stress can be felt physically and psychologically.

Using a sand castle bucket and a measuring cup I ask young people and their parents to think about how each of the events or situations on the ‘stress o meter’ would equal in measuring cups and add it to the sand castle bucket – if the bucket overflows because they are experiencing too much stress I encourage the family to work on ways of reducing stress. This has been a fun way to investigate stress and highlight what young people and their parents are already doing to reduce stress as this can be taken out of the bucket so it doesn’t overflow!

A particular highlight I have experienced when working with young people and their parents is the review sessions I run once all the communication skills have been introduced and practised – the skills are presented on coloured paper, a different colour for each skill. Green – expressing pleasant feelings, red – making requests, yellow – active listening and blue for expressing difficult feelings. Using these colours as reference I take along the board game ‘Trouble or Frustration’. Each person has 4 counters of one colour.

When this person lands on another player they have to practise the skill relating to the correct colour. Alongside practising the skills young people have commented on how much fun they have playing board games with their parent – something they haven't always experienced. This is a highlight for me as I am able to feed back to the family how well they have learnt the skills and what they have remembered as well as witnessing a lot of laughter and fun.

During review and feedback sessions I will discuss with the family what they learnt about the skills and mental health. These comments below are a snapshot of a family's experience of Behavioural Family Therapy.

What have you found helpful?

“Learning about depression and how stress can impact my symptoms, but by my family knowing more about depression I have been able to seek help and feel supported.” Answer provided by a Mother

“Having fun and playing games with Mum, we didn't do that very much but now we do it more.”
Answer from a 6 year old

What have you learnt about depression?

“Depression means you are really really sad a lot of the time but you can be happy too and you don't have to have depression forever.” Answer from a 9 year old

How would you describe this work to other families?

“Helps with communication and learning about mental health from the person's own experience because everyone is different.” Answer provided by a Father

“Anna comes to our house to help us learn about depression and how to talk to each other nicely.”
Answer from a 9 year old

When I have asked the young people what I could have done differently, the majority of answers are in response to my pronunciation of words – my 'Brummie' accent often needs translation but can be a great and very effective engagement tool!

Anna Aherne

Email: aaherne@mindaustralia.org.au

Website: www.mindaustralia.org.au



From left to right: Elise Whatley, Family Worker (MIND Australia), Julia Danks, Clinical Specialist (Meriden Family Programme), Anna Aherne, Family Worker (Building Family Skills Together – MIND Australia), Judy Hamann, General Manager (MIND Australia) and Chris Mansell, Deputy Director (Meriden Family Programme)

Carly Johnson spent three months with our Programme from February to June this year after being awarded a scholarship to undertake work experience training. Below, she describes her experience with us and how she is hoping to put this into practice on her return to Australia.

Work Experience with the Meriden Family Programme

**By Carly Johnson,
Senior Mental Health Clinician**

**Ballarat Mental Health Services, Ballarat,
Victoria, Australia**



In late March 2012, I set off from Australia towards Birmingham. I had won the Ken Burnett Traveling Scholarship offered by my employer Ballarat Health Services Psychiatric Service. The scholarship's aim is to allow one employee per year an opportunity to receive training and/or gain some work experience at a centre of excellence in psychiatry. Needless to say my application was to spend three months working within the Meriden Family Programme.

I had previously received five days training in Meriden's Behavioural Family Therapy (BFT) in 2006 when the Meriden team was asked to come to Australia and train our Mental Health Team. I again had an opportunity to have a three day refresher course in 2010. Therefore, I have had the chance to practice BFT with families accessing our public mental health programme in Ballarat, Victoria and have found it to be a therapy that clients, families and the service has found particularly successful.

The start of my three months with Meriden began with attending the BFT Training Trainers course. An intensive 5 day programme with copious amounts of experiential learning – yes role plays! Above anything, this course consolidated my knowledge of BFT and really brought home how simple it is to have all clinicians apply it to their daily work once you get over the usual difficulties of cultural and attitude change that may be needed – which of course the Train the Trainer course addresses in a unique and fun manner.

During my remaining time with Meriden I had the fantastic opportunity of being involved in training projects, clinical supervision and carer forums and events. One of these projects included delivering a specially adapted version

of Meriden's Caring for Carers training programme to a group of carers from the Chinese Community Carers' Centre. What a wonderful and challenging experience! As trainers we had the difficulty of language and cultural barriers that provided me with anxiety of how we could accurately communicate the principles of BFT to ensure that it was beneficial to the group. However, with help from workers at the Chinese Community Centre and a little humour we got past all the barriers and the course was enjoyed by all with feedback from participants indicating that they had found it beneficial.

So now, where to for me? Well after a bit of travel with my family, I plan to go back to Ballarat Health Services Psychiatric Services and put to work all my learning! Included in this plan is the vision that over the next 5 years our service will be applying BFT as a part of daily course, that all clinicians will have in-house access to BFT group supervision and regular training and refresher courses on BFT. Above all the plan is to have a significant reduction of illness relapse and hence reduce admission rates and overall pressure on the service in responding to crisis.

New Meriden Telephone Numbers!



The team now have new telephone numbers which are listed on the back page for your information.

Planes, Trains and Automobiles

An unlikely title for an article about delivering training in Australia!

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

The day had finally arrived, I was about to embark on a journey to the other side of the world to deliver training with my colleague Chris Mansell. I was excited at the prospect of visiting a country I had never been to before but there was also a certain amount of trepidation; being so far away from my family, spending two weeks with a colleague and wanting to make sure that after travelling that far, that we delivered our usual high quality training.

Those of you who have made the journey will know how long the flight is and we arrived in sunny Melbourne at the start of the Australian spring. Our first week was hosted by Ballarat Mental Health Services as we were delivering 5 days training to their staff. So although we had arrived slightly dazed and tired at the weekend, after a long walk on Sunday and 'much weather' (wind, rain, cold and sunshine!) we were ready to go bright and early Monday morning.

Tamara Irish (Executive Director – Mental Health Services) and Julia Hailes (Manager, Education, Training & Professional Development/Senior Psychiatric Nurse) at Ballarat Health had been our direct links. Julia was present throughout the whole week to support both the staff in their learning as well as Chris and myself, making sure we had what we needed, in terms of being trainers and that we were comfortable after work.

BFT Training – Community Staff

A condensed BFT course was delivered over three days to 46 community mental health staff. Some of the staff had completed BFT training in 2006 on Meriden's previous



visit to the area, so this course was a welcome refresher. Again, Julia helped us out by providing facilitators to help with the group work as it was such a large group.



Having Julia present throughout the week was useful as she was able to take any issues and feedback to Tamara and keep the group informed of developments in a 'live' fashion. For instance, the INA (integrated assessment) tool used by staff in Ballarat is very similar to that used within BFT as both are adapted from Ian Falloon's work. However, the tool we took with us has been amended over time following feedback from those using it and those being assessed. Julia was keen to take those changes on board to improve their own version and informed the group that following their feedback it would be progressed further. This was helpful to the group as not only were they participating in developing their skills but they had also contributed to the improvement and development of the assessment tool.

There was a huge amount of work to get through in three days so everyone was tired at the end of each day but the delegates embraced the idea of working with families in a flexible but structured approach.

Feedback from the three day BFT course:

"The content was excellent, extremely user friendly."

"Focus on skills training. Highly relevant and useful."

"Useful, practical information, very helpful in applying to practice sessions."

"The presentation was done in such a way that it makes me believe that I can take this and use it."

"Excellent. Role-plays whilst challenging, are a great way to consolidate skills and learning."

"The DVD's are good to see examples in practice."

In-Patient Training: Skills for working with the family within an in-patient setting

Training in the second part of the week was delivered to 28 in-patient staff over two days to accommodate the needs of the wards. The training was focussed around engaging with families, information sharing and problem solving with family members particularly around issues relating to discharge planning.

