The end of another year already – I know it’s a bit of a cliché, but the months do seem to fly by. We were keen to get another newsletter out to everyone by Christmas, following our last large newsletter in summer which was very large, as there had been a gap since the previous one because of other work demands. We anticipated this would be smaller, but as you can see, people are very keen to write about how they are developing family sensitive services, so we have another large edition. This is really positive, although it adds to Sam’s workload!

In the current edition, you will read interesting articles on a number of themes. One key theme is the adaptation of family work for in-patient services and those in rehabilitation settings. It is interesting to read how Rumina Taylor and Nicola Gawn in London and Julia Danks on our team in Birmingham have looked at how to implement family work in a meaningful way given the constraints of staffing and other demands that frequently apply in any kind of residential setting. There is much learning from their reports which I hope will be inspiring and beneficial for others in similar settings. Our colleagues in Nova Scotia have also been receiving bespoke training for working in acute settings.

There are updates on work in Birmingham to ensure that family work is embedded in our early psychosis services, with Eleanor Baggott describing a recent initiative as part of the World Mental Health Day activities to provide information sessions for families using our new library in Birmingham. This was a really successful event, with families appreciating the de-stigmatising and normalising atmosphere of the library. Louisa Alderson has been on secondment with us as part of the Increasing Access to Psychological Therapies (IAPT) for Bipolar Disorder work has updated us on the new NICE Guidelines for Bipolar Disorder.

In addition to the local activities and description of what is happening in England there are updates on our work globally. We have had more visitors from Japan who have been visiting services across Birmingham. Chris Mansell and Cheryl Billard describe the broader work that has been going on in Nova Scotia and our colleagues in Nigeria have written about their attempts to implement training locally, although this has been hampered by the more pressing demands of managing the Ebola crisis. Our work in Ireland will continue over the coming year, and Martin Atchison and Veronica Burke have updated us on developments. Information on the new British Psychological Society document on psychosis and some very useful You Tube videos of young people with early psychosis will hopefully be of interest too.

In Scotland, Padhraic Dolan retired after many years of promoting family work, but we know that his colleagues who are trained as trainers and supervisors will carry on the good work. On a very sad note, we had the untimely death in August of Francis Gair who was one of our early trainers here in the West Midlands and then moved to work in Scotland. We pass on our condolences to her family.

To end on a positive cheery note for the Christmas season, we have a feature on awards and the launch of our new website on Recovery for Families, Carers and Friends. Meriden has been giving awards to those who have implemented family work effectively, both at individual and team level. We have also been fortunate to be the recipients of an award nomination for joint work with colleagues in the East Midlands. We were also delighted to be the overall winner in the local board challenge awards in Birmingham & Solihull Mental Health Trust for our new website material on recovery. Do have a look at our revamped website and particularly the recovery section which we hope will be very helpful for anyone living with mental health difficulties (www.meridenfamilyprogramme.com/recovery).

I finish by wishing you all a very warm and happy Christmas season – goodwill to all and hoping that the New Year will be successful and prosperous for all.

Dr Gráinne Fadden
Our Experiences on Pioneering Implementation of Behavioural Family Therapy and Initiation of Carer Groups in Nigeria

By Dr Nosa Igbinomwanhia, Dr Felicia Thomas, Dr Blessing Uteh, Mrs Nkechi Igbinigie
Federal Neuro-Psychiatric Hospital, Benin City, Nigeria

The 2014 Commonwealth team to the Meriden Family Programme had ten weeks of intensive training in the United Kingdom that encompassed training and skill acquisition in Behavioural Family Therapy (BFT), Caring for Carers, and Training of Trainers. Acquired skills were meant to be utilized and transferred upon our return to Nigeria.

The team returned to Nigeria on 3rd March 2014, and by the end of the second week of arrival we submitted a comprehensive report of our training to the hospital Medical Director. There has been some enthusiasm on the part of management on the possibilities inherent in the training received when incorporated into our service delivery, especially as the acquired knowledge and skills are relatively new to this environment.

Acting on management directive, the four members of the Commonwealth team presented an introductory talk on BFT and Caring for Carers to clinical staff of the hospital. Fortunately, there was overall appreciable acceptance from the staff, despite some reservations, about wholesale application of these skills. There were suggestions on how best to implement, and possible areas of modification and adaptation.

At present, there is ongoing identification of families that would benefit from BFT. This is mostly being done by members of the team while running out-patient clinics. It is hoped that these identified families would form the initial group for family work. At the request of the hospital management, the team submitted a list of clinical staff that will form the pioneer group of persons to be trained on BFT skills and Caring for Carers. This initial group consists of twenty carefully selected persons.

With regards to Caring for Carers, because there has not been any Carers’ group in this environment, a needs assessment survey was conducted by the team on the directive of the hospital management. Questionnaires were given to carers to identify areas of challenge in caring for their wards and carers’ willingness to participate in a carer groups. All questionnaires have been received back and data are being analysed. We hope to subsequently form Carer Groups and oversee them.

The team and hospital management had hoped to achieve much more than this in the time frame so far, unfortunately unforeseen circumstances have slowed our pace. A nationwide two month strike action by doctors and an outbreak of Ebola virus infection (which took centre-stage attention for the period it lasted) were impediments to a speedier implementation of BFT. Nevertheless it is noteworthy that the hospital management has graciously provided presentation equipment to facilitate training of staff on BFT.
Publication of the Updated and Revised NICE Guidelines for Bipolar Disorder

By Louisa Alderson, Birmingham & Solihull Mental Health NHS Foundation Trust

The updated Nice Guidelines for the treatment of bipolar disorder in adults, children and young people in primary and secondary care was published in September 2014. This guideline updates the previous guidelines which were published in 2006 and reflects advances in the understanding and treatment of bipolar disorder.

The new guidance emphasises the need for early recognition of bipolar disorder, including when to refer to specialist services for further assessment. Director of the Centre for Clinical Practice, NICE, Professor Mark Baker stated “More needs to be done to raise awareness of the condition. This guideline provides information for young people, parents, carers and professionals on the signs to look out for to recognise the condition early and treat it appropriately.” (www.nursinginpractice.com).