The aims of this training were that the participants would:

- Have an increased understanding of the experience of families who are in a caring role
- Have an increased understanding of the evidence base in relation to the impact of caring and the reasons for supporting families
- Have increased skills for engaging with carers and family members
- Have increased confidence in sharing information with families
- Develop skills to assist families with problem solving and achieving goals



Service users at the in-patient service have a very short average length of stay, which can present its own challenges when trying to build a relationship not only with the service user but also with their family too. Staff in Ballarat work hard to encourage families to visit their loved ones, e.g. by telephoning people to keep them informed and offering petrol vouchers to help with transport costs.

The morning started with delegates thinking about their own experiences of looking after a family member, what was helpful about services and what might have been done better. This is a useful exercise at the start of any family sensitive training as it sets the training in context and participants are able to relate their own experiences.

After looking at the research and rationale for working with families the group worked in pairs using a revised individual assessment tool that can help staff to begin to engage with families. One of the pair role-played the family member and the other played a member of ward staff. After practice, participants were invited to feedback

on the usefulness of the individual assessment tool and identify any learning points, from the perspectives of both the clinician and the family member.

After lunch, we looked at information sharing with families. Sharing information in a collaborative way is very different to 'illness education' which staff are more familiar with. Information sharing lets the family ask what they need to know and also provide answers to other family members where possible. The service user is encouraged to share with the family what it is like for them to experience, for instance, psychosis and the family are also encouraged to share what concerns them and what it has been like for them as a family. The clinician acts as a facilitator, to keep the discussion safe, promote a deeper empathy within the family unit and to fill in the gaps of the family understanding. The trainers gave a live role-play demonstration in front of the group, Chris played a member of ward staff and participants were asked to throw in questions, problems and comments for Chris to deal with showing how this might be shared with the family.

The final session was spent looking at problem solving, particularly in relation to discharge planning. The group were taken through a six step method of problem solving and looked at how to share this with a family. Again, we demonstrated through a live role play in front of the group. The large group then divided into three smaller 'family' groups to have a practice. Each group was asked to consider problems that families might be concerned about in relation to their relative being discharged from hospital and work through these issues with the 'family' using the problem solving technique we had demonstrated earlier. Again the delegates were asked to feedback their learning points to the large group.

The day ended with each participant being asked to consider their individual action points following the day's training.

Examples of feedback from the one day in-patient training:

"Great to remind people of the importance of family to treatment and recovery."

"Learnt a lot in a short time. I will now reflect on my practice."

"Problem solving was really good and relevant."

"Great to have specific training for in-patient nurses, we are quite often forgotten. Cheers!"

"Excellent. The day was extremely useful. Thanks."

That concluded our training in Ballarat and it was then off to Warrnambool to deliver a day's training on Confidentiality and Information Sharing. We even managed a glorious trip down the Great Ocean Road to see the sights of this beautiful area of the world.



Chris Mansell with one of the delegates from the training

Confidentiality Workshop - Sharing Information with Carers and Friends

This training involved 25 delegates from Warrnambool Mental Health Service.

It was a collaborative day that involved a service user and their carer throughout the training. Their input and perspective were invaluable.

The learning objectives for the workshop were as follows

- To clarify what is meant by confidentiality, privacy and similar terms and different types of information
- To encourage participants to reflect on issues relating to confidentiality and information sharing
- To explore the benefits of sharing information and of establishing more collaborative patterns of working
- To support participants in expressing their anxieties around information-sharing
- To discuss common scenarios and dilemmas that can arise in relation to information sharing and how these can be addressed
- To encourage participants to identify actions they will undertake as a result of the training
- To provide participants with further reading in relation to the topic

Participants were asked to describe what ‘confidentiality’ meant to them at the beginning of the day. They were also asked to consider their own experiences when in a caring role, to set the day’s training in context.

Small group work enabled delegates to consider the benefits of sharing information with service users, families and service providers. The service user and carer were then invited to share their experiences, which was a moving and powerful session for the staff and also emotional for the service user as he recounted painful experiences. This session was very much appreciated by all those that attended the training.

The sessions after lunch were spent looking at current ‘best practice’ both in Australia and the UK. Then, inspired by the service user and carer’s previous session, the large group broke into smaller groups to consider various scenarios relating to confidentiality issues.

Prior to ending the training with personal action points, the group was asked to reconsider their original definition of ‘confidentiality’ to see if there had been any changes.

Examples of feedback from the day

“I really liked the fact that both a consumer and carer were part of the training.”

“Good to re-visit principles and scenarios. Good to identify possible gaps in service system to empower clinicians to improve consent processes.”

“Absolutely relevant to have a consumer and carer as part of the training. Younger staff are being exposed to newer more positive attitudes.”

Chris and I ended the day’s training with a brief trip to a local nature reserve, on the recommendation of our host Janet Punch, who very kindly drove us there. Tower Hill Reserve, nestled inside a dormant volcano, is a beautiful haven for wildlife. A lake and wetland are features of the reserve and we managed to see kangaroos, koalas, emus and various birds much to our delight.

Next on our whirlwind tour of training was Melbourne and so we caught the Victoria Line train the following day and commenced two days of meetings and consultations with various organisations, including the Bouverie Centre, MIND Australia and other interested parties.

Then home, our final leg of the journey, which made in total: 4 planes, 1 train and 3 automobiles!



Left: Janet Punch, Staff Development Officer (South West Healthcare Mental Health Services) with family members at the Confidentiality workshop

Helping Families in Uganda

Thomas Walunguba is a Senior Psychiatric Clinical Officer from the Masaka Region of Uganda in Africa whom different members of the Meriden team have met at several international conferences at which the focus has been on families. I have met Thomas at these conferences in India and also in Canada and he has always shown great interest in the work of Meriden and has been passionate about how our work might be able to help families in Uganda.

He emailed me last year to enquire if we could offer him training in family work here in the UK so that he could then train other staff in his region of Uganda and also provide more structured support and guidance for families. He was able to introduce us to the Commonwealth Professional Scholarship Commission which has a scheme which provides some funding towards this type of mid-career training if certain criteria are met.

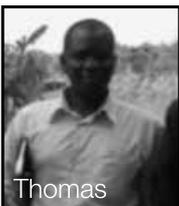
We have been able to meet these criteria and so we were absolutely delighted that Thomas was able to join us for an 8 week training programme earlier this year.

The programme was built around our core training courses which are the 5 day Behavioural Family Therapy course, the 3 day Caring for Carers course and then the 5 day Training Trainers course. This formal training was supplemented by supervised visits to different teams, services and carer groups around Birmingham and Solihull where family work and carer education initiatives are being implemented.

He also received formal supervision from Clinical Specialists within the Meriden team, which continues to be provided by phone now that Thomas has returned to Uganda.

Before arriving in the UK Thomas wrote the article below for us about what he hoped would be the outcome of the training he received from us for the people of Uganda. We in the Meriden team are very excited about the prospects of what might be achieved for families there. We very much hope that there will be articles in future newsletters about the progress being made on this in Uganda.

Peter Woodhams, Carer Consultant



Thomas

I am a Senior Psychiatric Clinical Officer who first worked as a Registered Psychiatric Nurse with Butabika National Mental Referral Hospital before going for promotion. I have worked with families of those affected with mental health problems for many years and I

have found out that families have problems with accepting that something wrong is happening to their beloved one. There is a lot of denial and misunderstanding eventually causing poor relationships in the family. Currently families face stigma and discrimination because of mental illness.

They also face problems with housing, food and transport for their beloved relatives. Fortunately, the family members are eager to learn how to support their beloved ones. Mental health services in Uganda are improving all the time. The Ugandan Government is doing its best to see that people affected by mental health problems are cared for like any other person.