Recommendations are outlined regarding pharmacological treatment at all stages, psychological interventions, the monitoring of physical health and specific recommendations regarding the management of different phases of bipolar, including crisis and risk. The long term management of bipolar disorder and the promotion of recovery are also discussed.

The new guidance places a clear emphasis on the need to involve carers and family in the care of people with bipolar disorder. Recommendations 1.1.12 – 1.1.19 relate specifically to carers of people with bipolar disorder. In brief, these relate to the need to offer assessment to carers, the provision of information, negotiation regarding the sharing of information, inclusion of carers in decision making, offering carer focused education and support, identification of adults, children and young people living with a person with bipolar who may be at risk of abuse.

With regard to family intervention, the new guidelines bring bipolar disorder in line with the guidance for psychosis and schizophrenia:

‘1.7.2 Offer a family intervention to people with bipolar disorder who are living, or in close contact, with their family in line with recommendation 1.3.7.2 in the NICE clinical guideline on psychosis and schizophrenia in adults.’

This reflects the growing evidence base for the effectiveness of family work with bipolar disorder (Miklowitz et al 2007a, Miklowitz et al 2007b).

Bipolar UK, a major UK charity supporting people with bipolar disorder and their families have responded positively to the new guideline with a statement issued on their website: ‘The new guidance acknowledges that there should be more support given to help carers and loved ones cope with the challenges of supporting someone with bipolar. We welcome NICE’s guidance as an important step to recognising the prevalence of bipolar and its impact, particularly on people concerned about the potential of bipolar, including young people and children, and their loved ones.’ (www.bipolaruk.org.uk).

Behavioural Family Therapy includes the sharing of information with families about the mental health issues affecting them and supports the family to develop and enhance their communication and problem solving skills. This approach addresses the need to provide family based intervention for bipolar and working with carers as outlined in the NICE guidelines. Birmingham & Solihull Mental Health NHS Foundation Trust is currently a demonstration site for the Increasing Access to Psychological Therapies (IAPT) for serious mental illness project for bipolar disorder. This has involved the Bipolar Service and Meriden Family Programme in providing a group based intervention for individuals with bipolar disorder (Mood on Track) and family work. I have been involved in the direct provision of family work as part of this project and have had positive feedback from families about the impact it has had for them.


References:


Westways Behavioural Family Consultation Service: A Pilot Project on a Rehabilitation Unit

By Dr Nicola Gawn, Chartered Clinical Psychologist, Westways Rehabilitation Unit, Bethlem Royal Hospital, South London and Maudsley NHS Foundation Trust

Westways Inpatient Rehabilitation Unit have responded to the challenges they have experienced in implementing BFT by developing a new Behavioural Family Consultation Service which is being offered to every service user who is in contact with significant others. They are currently piloting the service, but the initial outcomes look positive...

Westways Rehabilitation Unit

Westways is an 18-bedded mixed-sex inpatient rehabilitation unit, based in the borough of Croydon in South London. The unit sits in the trust’s complex care psychosis pathway with a primary referral criteria of severe and recurring psychosis and repeated acute admissions. The team work towards a 9-month care pathway.

Problems Implementing Family Intervention

Despite evidence indicating that this is a population for whom family intervention (FI) is particularly relevant (e.g. NICE, 2014); much as with other services of this type, there had been a highly limited history of provision of interventions with families.

Prior to 2011, no family work had ever been undertaken on the unit. At this time three staff members were trained in BFT following a localised implementation of a ‘hub and spoke’ model (Griffiths, 2011). In total two families were seen for BFT between 2011-2012 (although only one family completed). However, no further FI took place over the following year, and attendance at the monthly supervision groups offered by the hub was negligible.

A number of barriers were identified, including:

- Shift patterns and 4-week block night duty rotas, preventing regular scheduling of appointments, and making co-working with a family particularly difficult to achieve
- Difficulties releasing nursing staff from core unit-based tasks which needed to be prioritised over family work and supervision
- Significant staffing shortages, and high staff turnover; specific difficulties releasing permanent staff time due to high numbers of bank staff on shift
- A requirement for unit-based work rather than home visiting, due to the nature of staff roles
- Transitions from the unit to community settings and associated time frames, which can be highly variable and unpredictable
- The impact of crises and physical health problems on routine care
- The impact of acute positive and negative symptoms on engagement
- The highly limited capacity and profile of psychology on the unit
- Family workers having to use annual leave or unpaid overtime to undertake family sessions
- Logistic difficulties preventing nursing staff (the majority of permanent professionals on the unit) undertaking evening family work appointments due to protected mealtimes, medication times and handovers

This reflects the work of Fadden (1997) who reviewed research detailing evidence for low implementation of FI training, finding this was often due to time and
organisational barriers. In her survey of 86 professionals from a range of settings who had received BFT training, she found that inpatient nursing staff were the least likely to put their training into practice, and saw the fewest number of families when they did. Staff in inpatient settings reported significantly (p=0.006) more difficulties implementing BFT due to a range of factors – these included a lack of time, problems with flexible working, difficulty fitting the work in with other responsibilities, and finding the approach too daunting for families.

These themes have been strengthened further by Eassom et al’s (2014) recent systematic review focusing on the barriers and facilitating factors for implementing family involvement in psychosis. Amongst a wide number of factors, they highlight the primary significance of the organisational context, and conclude “Family work can only be implemented if this is considered a shared goal of all members of a clinical team… This may imply a change in ethos and practices… as well as the establishment of working routines that facilitate family involvement approaches.”

**Westways Behavioural Family Consultation Service**

**Proposal Rationale**

In response to these issues, a proposal was developed in May 2013 to pilot a new family intervention service on the unit. It was felt that this should be offered to as many of the unit’s service users as possible due to the good evidence base, national recommendations, and high relevance relating to this population.

It was also felt that BFT should be used due to the local training and support infrastructure, and the robust evidence base of the model. However, it was acknowledged that:

- The capacity of the service is too limited by a significant extent to offer BFT to all service users for whom it is indicated.
- There are significant challenges in delivering formally structured BFT due to the barriers outlined above.
- It was considered preferable to offer some family work, than no family work at all (e.g. Fadden, 1998). (It is acknowledged that the ideal standard is a minimum 10-session intervention; NICE, 2014)
- Significant concern was raised that it was not uncommon for this population to have a very lengthy history of relapsing psychosis with no offer of psychological intervention, poor engagement history, and “too late” service narratives; counterpointed with the excellent opportunity that a rehabilitation admission offers to overcome these barriers

Therefore a modified clinical model and delivery structure was developed in order to enable BFT components to be used as realistically and comprehensively as could be feasible on the unit; and to ensure that this could be offered to as many families as possible.