Families are valuable resources for the support of people with mental ill health therefore they need to be supported.

I have been working with these families but did not have adequate skills. I am hopeful that the opportunity that I have got to be sponsored for the Commonwealth Fellowship will definitely help me gain more skills in working with people affected by mental illness from an internationally renowned organisation – the Meriden Family Programme – in the field of family work.





This will help me to train other mental health workers / clinicians in working with families. I am hopeful to train 15 of them on my return to Uganda within 12 months following the fellowship. This will impact on about 30 families. My medium term goal is to train 30 mental health workers within the Masaka Region in Uganda within two years to enable them to provide better training and support to families of those affected by mental health problems.

The long term goals are:

- To train all mental health workers in the Masaka region.
- To train fellow psychiatric clinical officers from other districts.
- To follow-up trained families and health workers.

Due to a lack of resources, the role of families is very vital in providing care and support. When a member of the family is affected by mental health problems it is always up to the family to provide the immediate support and care. So it is very important for the families to be provided with the knowledge and skills of caring for people with mental illness. It will reduce relapses, stigma and discrimination, problems with housing, food, and transport and our people with mental health problems will become productive.

It is also true that family work will save costs for Masaka Regional Referral Hospital through families being partners in care alongside clinicians and nurses. Families will be more empowered and will be involved in shaping and improving mental health services.

Training fellow psychiatric clinical officers from other districts of Uganda will enable them to do their job well in the care of families affected by mental illness. This is going to be a pilot program that I am hopeful will generate interest in other mental health professionals in the entire country of Uganda. The Meriden Family Programme will provide on-going supervision for the implementation of the family work and Masaka Hospital will support the programme. The ‘Millennium Goals’ (set by the Commonwealth Fellowship) that will be most addressed are public health, mental health and education.

We shall also try to reduce extreme poverty and hunger especially for the people affected by mental ill health. Families will be encouraged to engage themselves in agriculture like growing of maize, green vegetables, keeping poultry and rearing of pigs. People with mental health problems will be encouraged to take their medicines on time and regularly with the help of their caregivers. And when the patients are stable, their family members will be able to engage themselves in other developmental activities.

I will, together with the trained mental health workers encourage families to form support groups so that they can be supported in an organised manner. Following the training of health workers there will be improved relationships with families and trained families will encourage their children who would have recovered from mental illness to go back to schools and in so doing people with mental health problems will be empowered.

This is in line with the national development plan which has an emphasis on investing in the promotion of people’s health – a fundamental human right for all. Constitutionally the government of Uganda has an obligation to provide basic medical care for all the people in Uganda to enjoy rights, opportunities and have access to education and health services.

My sponsorship of the Commonwealth Fellowship is very timely and I am hopeful it is going to benefit not only the people in my region but also in the entire country.

Thank you so much The Commonwealth Scholarship Commission and Meriden Family Programme for making this Fellowship a reality.

Thomas Walunguba
Senior Psychiatric Clinical Officer
Head of Mental Health Department – Masaka
Regional Referral Hospital
National Chairman – Uganda Schizophrenia
Fellowship
General Secretary – Uganda National Association
of Psychiatric Clinical Officers



Family Interventions in the Global Context

By Dr Ross White, University Teacher/Clinical Psychologist
Institute of Health and Well-being, University of Glasgow

The global burden of mental health difficulties

The World Health Organisation has highlighted the growing threat of mental illness to the health and well-being of the global population. Whereas depressive illness is currently the third biggest cause of disease burden (i.e. years lost through disability and/or premature death), it is projected that depression will become the single biggest cause of disease burden by 2030 (WHO, 2004). There is widespread recognition that insufficient resources are available to meet the mental health needs of the global population. This is particularly the case for countries that the World Bank classifies as being low and middle income countries. For many years priority has been given to focusing resources on meeting the physical health needs of populations in low and middle income countries. Conditions such as malaria, HIV and diarrhoeal disease have claimed the lives of millions of people. Whilst acknowledging the huge importance of combating these conditions, there is a growing recognition that there can be no health without mental health. It is in this context that the Global Mental Health movement has emerged in recent years.

Global Mental Health has been defined as *'the area of study, research and practice that places a priority on improving mental health and achieving equity in mental health for all people worldwide'* (Patel & Prince, 2010). The inequities and inequalities in mental health provision between high income countries compared to low and middle income countries can be stark. It is estimated that four out of five people in low and middle income countries who need services for mental, neurological and/or substance use disorders do not receive them (WHO, 2008). This has been referred to as the 'treatment gap'; the difference between the levels of mental health services required by low and middle income populations and what is actually available on the ground. The recently published Mental Health Atlas (WHO, 2011) indicated that:

- Globally, spending on mental health is approximately \$2.00 per person, per year. However in low income countries this is less than 25 cents.
- Only 36% of people living in low income countries are covered by mental health legislation compared to 92% in high income countries.
- Outpatient mental health facilities are 58 times more prevalent in high income compared with low income countries.

- Whereas 45% of high income countries have a majority of facilities offering routine follow-up community care, only 7% and 29% of low and lower-middle income countries respectively do so.
- Whereas 59% of high income countries provide psychosocial care at a majority of facilities, only 14% of low income countries and 34% of lower-middle income countries have a majority of facilities offering psychosocial care.

An article published in a July 2011 issue of *Nature* identified what were termed 'Grand Challenges for Global Mental Health' (see: Collins et al., 2011). These represent the top 40 priority areas for reducing the global burden of mental disease over the next 10 years. One of the grand challenges that were identified was the need to: 'Enable family environments that promote physical and mental well-being across the life course'.

Family interventions for mental health difficulties in low and middle income countries

There is growing research evidence supporting the potential efficacy of psychological interventions in treating mental health difficulties in Low and Middle Income (LAMI) countries. For example, a recent review of seventeen studies (recruiting a total of 3,010 participants) concluded that psychological treatments for depression and anxiety disorders are effective in LAMI countries (Van't Hof et al., 2011). Consistent with this line of research, a number of studies have also explored the potential efficacy of family interventions for addressing complex mental health problems (mainly psychosis) in LAMI countries. Doubts have been raised about the relevance of formal family interventions for populations living in LAMI countries. These have chiefly been based on the notion that expressed emotions (EE) (e.g. emotional over involvement, hostility and criticism within families) may be unique to Western cultures.

Family interventions have also been criticised for being too costly, time consuming and labour intensive for countries, where trained personnel and mental health services may be in short supply (Chakrabarti, 2011). However, Chakrabarti (2011) counters that this scarcity of mental health professionals actually emphasizes the importance of supporting the family to meet the needs of individuals experiencing mental health difficulties. Whereas in the

West only about a third to two-thirds of persons with psychosis live with their families (or have regular contact with them), the proportion of patients staying with their families is much higher (over 90%) in countries like India or China (Murthy, 2003; Shankar & Rao, 2005; Chakrabarti, 2010). In LAMI countries families often become the sole caregivers of the mentally unwell (Shankar et al., 2005; Chakrabarti, 2010).

Less expensive brief psychoeducational family interventions that increase knowledge, insight, and management of psychosis have been tested in China (Ran et al., 2003; Li & Arthur, 2005). Patients and family members were provided with support, information about medication and the illness, and management strategies, either in small groups or on a one-to-one basis. This research demonstrated that approaches of this type can improve compliance, decrease relapse, and decrease readmission. Research has also evidenced promising findings for the use of family interventions in India (Kulhara et al., 2009), Iran (Reza et al., 2004; Koolaei et al., 2010), Pakistan (Nasr et al., 2009), Thailand (Worukul et al., 2007), and Malaysia (Paranthaman et al., 2010). However, the theoretical assumptions underlying these family interventions (and the particular focus of the interventions) tends to vary across these studies.