**Anticipated take up and capacity**

Based on our awareness that many of our service users did not have significant others with whom they were in contact, along with anecdotal evidence and unpublished research from services in the local area, we were aware that there would be a mixed response from service users and families in terms of their interest in family work. We anticipated this would translate to an approximate take-up of 10 families over the first year, allowing the service to see each family for approximately 4–5 sessions (given available resources and depending on personal preferences).

**Behavioural Family Consultation Model**

**Brief Consultation Approaches**

Barkham’s (1989) ‘two-plus-one’ approach and Aveline’s (2001) ‘three-plus-one’ model were both developed in adult mental health services; partly grounded on observations that longer treatments were associated with improved outcome – yet resources were limited and engagement variable. These models advocate meeting as soon as possible and again once or twice more; with a follow-up session after a longer break to assess the need for further input.

Street, Downey & Brazier’s (1991) ‘Brief Consultation and Advisory approach’ for family work in CAMH services draws heavily on these approaches. In addition they emphasise maximising engagement and change within the brief approach by flexibly identifying with the family’s needs and expectations in each session. This approach has been found to be experienced favourably by families when trialled as a waiting list approach (e.g. Heywood et al, 2003) and has been shown to have clinical benefits over treatment as usual at 6 months (p<0.05) (McGarry et al, 2008).

These models are noted to share a number of characteristics:
- An emphasis on engagement and building relationships
- Addressing immediate concerns and breaking impasse
- Promoting self-efficacy and building knowledge
- Identifying families’ needs and expectations in order to maximise potential change
- Valuing work between sessions

These were felt to be highly compatible with the BFT model, and with the clients and families in question. This model also offered a number of further characteristics relevant to the challenges of an inpatient setting:
- Low resource intensity
- A triage function
- Potential for broader team-work approach
- Lower demands and expectations for engagement
The models were therefore combined by the author into what was called Behavioural Family Consultation (BFC).

**Aims and format of BFC**

The aims of BFC are to:
- Provide a brief family intervention for schizophrenia, in keeping with the evidence base so far as resources and length of stay will allow; and drawing on BFT skill components
- Improve relationships, communication, and feedback between unit staff, carers and service users
- Increase availability of information (e.g. regarding symptoms, resources, and unit life etc) for service users and carers
- Act as a screening, assessment and signposting opportunity for other approaches, including BFT
- Contribute towards a culture change within services

Sessions are timed flexibly with the needs of the service user and family in mind, with the initial session arranged as soon as possible; and intervals between sessions gradually increasing over a total of at least 6 months, with the aim of a follow-up session close to discharge.

Content of sessions are guided by the needs of families, and prioritise engagement but draw heavily on BFT training, such that typical areas of focus for sessions include:
- Support with regards to immediate concerns and crises (particularly problem-solving these as a family)
- Information sharing regarding the unit, rehabilitation, or other aspects of mental health care
- Psycho-education
- Collaborative formulation of family resources, problems and goals
- Planning, goal-setting, and establishing family meetings
- Communication skills training
- Problem solving skills training

No family is offered all of these components; and staff work together in debrief and planning meetings to help collaboratively guide sessions towards components which they feel families would most benefit. Families are always included in decisions about how sessions could best be used.

**Clinic Structure**

The structure of a protected weekly clinic has been implemented to enable regular family sessions and supervision to occur regardless of the barriers highlighted. This was timed to fit around protected meal and medication times, as well as other existing staff commitments; and the rota has been arranged so that two BFT trained staff members are always available during this time slot.

**Available resources and staffing**

The BFC service is co-ordinated by the Senior Clinical Psychologist, who manages referrals, provides regular supervision as part of the clinic, ensures appropriate training is attended, and acts as a ‘link-worker’ to the local family work hub (and therefore to the acute wards and community teams).

In order to contribute to the service, BFC team members are expected to undertake the 5-day BFT training, attend regular update training as appropriate, attend supervision within clinic hours whenever on shift, and attend the full clinic on a rota (typically monthly). Ongoing staff training in BFT is facilitated to allow the clinic to be staffed regardless of leave arrangements and night duties.

**Fig: Clinic Structure**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity Description</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.30</td>
<td>BFC Supervision</td>
<td>All BFT trained staff on duty</td>
</tr>
<tr>
<td>2.45</td>
<td>Session Planning</td>
<td>Two family workers, family and service user</td>
</tr>
<tr>
<td>3.00</td>
<td>BFC session</td>
<td>Review information, previous sessions, share concerns etc.</td>
</tr>
<tr>
<td>4.30</td>
<td>Debrief</td>
<td>Reflection, discussion, review, planning</td>
</tr>
<tr>
<td>4.45</td>
<td>BFC admin</td>
<td>Notes, letters, reports, appointment booking</td>
</tr>
</tbody>
</table>

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**Fig: Unit staff trained in BFT**

<table>
<thead>
<tr>
<th></th>
<th>Psychologist</th>
<th>OT</th>
<th>Unit Manager</th>
<th>Band 6 Nurse</th>
<th>Band 5 Nurse</th>
<th>STR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total trained</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Currently employed</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
All other team members and senior managers are asked to enable this by supporting BFC team members to attend clinics, supervision, and training within their shifts, on time, without interruption, and without guilt. Necessary rooms are dedicated on the unit during clinic hours.

**Linking Up**

Staff are conscious of the potential need for further input opening up following brief consultation, and the following options are routinely considered (with appropriate consent of individuals concerned):

- Signposting to information, voluntary resources, and services
- Offering additional BFC sessions – especially in response to crisis periods
- Encouraging informal contact with unit staff where extra support is necessary or potential risks apparent
- Referral to BFT in community services (via the hub)
- Referral to clinical psychology or other professionals
- Referral of family members for individual services via their GP

The hub continues to offer monthly supervision and ongoing refresher training to family workers who are strongly encouraged to attend, although attendance remains logistically difficult. An FI peer supervision group has enabled the service co-ordinator to work closely with local FI leads in community and acute services. A family service leaflet was jointly developed with the local acute service who is the largest referrer to the unit, with the aim of offering a more seamless care pathway for families.