Chakrabarti (2011) emphasizes the importance of culturally adapting family interventions to meet the needs of particular populations. For example, research has highlighted the central role that cultural factors such as subordinating personal interests to the needs of the family (familism) or the offspring (filial obligations) play in Asian families (Knight et al., 2010). Similarly, it may be necessary to culturally adapt family interventions for use with ethnic minority, refugee and asylum seeking populations living in high income countries. Barrio & Yamada's (2010) recent evaluation of a *Culturally based Family Intervention for Mexican Americans* (CFIMA) experiencing psychosis is a good example of this. Their results indicated that the family intervention increased knowledge about psychosis and reduced family burden. Although initial attempts to explore the cross-cultural application of family interventions have been encouraging, further research exploring the efficacy of family interventions in diverse cultural settings is required. To facilitate this, it will be important to have sufficient numbers of trained and motivated personnel available to work with families so that the benefits of family-interventions can reach those families who require it the most (Shankar et al., 2005; de Jesus et al., 2009; Chakrabarti, 2010).

MSc Global Mental Health at the University of Glasgow

There is a clearly a need to educate people about designing, implementing and evaluating culturally appropriate policies, services and treatments for mental health

difficulties in low and middle income countries. With this in mind, the Institute of Health and Well-being at the University of Glasgow is launching a post graduate Masters programme in Global Mental Health that will commence in September 2012. The 'Intended Learning Outcomes for the MSc Global Mental Health' programme draw heavily on the *Grand Challenges for Global Mental Health*. As such, the programme aims to:

- Offer specialist education on the global burden of mental health difficulties.
- Develop students' capacity to reflect on the important role that cultural, social and biological factors play in how mental health difficulties are manifested across the life-span.
- Foster a critical appreciation of the complexities associated with classifying and measuring mental health difficulties in a global context.
- Develop students' ability to reflect on the importance of developing culturally appropriate, evidenced-based treatments for mental health difficulties. This will include family-based interventions.
- Examine how the concept of 'recovery' is understood across the globe.
- Develop students' knowledge of research methods to allow them to critically appraise research, and design research protocols for investigating relevant aspects of Global Mental Health (e.g. epidemiology, interventions, and mental health care delivery).
- To encourage students to think creatively about the design of viable systems and policies aimed at promoting mental health in low and middle income countries.

Graduates of the MSc Global Mental Health programme will gain employment in mental health policy and planning, epidemiological and mental health services research, as well as advisory and advocacy roles in governments, international agencies and non-governmental organisations.

It is anticipated that people who are currently in full-time employment will be interested in completing the MSc Global Mental Health programme. These individuals could be mental health professionals, mental health advocates, academics in Global Health, government policymakers/health service planners, public health specialists, and/or employees of non-governmental organisations. To keep the MSc programme open to individuals who are in employment, teaching will be delivered in five 2-week intensive teaching blocks spread over one year (full-time) or two years (part-time). Students can travel to Glasgow to complete the teaching blocks and then return home. Alternatively, students can opt to stay in Glasgow. Online seminars will be used to guide reading and facilitate discussion on key themes and issues during the time between teaching blocks. Students completing the MSc Global Mental Health programme will conduct a project in collaboration with an organisation doing mental-health related work in a low or middle income country or cross-

cultural mental-health related work in the UK. Students will have the opportunity to arrange placements with these organisations during the completion of their project.

In summary, exciting opportunities exist for developing and adapting family interventions to help reduce the growing global burden of mental illness. The MSc Global Mental Health programme at the University of Glasgow will educate students about this and many other relevant topics.

For further information about the MSc Global Mental Health programme at the University of Glasgow please contact Dr Ross White (MSc Global Mental Health programme co-ordinator) by email: Ross.White@glasgow.ac.uk

References

- Barrio, C. and Yamada, A.-M. (2010). Culturally Based Intervention Development: The Case of Latino Families Dealing With Schizophrenia. *Research on Social Work Practice*, 20, 483-492.
- Bustillo J, Lauriello J, Horan W, Keith S. (2001). The psychosocial treatment of schizophrenia: an update. *Am J Psychiatry*; 158: 163-175
- Chakrabarti, S. (2011). Family interventions in schizophrenia: Issues of relevance for Asian countries. *World Journal of Psychiatry*, 1, 4-7.
- Collins, P.Y., Patel, V., Joestl, S.S., March, D., Insel, T.R., Daar et al., A.S. (2011). Grand challenges in global mental health. *Nature*, 475, 27-30.
- de Jesus, M.J., Razzouk, D., Thara, R., Eaton, J., Thornicroft, G. (2009). Packages of care for schizophrenia in low and middle-income countries. *PLoS Med*; 6: e1000165.
- Knight, B.G. & Sayegh, P. (2010). Cultural values and caregiving: the updated socio-cultural stress and coping model. *J Gerontol B Psychol Sci Soc Sci*, 65B: 5-13.
- Kulhara P, Chakrabarti S, Avasthi A, Sharma A, Sharma S. (2009). Psychoeducational intervention for caregivers of Indian patients with schizophrenia: a randomised-controlled trial. *Acta Psychiatr Scand*, 119: 472-483.
- Koolae A.K., Etemadi, A. (2010). The outcome of family interventions for the mothers of schizophrenia patients in Iran. *Int J Soc Psychiatry*, 56, 634-646.
- Li, Z. & Arthur, D. (2005) Family education for people with schizophrenia in Beijing, China: randomised controlled trial. *British Journal of Psychiatry*, 187, 339-345.

Mojtabai, R, Nicholson, R.A., Carpenter B.N. (1998). Role of psychosocial treatments in management of schizophrenia: a meta-analytic review of controlled outcome studies. *Schizophr Bull*, 24: 569-587.

Murthy, R.S. (2003). Family interventions and empowerment as an approach to enhance mental health resources in developing countries. *World Psychiatry*; 2: 35-37

Nasr, T., and Kausar, R. (2009). Psychoeducation and the family burden in schizophrenia: a randomized controlled trial. *Ann Gen Psychiatry*, 8: 17.

Patel, V. & Prince, M. (2010). Global mental health: a new global health field comes of age. *JAMA*, 303, 1976-7.

Paranthaman V., Satnam K., Lim, J.L., Amar-Singh, H.S.S., Saraks, S., Nafiza, M.N., Ranjit, K., Asmah, Z.A. (2010). Effective implementation of a structured psychoeducation programme among caregivers of patients with schizophrenia in the community. *Asian J Psychiatry*; 3: 206-212.

Pharoah, F., Mari, J., Rathbone, J., Wong, W. (2010). Family intervention for schizophrenia. *Cochrane Database Syst Rev*, CD000088.

Ran, M.S., Xiang, M.Z., Chan, C.L., Leff, J., Simpson, P., et al. (2003) Effectiveness of psycho-educational intervention for rural Chinese families experiencing schizophrenia – a randomised controlled trial. *Social Psychiatry & Psychiatric Epidemiology*, 38: 69-75.

Reza, G.G., Shikha, M., Habibollah, T., Ali, A.G. (2004). Efficacy of a psychoeducational programme for the social adjustment of psychiatric patients. *Hong Kong J Psychiatry*, 14: 7-14.

Shankar, R., Vartak, A., Goswami, M. (2007) Voluntary initiatives in low-income countries – the potential for partnership. In D. Froggatt, G. Fadden, D.L. Johnson, M. Leggatt, R. Shankar 'Families as Partners in Mental Health Care – A guidebook for implementing family work: Toronto: World Fellowship for Schizophrenia and Allied Disorders.

Shankar, R., Rao, K. (2005). From burden to empowerment: the journey of family caregivers in India. In: Sartorius, N., Leff, J., Lopez, Ibor, J.J., Okasha, A., editors. *Families and mental disorders*. Chichester: John Wiley and Sons Ltd: 259-290.

Van't Hof, E., Cuijpers, P., Waheed, W., Stein, D.J. (2011). Psychological treatments for depression and anxiety disorders in low and middle-income countries: a meta-analysis. *Afr J Psychiatry*, 14, 200-7.

World Health Organisation (2004). *The Global Burden of Diseases: 2004 update*. Geneva: World Health Organisation.

World Health Organisation (2008). *mhGAP: Mental Health Gap Action Programme: Scaling up care mental, neurological, and substance use disorders*. Geneva: World Health Organization.

World Health Organisation (2011). *Mental Health Atlas 2011*. Geneva: World Health Organisation.

Worakul, P., Thavichachart, N., Lueboonthavatchai, P. (2007). Effects of psycho-educational program on knowledge and attitude upon schizophrenia of schizophrenic patients' caregivers. *J Med Assoc Thai*, 90: 1199-1204.

Staff Changes

A lot has happened since our last newsletter!

As you know Becky Heelis our Psychology Research Assistant left us last year to embark on her clinical psychology training and as we haven't had a newsletter since then so we haven't been able to introduce Kuljit Heer who we appointed to the role.

After achieving a BSc in Psychology, Kuljit worked as a Research Assistant within a variety of National Health Service (NHS) departments. She recently completed her PhD which explored the cultural context of care-giving amongst South Asian carers caring for children with developmental disabilities in the United Kingdom. This involved holding consultations with carers to explore their experiences of care-giving using a phenomenological approach.

Whilst with us, Kuljit has been involved in the development of the Carer's Strategy for Birmingham & Solihull Mental Health NHS Foundation Trust and has co-written an article featured in this newsletter.

Kuljit has recently had an exciting opportunity to further her career at the Institute of Psychiatry in London and after much deliberation has decided to take up post with them. So, very sadly, we are having to say goodbye to Kuljit who has become a much valued member of our team.

We wish Kuljit the best of luck for her future career and hope that the next member of staff that we appoint to this role will be able to live up to the high standards we have come to expect given how lucky we have been with all the colleagues that we have had in this role.

Good luck Kuljit!



Kuljit Heer

Delegation from Japan

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



From left to right: Chris Mansell, Deputy Director (Meriden Family Programme), Mirai So, Psychiatrist, (Japan), Martin Atchison, Deputy Director (Meriden Family Programme), Atsushi Sato, Psychiatric Social Worker/Associate Professor (Kyoto Notre Dame University) and Executive (Assertive Community Treatment, (ACT), Kyoto team) and Atsuko Fukuyama, Nurse, member of 'Cat's Hand', (ACT, Kyoto team)

The Meriden Family Programme was delighted to meet with some mental health professionals from Japan, as part of their visit to different services across Birmingham and Solihull Mental Health Foundation Trust during September 2011. The delegation included Mirai So, Psychiatrist, Atsushi Sato, Psychiatric Social Worker, Associate Professor of Kyoto Notre Dame University and Executive of the Assertive Community Treatment (ACT) Kyoto team and Atsuko Fukuyama, Nurse, member of 'Cat's Hand', ACT-Kyoto team.

The group was keen to learn more about family approaches in mental health and it was hoped that the visit would provide them with a number of ideas to take back to Japan and look at how mental health services could be developed.

At our meeting we talked through the way in which the Meriden Family Programme operates, what kind of training we deliver and how the model of Behavioural Family Therapy (BFT) works. What became apparent was a sense that the model would work effectively in Japan. The impact on the family of a family member developing mental health problems seems to be a global experience in terms of the family's need for information and support with managing stress. Although there would need to be some adaptations made to the model to make it culturally appropriate, it was thought that Japanese families would benefit from BFT. We were informed that around 75% of people with mental health problems in Japan live with families, so the need to work alongside families is apparent, but is something that mental health services have traditionally struggled to do. The earthquake in March 2011 was also something that had had a major impact in a range of ways. With homes and businesses being destroyed and the country experiencing financial difficulties, people were even more reliant on their family to support each other.

The biggest challenge to family work being delivered in Japan seems to be the way in which mental health services are organised. The most powerful people within mental health services in Japan are the hospital managers, who historically have had control over access to mental health care, which has until fairly recently been hospital based care. Families have become accustomed over the years to the idea that mental health care is delivered in a hospital setting and are not in a position to start to get involved in shaping the way services are delivered. The visitors were impressed with the level of involvement of carers in our services, and also that carers are involved in the delivery of family work. This was something that wouldn't be an easy thing to achieve in Japan, given the way services are currently set up.

However, around 20 teams have been created across the country under the umbrella of 'Assertive Community Treatment', which has been focussed on providing support and treatment in people's homes and social networks. In a traditionally conservative country, these teams have not found it easy to become part of the mental health system. What was pleasing to hear was how these teams have supported each other and thrived, which is due to the commitment and dedication of the people involved in trying to broaden the scope of mental health care available in Japan.

We met again after the group had visited other parts of the trust and discussed how the Meriden Family Programme could link up with clinicians in Japan. Our visitors felt it would be difficult to develop community services further without the essential aspect of supporting families through family work. What they felt was that there needed to be some programme of training in family work if services are to develop. However, from a cultural perspective, introducing changes to the way in which services are delivered is not straightforward. The way in which change is most quickly brought about in Japan is if someone from outside the country becomes involved and introduces the idea of delivering services in a different way.

The ACT teams from across the country meet every year for a conference, and Dr Gráinne Fadden, Programme Director, and Peter Woodhams, Carer Consultant were asked to make a short film to be shown at the March 2012 conference in Tohoko Fukushi University. This film would be used as a starting point to support the development of family work in ACT teams. There have been some emails after the visit and it would seem that clinicians are starting to think more about working with families in a more effective, evidence based way. Gráinne and Peter were also asked to make an additional film which was shown at a forum of family members in March 2012. This will help families to be more aware of the available support and to create more momentum to provide family work to families in Japan. We hope to bring more information in the future about developments in relation to family work in Japan, and readers will also find the following article in the newsletter of interest.

Anglo-Japanese Exchange Visit

November 27th - December 5th 2011

From Japan: Dr Takashi Iseda, Dr Atsushi Nishida, Ms. Shigeeko Ishikura, Ms. Etsuko Aono and Dr Yuji Okazaki

From England: Dr Paul French, Dr Jo Smith and Dr David Shiers

Early intervention for young people and their families

We are delighted to offer this report of a successful international exchange that has taken place between England and Japan. The intention of the exchange was to further our countries commitments to mental health service reforms which aim to improve the experiences of young people with psychosis and their families by providing a community based early intervention approach.

Background

The last decade has seen England establish itself as one of the world's fieldleaders in providing community-based Early Intervention in Psychosis (EIP) services. The joint leads of England's national EIP development programme (2004-10), Dr Jo Smith and Dr David Shiers met with a Japanese delegation of mental health professionals, led by Dr Takashi Iseda and Mr Atsushi Nishida in England in 2008. Two site visits were made: firstly a clinical exchange meeting with members of the Worcestershire EIP service and their clinical lead Dr Jo Smith and secondly, a Japanese film crew from NHK television followed Worcestershire EI service team members making home visits to families. They filmed several EI clients and carers including a visit to the home of Dr David Shiers, his wife Ann and their daughter Mary.