**Outcomes**

In the first 15 months of the project (August 2013 - October 2014), a total of 38 sessions were attended by 9 families. Three families completed BFC, undertaking an average of 5.3 sessions (16 sessions in total). At the end of this period, 6 families were open to the BFC caseload, having undertaken an average of 3.5 sessions each (21 sessions in total).

**Fig: Snapshot of current engagement with BFC on the unit**

| Completed BFC | 1 |
| Current BFC caseload | 6 |
| Referred/not yet attended | 1 |
| Considering consent | 3 |
| Not appropriate | 7 |
| **TOTAL** | **18** |

BFC is now being offered to every service user who enters the unit and is in contact with significant others. Although sessions in the initial months were occurring intermittently (due to a combination of staff availability and limited family engagement); the clinic is now typically booked out several weeks in advance, thanks to the dedication of the whole team who work together to ensure that families are engaged, and that the time is protected. Importantly, responsibility for booking appointments has been shared by the nursing team, with family workers taking a pro-active lead.

Formal evaluation and feedback forms have been offered to service users and families who have competed BFC. However, sample and response rates have been too low at this early stage to be meaningfully reported.

Feedback received so far has been very encouraging, including from family workers that the work has helped them develop awareness of the needs of service users and families, and to build trusting and engaging relationships. Negative feedback has largely related to the lack of evening and weekend appointments available.

**Fig: Feedback regarding BFC at Westways**

**Patients**

“I found it helpful to cope with the relationship.”

“I liked the pleasant manner in which it was done.”

**Families**

“Some family members gave feedback that they feel relaxed and they have chance to think about themselves.” (via STR)

**Unit Staff**

“I have heard excellent things from service users and carers about the family sessions, and I have noted its beneficial effects in my interactions with them too. Carers have felt they have a better understanding of what their relative is going through, and the service users feel more supported and understood. I feel it has made a huge contribution and enables our unit to offer a truly “holistic” service that our carers, service users (and me personally) value a great deal.”

(Consultant Psychiatrist)
Family Workers

“Family work has in a way helped build a relationship of trust between myself, the patients and their family members.” (Nurse)

“I found that I can work more closely with clients on the unit. I get to know more client’s family backgrounds and the (client’s) perception of each family member.” (STR)

“I have gained a much more thorough understanding of my clients in a way that was more informative than my standard approach.” (OT)

“It has not been a completely easy task to engage every patient and their family members in the family work that takes place on the ward.” (Nurse)

“For family members that work, taking time off work to attend … can be difficult.” (Nurse)

Discussion

The team is proud of the BFC service offered, and the impact this has had on care and relationships. Offering family work to a significantly greater number than would have been offered under the previous system; with the chance to assess interest, suitability and need for ongoing work is an important achievement. Perhaps most significantly, the weekly clinic has become as much a part of the unit’s routine as ward rounds, indicating something of a culture change.

However, despite these achievements, a number of issues are identified. In particular, it is acknowledged that the clinic hours are not suitable for all families, and it is important that the service continues to develop such that we continue to offer greater flexibility as our capacity grows.

Due to the shift and clinic systems, families are not consistently seen by the same staff members. This brings disadvantages, particularly in the impact for family workers who express frustration at not being able to follow a case through. However it also brings advantages, in increased opportunities for broad ideas and professional perspectives; closer team working and flexibility. We have been surprised to find that families suggest that they are generally unconcerned by this issue. We wonder if this is in part because they are familiar with most unit staff already; because the approach being offered is consistent; and perhaps because at present there remains at least one consistent staff member.

The BFC model requires a period of mentorship, as staff new to family work will not necessarily experience all components of the model in a short time period. The clinical psychologist currently attends all clinics, as the workers are beginning to grow their experience. It is hoped that over time, other family workers will gain the confidence and expertise to co-facilitate clinics in her absence.

Looking towards the future, full audit will be important in further evaluating the efficacy of the BFC approach. Finally, we cannot overstate the valuable role that the nursing team have in engaging with families and booking appointments. This difficult and time-consuming task has been thoughtfully adopted by Lead Nurses and Support Time and Recovery Workers; who are often closest to service users and families and have a wealth of ideas to support engagement. We encourage all inpatient teams to identify their barriers to working with families, and to find creative ways around these – as the results are worth it!

References


Promoting the Inclusion of Families Within the Acute Inpatient Care Pathway: Piloting a New Service

By Dr Rumina Taylor, Clinical Psychologist, South London and Maudsley NHS Foundation Trust

This article gives an overview of a project in Croydon, South London designed to increase the provision of family work within acute inpatient care. Croydon borough mental health services are provided by the South London and Maudsley NHS Foundation Trust – a large mental health trust covering four boroughs in South London. The trust has made a commitment to increasing families’ access to appropriate support and treatments in general, and more specifically for service users with psychosis, in keeping with the NICE guidelines for Psychosis and Schizophrenia (NICE, 2014). This article describes the outcome of a pilot service that has been developed and implemented specifically for service users and their families accessing acute inpatient care.

Why does it matter?

Carers are a well known resource and a valued asset. They are often the people who become first aware of their relative’s mental health difficulties, whether it be at initial onset or later relapse, and enable people to seek help (Carter, 2011). Moreover, relatives also provide continued support and care after someone has left hospital. They can play a central role in a service user's care and recovery, and respond to areas of unmet need (Addington, Collins, McCleery, & Addington, 2005). Relatives improve treatment adherence (Garcia, Chang, Young, Lopez, Jenkins, 2006) and service users tend to have better outcomes when they have carer contact (Fleury, Grenier, Caron, & Lesage, 2008). However, despite their important contributions, many carers report feeling isolated, unheard, and excluded (Burbach & Leftwich, 2012). Many feel unacknowledged by mental health services as partners in care and report they lack information about their relative’s care plan (Burbach & Leftwich, 2012). Research has also confirmed that caregivers experience high levels of distress especially in the context of recent inpatient admissions (Boye & Malt, 2002).

The Schizophrenia Commission (2012) showed families who are carers save the public £1.24 billion per year but that they are not receiving adequate support or treated collaboratively. Service users from our wards are often discharged back into the care of their family. Working more closely with family members in this process is likely to have benefits for risk management in the post-discharge period and therefore also has the potential to reduce re-admission rates. Family work can improve access to carer support, improve service user and carer coping, promote problem-solving, warmth and positive interactions between family members. It includes an information-sharing component and specific “staying well planning” work to allow family members to be partners in their relative’s care. There is clear evidence that family intervention for psychosis does work in consistently reducing relapse (NICE, 2014).

A number of national polices have highlighted the importance of mental health services working collaboratively with carers and service users (Department of Health, 2010; 2011) and that family intervention should be offered to all those with psychosis (NICE, 2014). Family work projects within acute care have been recognised by the Care Quality Commission (CQC, 2010) and such initiatives recommended. The Triangle of Care
What did we do?

When developing family interventions a critical issue to consider is the wider context of services the family and service user are involved with (Cohen et al., 2008). Formal family work may neither be appropriate, cost-effective, or acceptable for all service users and families. Some may benefit from support but not necessarily need an intensive intervention (Cohen et al., 2008). Therefore, interventions for families and service users should be tailored to their needs.

With this in mind, three different types of intervention across the acute wards within the Gresham Unit (Gresham 1, 2, and PICU), Bethlem Royal Hospital, were implemented over 18 months. A family ‘awareness-raising’ teaching session was provided to staff as part of a teaching timetable already established on each of the wards and facilitated by a Carer Consultant. This was based on Stanbridge, Burbach, and Leftwich’s (2009) staff training programme but was significantly shorter and primarily covered issues such as engaging families, recognising the need for collaboration, sign-posting, information-sharing and issues around confidentiality. A weekly carers’ clinic facilitated by psychology, nursing and medical teams was made available on Gresham PICU and Gresham 1 and was based on the work of Carter (2011). The clinic aimed to allow a rapport to be created with the family, emphasise the need for the family and team to work together, and elicit the family’s perspectives of how and when the service user’s problems first appeared and what appeared to trigger them. It was hoped that by communicating with families in supportive, informative and caring ways early on, admissions would be improved. Lastly, on Gresham 2 structured family work was offered to service users with psychosis and their families. This comprised of an adapted version of Behavioural Family Therapy (Falloon et al., 2006) over four sessions.

What did we find?

Staff training: A total of 48 staff attended training. The attendance target of 50% or more staff per ward was met. There appeared to be some increase in the number of interactions between families and staff on Gresham PICU following the training session.

Carers’ clinics: These have been implemented weekly on Gresham 1 and PICU. The clinic has been available for the last year and 49 carers and families have attended to date. 100% of carers and families have reported being very satisfied or satisfied with the clinic and all would recommend the service to others. Service user and carer complaints reduced since implementation of the service.

The service has received positive feedback:

“Just know how grateful I am that I am not on my own battling to get the care my sister needs.”

“This is a helpful service for people who are not knowledgeable about mental health like myself and provides a service for them to understand what is going on behind the scenes.”

Family work: Structured family work sessions have become available to service users from Gresham 2 ward and their families and carers. 90% reported having made a lot of progress during the sessions and 90% felt they would be able to continue to make a lot of progress as a family as a result of the intervention. 100% feedback was very satisfied or satisfied with family work. Pre and post outcome measures indicated that following family work service user and carer distress reduced and well-being increased; family members felt less burdened with scores on the Care-giver Burden Inventory (Novak & Guest, 1989) moving to the non-clinical range; carers also perceived their loved ones’ illnesses as less threatening, meaning they had a greater understanding and felt more in control of symptoms and difficulties. Data on relapse and readmission over a 3, 6-month, and 1 year period are being collected and will be available shortly. It is hoped this brief intervention will impact readmission rates.

The carer feedback has been very positive:

“These meetings have made me feel that someone cares and was willing to listen to my concerns. I feel a lot better and not so alone.”

“It has felt like someone has listened and acted practically for the first time in around 10 years. We have felt supported as a family, felt as if X (service user) was truly cared for, respected and understood, and that we know where to go if things become bad again. For the first time I feel like I know what to do if X (service user) falls unwell again. Thanks!”

Service user and carer feedback: The pilot family service initial proposal benefited greatly from carer consultation and feedback. During service development and implementation, carers and services users have continued to be involved:

“As Hear Us Linkworkers, we see this service as an integral part of the acute inpatient wards, assisting patients to enhance relationships with their family. By talking and supporting patients and families, admissions can be meaningful and therapeutic. The pilot family work service has received excellent feedback from carers and service users and we are keen for it to
continue and for the service to be expanded to other wards.” "

Julie Connolly and Lucy Michalak, Hear Us

What does it all mean?

Despite the difficulties implementing family work on the wards thus far, it remains highly indicated given the evidence base, NICE (2014) guidelines, and the Triangle of Care (2013). This pilot has shown that it is possible to develop and implement an effective, beneficial, and much needed service within the acute pathway in a relatively short time frame.

The Family Work Service has received the Highly Commended nomination by the National Positive Practice in Mental Health Awards for Improving Care for People in a Mental Health Crisis. Dr Rumina Taylor who developed and leads the service was runner-up for an NHS Leadership Award for Innovator of the Year. Winners will be announced at the end of November.

References


Department of Health (DoH). (2010). Recognised, valued and supported: Next steps for the carers strategy.


On a very wet Wednesday afternoon in October, over twenty family members of Early Intervention service users braved the weather to come along to our first service event of this kind. It had been in planning since April, when members of the Early Intervention Service and The Meriden Family Programme got together to discuss the needs of the carers and families of our young people with psychosis. We planned to pilot an event to offer to family members new to the service an opportunity to learn more about psychosis, hear about the services and support available to their young family member and to themselves, and to help promote a sense of hope for recovery, while validating the darkness and distress of those early stages.

This event was in line with the BSMHFT Carer’s strategy, consistent with the principles recommended by the Triangle of Care and a core component for our own Early Intervention Family and Carer Strategy. If the afternoon was successful, in that it was valued by the carers who attended, we would roll out the programme on a more regular basis, to offer it to new family members coming into contact with the service. So the pressure was on!