Tangible benefits following this initial visit

1. The recording of the Shiers' family experience of mental illness and Early Intervention care in the UK that has developed in response to the concerns highlighted was subsequently televised in Japan in December 2009. This TV broadcast also featured an interview with Professor Louis Appleby, the then UK director of mental health. This NHK TV programme, shown on prime time Japanese television, prompted significant public interest and was to influence Mr Nagatsuma, the Japanese Minister of Health, Labour and Welfare and encourage political momentum toward mental healthcare reform in Japan. The pressure for national mental healthcare reform was further reinforced by the subsequent development of the Mental Health Policy Council Initiative (MHPCI) which included in its membership service users, carers and mental health

professionals. Following these movements, an all party group from the elected Japanese Parliament (known as DIET), has formed to enact the mental health basic act. This is historic for Japan as no all party parliamentary support for mental health reform has ever existed before.

2. Ongoing clinical training exchange has evolved in a collaboration between Worcestershire EI service and Japanese colleagues where Worcestershire EI service has hosted two visits by Japanese delegations and supported a 3 month placement (from September to December, 2010) of Ms. Etsuko Aono, a Japanese psychiatric nurse to train in family intervention with the Meriden Family intervention Training Programme in Birmingham, UK and learn about early intervention and family intervention in clinical practice in the UK health system. Subsequently, Ms Aono has been involved in the Early Intervention Service Programme of Tokyo Metropolitan Matsuzawa Hospital leading on the development of family support to users and carers from the programme.
3. In Manchester the Early Detection Intervention Team (EDIT) hosted a visit from a group based in Sendai who were particularly interested in developing early detection and prevention services. This also led to the translation into Japanese of Early Detection and Cognitive Therapy for Preventing Transition to Psychosis (French & Morrison 2004).
4. The UK practitioner textbook, Promoting Recovery in Early Psychosis (French et al 2010) has been translated into Japanese and the Japanese version of the book was launched at an EI conference in December 2011. The 'Early Psychosis Declaration' and the 'Meaningful Lives International Consensus Statements' have also been translated into Japanese and shared widely with Japanese mental health colleagues at conferences and training workshops.
5. Dr. Smith and Dr. French have made several visits to Japan to train a large number of mental health staff from across Japan in early intervention principles and practice, Cognitive Behavioural Therapy (CBT) and family intervention.
6. There has been an ongoing e-mail exchange with Japanese colleagues to provide information and support for EIP development and carer support initiatives in Japan.

Exchange Visit

November 27th – December 5th 2011

1. DIET Inaugural Meeting December 1st

About sixty DIET members, including three previous Ministers of Health, Labour and Welfare and leaders of political parties, attended the inaugural meeting of the all party group, exactly two years from the date of the NHK broadcast. Providing the commemorative speech, Dr. Shiers talked about his experiences as a carer and his involvement in promoting mental healthcare reform in England. This speech resonated particularly with the service users and carers as they watched over this historic DIET meeting with strong and positive emotions.

2. 15th Conference of Japanese Early Intervention in Psychiatry

The main goal of the conference was to promote understanding of both the philosophy and practice of Early Intervention Services. About 250 mental health professionals and researchers attended the conference. Dr's Smith, French and Shiers were invited as guests to the conference. Dr. Smith led a seminar focusing on family education and support initiatives in Japan and the UK. In another seminar, Dr. French provided a UK perspective on EIP service development and aspects of service provision, particularly on the provision of CBT. Dr. French was also the discussant on several presentations by Japanese staff on EIP interventions in Japan. Dr. Shiers led a special evening seminar describing the historical developments behind the EIP social movement in the UK.

3. Lecture at Tokyo Metropolitan Institute of Medical Science on November 29th

Dr. Smith gave a talk about vocational and educational recovery in early psychosis to about 100 service users, carers, mental health professionals and researchers.

4. Workshop on CBT at National Centre of Neurology and Psychiatry November 29th

Dr. French discussed CBT for Early Psychosis with 50 mental health professionals.

5. Workshop / supervision exchanges November 30th

In a separate event, a supervision meeting on EIP Service provision was held at Tokyo University Hospital. Dr. Smith and Dr. French provided clinical supervision to about 20 mental health clinicians of Early Intervention Services of Tokyo University Hospital and Tokyo Metropolitan Matsuzawa Hospital who attended the meeting which was also relayed through Skype to two other mental health hospitals in Mie Prefecture (Mie Prefectural Mental Medical Centre and Hinaga General Centre for Mental Care).



Dr Paul French (left) with a colleague from Japan

Future Intended Actions

1. Continuing programme of collaborative clinical supervision

It was proposed that we prepare a joint funding bid to the Daiwa Anglo-Japanese Foundation which supports collaborations between British and Japanese research teams to support ongoing clinical supervision in CBT and family interventions for Japanese EI teams from Dr Jo Smith and Dr Paul French via monthly web based supervision and an annual visit.

2. Mutual support on policy discussions

User and carer empowerment will be encouraged by promotion of the Early Psychosis Declaration.

3. The Conference of the International Early Psychosis Association in 2014

This will be organised by the Japanese Society of Prevention and Early Intervention Psychiatry. EIP services have been set up in several locations in Japan and require support to develop and refine clinical techniques and to further reform the mental healthcare system in Japan. Within the overall conference our collaboration is planning for an Anglo-Japanese seminar reflecting aspects of mutual support and development from 2008 to the present.

Final comments

The collaboration through this Anglo-Japanese exchange has been effective on several levels as we have attempted to describe in this report. Perhaps one of the less tangible but more important aspects has been how this social and cultural exchange has generated a wonderful warmth, mutual respect and connectedness around a topic of shared international concern.

Developing a Carers' Strategy for Birmingham and Solihull Mental Health Foundation Trust (BSMHFT)

by **Kuljit Heer, Peter Woodhams & Gráinne Fadden**
Meriden Family Programme

Many of us will be carers at some point in our lives. Caring is often an unexpected role that occurs in response to a crisis. Estimates suggest that there are approximately six million carers in the UK, of whom 1.5 million are caring for a relative with a mental health problem (NCCSDO, 2002). The recent shift in mental health services to promote 'community based care' has placed a greater responsibility on family members to provide care within the home. Caring for a relative with mental health problems can place significant demands on carers and can impact on physical and mental well-being. As a result, carers have a greater need for support from services. The Government has recognised the need to develop more 'carer aware' services for people looking after a relative with mental health problems. Documents such as the Department of Health's (2010) "Recognised, Valued and Supported: Next Steps for the Carers' Strategy" make recommendations for recognising and responding to the needs of carers.

With this in mind the development of a Carers' Strategy within Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) was initiated by Meriden at the request of the Executive Director of Quality, Improvement, and Patient Experience and the Associate Director of Service User and Carer Experience in the Trust. The aim was to develop and implement a plan to raise the profile of carers within the Trust through improved support and more effective involvement over a three year period. The primary aim of the strategy was for carers of people who access services within the Trust to feel more engaged, better supported, better informed, listened to, more involved, valued and respected. The main thrust of this initiative was about supporting and involving

carers better. It is important to recognise that carers who feel well supported and respected are often more likely to become more confident in their caring role and become more involved.

The process of developing a strategy:

1. Initially a report was written by Meriden Programme staff ("Raising the Profile of Carers within BSMHFT") which formed the starting point. This provided a baseline of existing levels of involvement of carers in the trust. The report also outlined a number of key ideas that would need to be encompassed in order to develop a successful strategy.
2. This initial report informed the development of a consultation document ("Developing a Carers Strategy for BSMHFT"). The document outlines five guiding principles in the development of the strategy which are:

- Raising awareness of carers and their needs
- Improving the involvement of carers
- Supporting carers better
- Sharing and providing information
- Working in partnership with families

These guiding principles formed the basis of a series of consultations in the form of discussion groups with carers across the city.