One of our first decisions was where to hold the event: We wanted somewhere accessible for people who live across the whole city and Solihull, somewhere away from traditional mental health service stigma, and somewhere with a bit of ‘wow’ factor to launch the event and promote our services. We were delighted to find the interestingly named ‘Brain Box’ room at the new Birmingham Library. This iconic building was going to be easy to find for our attendees, and the room itself has wonderful floor-to-ceiling windows looking out over the city.

We promoted the event within the Early Intervention Service, by asking team members to pass on flyers and sending them out directly to family members identified by teams. In the run up to the day itself we had 11 family members confirmed to attend, so we were pleased when over 20 family members attended the event! After grabbing a few extra chairs from the library, and worrying about running out of biscuits, we settled in for the afternoon.

The afternoon was opened by myself (Dr Eleanor Baggott, Clinical Psychologist with the Early Intervention Service) and Peter Woodhams, a Carer Consultant for the Meriden Programme, who helped to bring a carer’s perspective to the planning of the session.

We first welcomed Dr Erin Turner, Consultant Psychiatrist with the Solihull Early Intervention Service, to talk to the group about psychosis and recovery. Erin discussed the characteristics of psychosis and the impact this can have on young people, whilst promoting hope for recovery. She spoke about the development of Early Intervention services and its potential benefits. After some brief questions and answers, we moved onto exploring the service provided by Early Intervention in more detail. Zara Parveen, Team manager of the South Early Intervention team, explained what family members can expect from the Early Intervention Service for their loved one. This included the opportunity to hear from Dr Ruth Clutterbuck, Clinical Psychologist with the East Early Intervention team, about our partnership with the Princes Trust and the social recovery interventions available.

With no time for questions (it was a jam-packed schedule!) we moved into hearing from Alison Lee, Clinical Specialist with the Meriden Programme, about the services they deliver and help support Early Intervention to deliver, in particular Behavioural Family Therapy. I spoke about some of the other support available to family members and carers in Early Intervention, including the E-Sibling project (www.siblingpsychosis.org) and the Early Intervention Carers groups, currently running in the East and West parts of the city and Solihull, with a new group starting in the South side of the city in January 2015. This part of the programme was also an opportunity to introduce the representatives attending from Stonham Home Group and the new Birmingham Carer’s Hub, who offer a range of support services for carers across Birmingham.
Then it was time for a break. It was a chance to have a much needed cup of tea and devour some biscuits. It was also a chance for family members to meet each other, talk to staff from the Early Intervention service, speak to the Meriden team and have a chance to see their new Recovery for Carers website in action (www.meridenfamilyprogramme.com/recovery), and pick up information about the services offered by Stonham, Birmingham Carer’s Hub and the Solihull Carer’s Centre. The atmosphere throughout the break was highly energising, with lots of interaction between everyone there, and no one left out. It was a shame to interrupt the conversation flow and bring people back to their seats ready to attend to the next session, but we still had a lot to come.

During the next session we heard from other carers about their experiences. We were fortunate to have Abe Cutajar, a carer for his son who experienced an episode of psychosis four years ago to help introduce this session. Abe had kindly shared his caring experiences during a video interview with me before the event, and we shared parts of his story during the session. I had also conducted a video interview with a couple who have been supporting their son with psychosis for the past two years, and they kindly agreed for their story to be shared. Both videos gave a balanced view, validating the ‘dark tunnel’ that can be encountered while caring for a young loved one with psychosis, whilst reflecting on the significant progress that can be made and promoting hope for recovery. They all offered valuable advice to the group, from finding something to do for yourself such as Abe’s gardening, to just ‘gritting your teeth’ and taking it ‘one day at a time’.

We also presented extracts from narratives written by carers in the recent book ‘Voicing Caregiver Experiences’ (Chandler, Bradstreet and Hayward, 2013). This included one carer’s story highlighting the importance of looking after yourself, using a metaphor of pushing rocks uphill and finding that just a small pebble can stop that rock from rolling backwards. This message of looking after yourself was key to the day, and led smoothly into the next session where Dr Gráinne Fadden, Director of the Meriden Programme, talked about Caring for Yourself. Gráinne used a metaphor of being on an aeroplane, and in case of loss of cabin pressure, fitting your own oxygen mask before helping anyone else. Gráinne talked through five steps to wellbeing (connect, be active, keep learning, give to others, take notice) and asked the group to reflect on small things they could do to be caring for themselves.

We finished the day with a question and answer session with myself, Erin, Gráinne, Zara and Abe taking questions from the group and discussing the issues raised. The group were engaged throughout this process, and raised interesting and salient issues. We discussed striking the balance between symptom reduction with the potential side effects of medication such as weight gain; ways of understanding and overcoming motivation problems such as the importance of finding activities meaningful to the individual; the role and timing of psychological therapies to support recovery; the importance of adaptation and acceptance to personal recovery; and the development of Staying Well Plans to help young people and their families self-manage their recovery. We encouraged family members to write down any further issues that they wanted to raise on follow up forms, which we passed onto their teams. This left us just a few minutes to collect feedback forms and extend our thanks to everyone for attending and showing their commitment to support their loved ones by being here today. Without the on-going support and care they provide, the Early Intervention Service would not be able to achieve the same recovery outcomes.

This event was a success that was highly valued by the carers who attended, as reflected in the feedback forms at the end of the day and conversations with carers and colleagues during the break and after the event. The afternoon was also a chance to promote the work that Early Intervention and Meriden offer, a real opportunity to strengthen our partnerships with Stonham Home Group, Birmingham Carers Hub and the Solihull Carer’s Centre, and a great example of team working, across the Early Intervention Service and Meriden Programme. Feedback from family members was extremely positive, as well as from Early Intervention staff and the representatives from Stonham and Birmingham Carers Hub. We intend to run this event twice a year, and offer it to all family members and carers of our new Early Intervention service users. Next time we’ll be prepared for higher numbers than expected, and make sure that there is no danger of running out of biscuits!

Comments from those who attended

“I gained a better understanding of my son’s problems and his treatment. Not alone with problem, acceptance.”

“I learned not to feel guilty if I take time out for myself.”

“Very useful to hear other peoples experiences; how they cope when feeling low.”

‘Before I came to this event I felt like I was the only person going through this, but coming to this event has given me hope, and positive thinking.’

“Excellent event, very informative.”

References

The Meriden Programme, as part of its 10th anniversary celebration gave out a series of awards to staff who had shown commitment to family work over the years. Many of the winners were nominated by families who had received support. We thought we should pick up the idea of acknowledging teams and individuals who have consistently tried to improve services to families in recent years. As part of the World Mental Health Day event held in our service where the contribution of many nurses was acknowledged, we gave awards to two teams in the trust who have worked over the past number of years to try to improve and develop the services they provide to families – these were Patrick House in the north of Birmingham, and Lyndon Clinic in the south. What is striking about both teams is that thinking about the needs of families has become part of the culture. Rather than just seeing the individual who presents to them, they naturally think about the family, what information needs they have and how to support them. In addition, they aim to deliver evidence-based family work where indicated, and in the past few years, they have embraced family-related initiatives such as offering support groups for carers. We would encourage other teams to talk with them about how they have achieved this.

Accepting the award on behalf of Patrick House, Louisa Alderson said: ‘The team at Patrick House CMHT were delighted to receive an award recognising the efforts that have gone into developing services for carers and families within the team. Over time we have all been able to see the benefits of offering family work and carers groups in terms of the outcomes for individuals and their families. It has not been easy to find ways to integrate family work into our practice but the whole team is committed to this way of working and, with the support of the Meriden Programme, we feel we have achieved a lot towards making family work a truly integral part of what we offer at Patrick House’.

In addition to team awards, we acknowledged two individuals, Claire Terrington and Steven Cox who have worked with us in Birmingham from when the Meriden Programme was set up, and who have consistently promoted family work in whatever service they have worked in. As well as delivering family work, they have provided talks, supervision, and delivered numerous training courses.

On receiving the award Claire said ‘By the time our service users reach Assertive Outreach they have usually been through the revolving door more times than they care to remember. It is easy to forget that carers and families have lived this experience too. It is important we remember that families are vitally important to the care and recovery of our service users and that they more often than not, do this without pay and without training. Working with families should not be seen as ‘extra work’ but part of our everyday responsibilities’.

Steven said ‘Thank you so much for my award, I feel very pleased and privileged to have my work recognised in this way. Working with families continuously for the last 14 years has always felt a necessary and integral part of my clinical practice, family support is often crucial in promoting recovery from mental health problems. Mental illness undoubtedly impacts on all family members. All clinicians have an obligation to actually deliver evidence-based psychological therapies like Behavioural Family Therapy, as part of routine good care, irrespective of obstacles and competing priorities. Meriden is an invaluable asset to support clinicians to do this’.

We would be happy to receive nominations for others who have been promoting and delivering family work in their services.
November 26th 2014 marked the retirement of one of our ‘veteran’ trainers, Padhraic Dolan in Lanarkshire, Scotland. We want to mark his retirement and acknowledge his significant achievements because for us in the Meriden Programme, Padhraic’s commitment to establishing family work in Scotland demonstrates what can be achieved, when a small group of people have clear vision and the persistence to see that their ideas are operationalised in practice.

There is a lot of debate in the literature on innovation and change management in relation to ‘top down’ or ‘bottom up’ approaches – whether management at the top or the workforce on the ground bring about change. In a number of initiatives we are involved in such as our work in Nova Scotia and Ireland, the decision to introduce family work is driven by governmental or statutory agencies. In Scotland, the drive to influence change started in the workforce with Padhraic and his colleague Michael Higgins, both clinical psychologists. In our training, we frequently quote Scotland as our best example of how a small group of people can influence and bring about lasting change.

In 2000, in Stratford-upon-Avon, we held our first Meriden ‘Working with Families’ conference. This was attended by Padhraic and Michael who were inspired by the evidence presented on family work and the impact it can have on the lives of those affected by mental health problems. They returned to Scotland determined to establish the approach in their own services. They put in a bid for funding for a training course for 10 psychologists which was successful, and the first Behavioural Family Therapy training course was held in Glasgow in 2001. Following the training, the group started delivering family work and were meticulous in terms of delivering what was required in order to become accredited therapists. Four of the group, including Padhraic and Michael attended the Meriden Training Trainers course in 2002 and became the first trainers trained in Scotland.

They then began to hold their first multi-disciplinary training courses, ensuring thorough careful selection processes that those trained knew the commitment required and had managerial approval. It was this rigour and attention to detail that ensured the gradual effective growth of family work which then began to spread across Scotland. Both Padhraic and Michael were meticulous about evaluating the progress of the work, producing detailed reports that ensured continued funding.

Padhraic developed links with National Education Scotland (NES), the statutory body responsible for staff training and development and also inputted to the group drawing up guidelines for the treatment of psychosis. In order to ensure equity of access to family work across the country, NES then commissioned Meriden training in other areas of Scotland including Perth, Glasgow and Inverness, and ensured that following the initial training there were trainers in all of the geographical areas.

As well as the geographical development, as more people from different specialties were trained, expertise developed in areas such as early psychosis, forensic services and learning disabilities. Each of these groups developed innovative ways of adapting family work to their services and these have been really influential e.g. the work and publications of Keith Marshall in adapting family work for people with learning disabilities.

All the way along over the 15 year period, Padhraic persisted in keeping family work on the agenda, both locally and nationally and doing all that was required to achieve this – writing reports, securing funding, attending meetings, liaising, fighting battles, regrouping after setbacks, all the time demonstrating rigour and persistence and not giving up. Now, in 2014, there are almost 600 people trained and 62 trainers. Family work is available in a majority of areas across the country. Padhraic has left a fantastic legacy that he can be rightly proud of, and because of the strength of the cascade model, one that cannot be reversed.

He has been a model of professionalism and hard work throughout and I know that his leadership has allowed...
The awards ceremony was held on Wednesday 22 October 2014 at the East Midlands Conference Centre in Nottingham and was attended by left to right: Scott Yates, Gráinne Fadden, Dan Pearson, Lina Gatsou and Nigel Goodrich. Although the team was not successful in winning the overall award, it was a real achievement to be one of the 18 finalists on the night and the team was presented with an award.