3. The next step involved organising and promoting a number of consultation meetings with pre-existing carers' support groups as well as three open meetings across the Birmingham and Solihull areas. In addition there were a number of consultation meetings with specialist groups such as young carers and those from different ethnic groups. The meetings were geographically spread, both within and outside the Trust, to capture the views of a range of carers including young carers, carers from ethnic minority groups, carers of older relatives, carers of relatives in forensic services and Carer Governors within the Trust.
4. In total, eleven consultation groups were conducted with carers and staff from across the trust and 106 people attended. The consultations were successful in capturing the views, experiences and suggestions of carers themselves to inform the development of the final strategy.
5. The information gathered from the consultation meetings was then collated and grouped into 'themes'



Dee Roach, Executive Director of Quality, Improvement and Patient Experience, Birmingham & Solihull Mental Health NHS Foundation Trust (BSMHFT) addressing the audience at the launch of the BSMHFT Carer's Strategy

or patterns across the group discussions, representing the issues and suggestions raised by carers. A detailed report was written, informing the development of the final strategy document.

6. The draft strategy was presented to the Clinical Governance and Clinical Board meetings in the Trust for review, and some minor changes were made.
7. The final strategy was officially launched by the Chair of the Trust at an event in April at Birmingham City football ground. It was announced at the launch that a Carer Governor would have specific responsibility for carers' issues in the Trust.
8. The next step is to develop an Implementation and Monitoring Plan which will take into account the priorities identified by carers.

It is a significant step forward to have launched this strategy, to have commitment and support from the Trust Board and Governors. Thanks go to all carers and members of staff who participated in the consultation meetings and also to Dee Roach, Executive Director of Quality, Improvement and Patient Experience, Di Markman, Associate Director of Service User and Carer Experience and the members of the Patient Advice and Liaison Service (PALS) for providing support within the Trust.

A more detailed report of the key findings from the consultation meetings and the strategy will be presented in the next edition of the newsletter.

References

Department of Health (2010). Recognised, valued and supported: next steps for the Carers' Strategy. Available from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

Social Care Institute for Excellence (SCIE) launch 'Think Family' (Guide 30) update and new parental mental health e-learning tool

**By Paula Conneely, Clinical Specialist
Meriden Family Programme**

In December 2011 SCIE reviewed its Guide 30 'Think Child, Think Parent, Think Family: a guide to parental mental health and child welfare' adding in new findings from the implementation sites across the United Kingdom. This new chapter looks at how the five English local authority areas and the five Northern Irish health and social care Trusts went about implementing the recommendations of Think Child, Think Parent, Think Family and is based on quarterly self-reports put forward by each of the sites. The findings can be accessed at:

www.scie.org.uk/publications/guides/guide30/puttingitintopractice/index.asp

In addition, SCIE has also produced an e-Learning tool which was launched in the Autumn of 2011. This is freely available to all and accessible on their website **www.scie.org.uk**

www.scie.org.uk/publications/elearning/parentalmentalhealthandfamilies/index.asp

It provides audio, video and interactive technology to assist in exploring the nature of parental mental health and its impact on families. Divided into 8 modules, it explores themes such as the "Family model", the 'Think Child, Think Parent, Think Family' principles of the SCIE guide 30, whole family working and effective communication with families. Each module is designed to take 20-30 minutes to work through which means that the resource

can be completed at a pace to suit the learner. The pages are bright and colourful and the text straightforward and easy to read. Additional resources and links are suggested and a notes page facility allows the user to jot down thoughts and reflections as they progress through each module.

The 8 modules consist of:

- Introducing the family model
- Think child, think parent and think family
- Working together with parents
- Working together with professionals
- Care planning and review
- Interventions
- Managing complexity and leading practice
- Communicating with families

This excellent resource is targeted at front line and management staff involved in adult mental health and children's services. However, the resources might also be useful for primary care services staff (GPs, Health Visitors, Midwives), schools, teachers and staff working within children's centres.

The resource forms part of the SCIE e-learning programme which provides a range of interactive courses aimed at self-directed learning, including courses on personalisation, the Open Dementia Programme, the Mental Capacity Act and parental substance misuse; all of which are free to access and can be found under the "Developing Skills and Services" section of the SCIE website.

ISPS UK 2012 Residential Conference

A great opportunity to catch up with the latest thinking in research and practice in psychological and social approaches to working with people experiencing psychosis.

2nd and 3rd October 2012: At Conference Aston,
Birmingham, UK

Changing realities: new developments in psychological approaches to psychosis

Keynote speakers and workshop leaders include: Alison Brabban, Jacqui Dillon, Gráinne Fadden, Chris Holman, David Kennard, Peter Kinderman, Julian Leff, Brian Martindale, Glenn Roberts, Jaakko Seikkula,

The conference offers updates on contemporary work and opportunities for skill development.

Plenary sessions and parallel workshops cover therapy approaches and service innovations:

- Trauma and psychosis
- Current work in different therapy models
- (includes cognitive behavioural therapy, psychodynamic therapy, arts therapies, open dialogue approach and others)
- Service user perspectives on therapies
- Early psychosis
- Recovery, including recovery for family members
- Peer support and peer led initiatives
- Making mental health services more therapeutic

Final programme
and detailed lists of
workshops and
posters now
available.

For more information on
ISPS or the conference and
to make a booking visit:

www.ispsuk.org

All enquiries to:
admin@ispsuk.org

Sutton Coldfield's New Project for Young Carers

'For young people by young people'

By Peter Woodhams, Carer Consultant
Meriden Family Programme

A new initiative has been launched by Sutton Coldfield YMCA to help young carers to feel better supported and less isolated. The project is called 'Release' and has received Youth in Focus funding via the Big Lottery in order to provide awareness and support for young carers aged 9-25 years old and their families in North Birmingham.

The project was the idea of youth workers who had a vision for a young carers youth group and they gained the support of Sutton YMCA which then enabled them to move their idea forward and apply for funding. Release is jointly managed by Danielle Godwin and Alan Burrows. The team is completed by Sean Jordan and Aphra Lewin and all are qualified youth workers.



The team photo shows left to right: Alan Burrows, Danielle Godwin, Sean Jordan, and Aphra Lewin

The team provides a package of support which gives young carers help and guidance which includes:

- A youth club for young carers with a range of activities
- An annual youth camp – this year they have been to Cornwall
- Providing information to young people that is helpful to them in their caring role
- Helping young carers to achieve their goals
- Supporting the whole family when needed and developing family action plans
- Participation in a local radio workshop
- Awareness activities in local schools
- Running drop-in sessions at local schools
- Support through personal advocacy if appropriate
- Developing peer support
- Lobbying for improved consideration for young carers

The team is really keen to promote the services they offer in North Birmingham where it is estimated that there are in excess of 12,000 young carers. They attend many events in Sutton and Erdington and their motto is **'Inspiring young carers to reach their full potential'**.

Well done to all involved in getting this much needed project off the ground! Further information can be obtained by visiting www.releaseproject.com or by telephoning 0121 354 5614.

EATING DISORDERS – 2 DAY WORKSHOP FOR PROFESSIONALS

8th & 9th NOVEMBER 2012 Time: 9.00am - 5.00pm

Venue: The Gulbenkian Room, Park Crescent Conference Centre, International Students House, 229 Great Portland Street London, W1W 5PN (Opp. Great Portland Street tube station and near Regents Park tube station) Cost: £200 per person

Overall Aims

Day One: Basic principles and practice of Motivational Enhancement Therapy

Day Two: Carers Skills Model

(Please note: Attendance at Day Two will require some knowledge and practice of MET)

For further details or to book a place please contact Veronica Kamerling on:
Telephone: 01256 704117 Mobile: 07733 260 475 Email: veronica@talktalkbusiness.net
www.eatingdisordersandcarers.co.uk www.londoncarersgroup.org.uk

Forthcoming Events Schedule

Behavioural Family Therapy (BFT) Five Day Training Course

Dates: 15–19 October 2011

Venue: Uffculme Centre, Birmingham

This five-day skills-based training course in an evidence based psychological approach to working with families proven to reduce relapse rates covers the following topics: Working with carers and families, policy and research around families and carers, carer and family assessments, early warning signs, communication skills and problem solving.

Learn more and feel more confident about:

Policy and research around families and carers • Working with carers and families
Carer and family assessments • Early warning signs • Communication skills • Problem solving

**For details please contact Nadine Berry on Telephone: 0121 301 2896
or email nadine.berry@bsmhft.nhs.uk**

BFT Training Trainers Five Day Training Course

Date: 4–8 March 2013

Venue: Beeches Management Centre, Bournville, Birmingham

Dates have been set so please make a note in your diaries of the dates now!

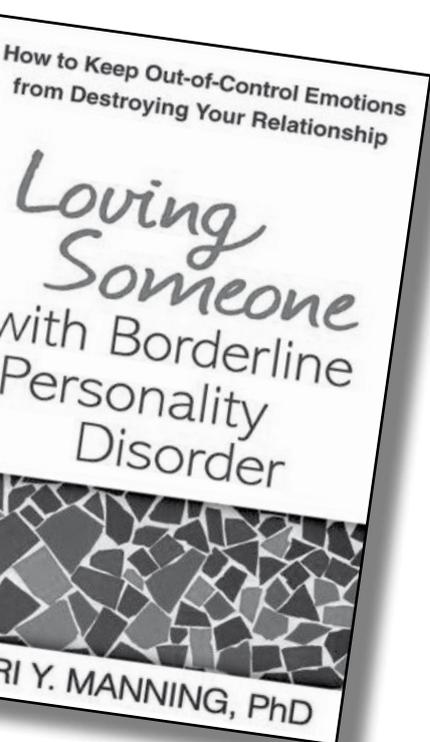
We are now taking bookings for our next annual Training Trainers course.

Places are limited so please get in touch as soon as you can if you would like to confirm your attendance on this course. Remember, you need to be trained in Behavioural Family Therapy to be eligible to train as a trainer.

**Please details please contact Sam Farooq on Tel: 0121 301 2896
Or email sam.farooq@bsmht.nhs.uk**

More information about training on offer can be found on our website www.meridenfamilyprogramme.com

There are several guidebooks and information leaflets available to help family members, other relatives and friends to understand and cope with more common mental health difficulties such as psychosis, depression, eating disorders and anxiety. It can be more difficult to find similar guidance and advice in an easily accessible format, which is why the following two books on Borderline Personality Disorder and Posttraumatic Stress Disorder are so welcome.



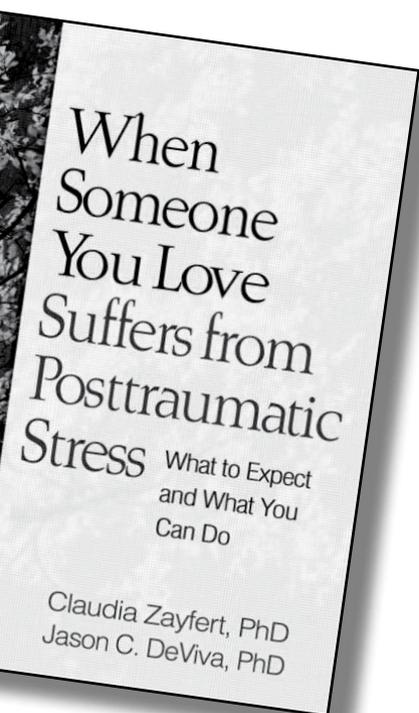
Loving Someone with Borderline Personality Disorder

How to Keep Out-of-Control Emotions from Destroying Your Relationship
by Shari Y. Manning, Ph.D.

People with Borderline Personality Disorder (BPD) can be compassionate, caring, smart and funny, but they are also prone to explosive emotional outbursts and highly self-destructive acts. BPD expert, Dr Shari Manning, helps overwhelmed loved ones understand why their spouse, adult child, or other family member can act in such an ‘impossible’ manner – and suggests ways of learning to respond differently. She presents simple yet powerful strategies that can radically transform a troubled relationship. There are many true stories which demonstrate ways to diffuse crises, set limits and help the person with BPD build crucial problem-solving and emotion-management skills. Empathic, hopeful, and science based, this is the first book for significant others grounded in dialectical behavioural therapy (DBT), the most effective treatment for BPD.

This book will be particularly important for loved ones facing the challenges of BPD, mental health professionals and students

Paperback: 253 pages. Publisher: The Guilford Press; 1 edition (August 15, 2011)
Language: English. ISBN-10: 1593856075. ISBN-13: 978-1593856076



When Someone You Love Suffers from Posttraumatic Stress

What to expect and what you can do

Claudia Zayfert, Dartmouth Medical School, New Hampshire, USA
Jason C. DeViva, Yale University Medical School, Connecticut, USA

Winner of the Association for Behavioural and Cognitive Therapies (ABCT) Self-Help Seal of Merit!

Trauma survivors frequently struggle with unwanted memories, intense emotions and problems with everyday functioning. Effective help is out there, but the needs of family members – confused and scared about what has happened to the person they love – are often overlooked. Will the person with posttraumatic stress ever get better? How can spouses and other loved ones promote healing? Where can family members turn when they feel like they just can’t cope? From experienced trauma specialists Drs. Claudia Zayfert and Jason C. DeViva, this highly practical guide is packed with information, support, vivid stories, and specific advice. Readers learn to navigate the rough spots day by day and help their loved one find a brighter tomorrow.

Paperback: 292 pages. Publisher: Guilford Press; 1 edition (19 July 2011)
ISBN-10: 1609180658. ISBN-13: 978-1609180652



Caring for Yourself

Self-help for families and friends supporting people with mental health problems

Rethink Mental Illness and the Meriden Family Programme have created a new resource called *Caring for Yourself* which has been developed to help carers, family and friends who support someone with a mental health problem.

Caring for Yourself is a self-help workbook in eight parts that can be used in an entirely flexible way. It is now available as a very useful information and educational resource designed to help carers. It will also be helpful for professionals who work with carers so that they can refer carers to the resource where appropriate.

Each of the eight parts of the workbook covers a different topic:

- 1. Introduction • 2. Being a carer • 3. Information • 4. Communication skills •
- 5. Problem solving and goal achievement • 6. Relapse management and staying well •
- 7. Recovery and hope • 8. Taking care of yourself •

The workbook can be used by carers at their own pace and in their own time. It can also be used along with training programmes for carers such as the Rethink Mental Illness Caring and Coping Programme or Meriden's Caring for Carers Programme.

**The resource is available online and is free to download at:
www.meridenfamilyprogramme.co.uk and www.rethink.org**

However, Caring for Yourself cannot be completed online. Carers who wish to have a hardcopy can contact: Sam Farooq on 0121 301 2896 or email sam.farooq@bsmhft.nhs.uk

(Please note P&P charges may apply)

MERIDEN CONTACT DETAILS

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

Gráinne Fadden , Director	0121 301 2711	Sam Farooq ,	
Martin Atchison , Deputy Director	0121 301 2889	Business Manager/PA to Dr Fadden	0121 301 2888
Chris Mansell , Deputy Director	0121 301 2894	Nadine Berry , Team Administrator	0121 301 2896
Alison Lee , Clinical Specialist	0121 301 2892	Maria Albanese , Team Administrator	0121 301 2895
Paula Conneely , Clinical Specialist	0121 301 2710		
Julia Danks , Clinical Specialist	0121 301 2893	Fax Number: 0121 301 2891	
Peter Woodhams , Carer Consultant	0121 301 2708	Email Addresses: firstname.lastname@bsmhft.nhs.uk	

Website: www.meridenfamilyprogramme.com

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

If your details have changed please let us know. Email sam.farooq@bsmhft.nhs.uk or telephone Sam on 0121 301 2888