Dr. Lina Gatsou and colleagues at the Leicestershire Partnership Trust (Dan Pearson) and De Montfort University (Nigel Goodrich and Scott Yates) were one of three submissions shortlisted in the East Midlands Innovation in Healthcare Awards (mental health category). This was a partnership project with the Meriden Programme and we developed and provided bespoke training for those involved. Their innovative programme of work entitled “Think Family – Whole Family Multi-agency Training and Intervention Programme” was chosen from almost 100 submissions from throughout the NHS, health and social care, universities, the third sector and industry.

The aim of the “Think Family” programme was to train 100 frontline professionals from across a range of organisations in an evidence based family intervention based on the principles of Behavioural Family Therapy and informed by the ‘Think Family/ Whole Family Approach’. The Meriden Programme trained multi-agency staff in a specifically adapted model of family intervention, providing a bespoke manual and adapted resource materials. The intervention used and evaluated by the team comprised of eight sessions with the following main themes:

- Engagement and ground rules
- Assessment and goal setting
- Signposting to other services
- Information sharing
- Developing relationships with agencies involved
- Staying well plans
- Problem solving
- Review and evaluation of goals achieved

During their work with families, family workers were receiving supervision and additional support through regular email contact, on-line resources and a blog.

The project was developed and delivered by the core Think Family Project Group with members from Leicestershire Partnership Trust (LPT), De Montfort University and the Meriden Family Programme. A full description of the programme by Dr. Gatsou can be found in our June 2013 newsletter.

In writing this, I was reminded of the quote by the anthropologist, Margaret Mead whom we learned about in our undergraduate days in Galway – ‘Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.’ Changing the world may be a bit ambitious, but Padhraic, you can retire in the knowledge that you have made a positive difference to the lives of thousands of people across Scotland who as service users or family members have benefitted from your work and commitment.
On 13 November, Birmingham & Solihull Mental Health Trust held its annual Board Challenge awards ceremony.

This is the ninth year that the trust has held these awards and is just one of the ways in which the Trust recognises the efforts of staff in providing quality care. It is also an opportunity for staff to showcase their work so that others can apply learning in their own areas. Whether it is adopting new technology or finding new ways of working, all the finalists have found ways of improving services for the people we care for.

The judging panel was made up of representatives from the Trust Board and Governors. Once all of the entries were received they were passed on to the judging panel to score, with the highest two entries selected as finalists.

There were 46 entries in different categories from across the Trust and of these 11 finalists were chosen.

The judges commented on the overall high standard of the entries, but there could only be six teams taking home a winner's trophy.

The winning teams were:

**Category One: Engaging With Service Users and Carers**

**Winners: Early Intervention Service**

‘Silver Linings, Early Intervention Mobile App’

To overcome the challenge of effectively engaging young people, Solihull’s Early Intervention Service (EIS) have developed an innovative mobile phone application, the first of its kind for Birmingham & Solihull EIS patients.

The app has already received a positive response and the service is planning to pilot it with service users over the next six months.

**Category Two: Service Improvement**

**Winners: Library Services / Mental Health Services for Older People (MHSOP)**

‘Supporting clinical teams to put research into practice’

After piloting a project with community teams based on the ‘Clinical Librarian’ model used in acute hospitals, our library services and MHSOP joined forces to take the library to clinicians to support the process of embedding research into practice.

Teams benefited from a librarians input to identify questions from case discussions such as reviewing service delivery, exploring drug side-effects as well as providing evidence-based research to help team with care planning and treatment intervention decisions.

The library compiled evidence-based summaries, giving staff easy access to good quality research in order to make decisions. The project has received positive feedback.
The Meriden Family Programme, which trains staff to work with carers, took it into their own hands to specifically design a website to advise, support and aid the recovery of carers, families and friends.

With carers affiliated with the Meriden Family Programme at the forefront of the project, both carers and services users can benefit from a wealth of helpful information that is available 24/7 at the click of a button.

The website was officially launched on World Mental Health Day 2014 and has received positive feedback, as one carer commented ‘It helped me to realise that one of the first things I need to do in order to support my son is to look after myself.’

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With the award money, they hope to develop an App for carers to keep pace with technology and the fact that many family members would access information in this way.

The site which was developed with funding from the Trust charity, Caring Minds, also has sections targeting young carers and siblings and gives families and friends the opportunity to hear about the experiences of other carers.
My Role as a Carer, in the Development of the New Website: Recovery for Carers (www.meridenfamilyprogramme.com/recovery)

By Carer and Web Page Editor – Michele Gladden

Meriden Family Programme’s new website ‘Recovery for Carers’ was launched on World Mental Health Day, Friday 10th October. The website was developed from the belief – supported by evidence from family work and research – that Recovery for carers, family and friends is as vital, for their own health and wellbeing, as the recovery of the person with mental health issues.

My own role in the small team who made this innovative new website for carers happen, resulted from a request from the Meriden Family Programme – who were keen to have carers playing a central role in the development of this site. They were also aware of my website writing and editing skills, gained in a previous job role.

Over the seven months spent developing the new website I worked as part of a small team from the Meriden Family Programme including:

- Mr Peter Woodhams, Carer Consultant, Meriden Family Programme
- Dr Gráinne Fadden, Director, Meriden Family Programme
- Miss Rubina Jhadray, Research Assistant, Meriden Family Programme
- Michele Gladden (Carer and Web Developer) and Sue Davis, (Chair, Birmingham and Solihull Mental Health Trust)

As a carer of two sons with psychosis, it wasn’t until my youngest son (now aged 25) became ill ten years ago – thirteen years after my eldest son (now aged 38) had his first episode of psychosis – that I first heard the word ‘Recovery’ in relation to severe mental illness.

When our eldest son experienced his first psychotic episode and emergency admission to hospital – now twenty three years ago – he was initially diagnosed with Schizophrenia and we were told that he would never fully recover. As predicted, he continues to remain chronically ill, struggles to cope with day-to day living and is not in employment, and has a current diagnosis of Bi-Polar Disorder and Asperger’s.

So, as you can imagine, I was very sceptical about the use of the word ‘Recovery’ when our youngest son became seriously ill at the same age. Yet, ten years after our youngest had his first episode of psychosis, he is currently very well, not on medication, living independently and in full time employment after achieving a Master’s Degree in Theoretical Physics. Recovery is possible if the right help and support is offered early on, and our youngest son (and our family) had several years of excellent, assertive support.
from our local Early Intervention Service and Behavioural Family Therapy whilst he recovered.

My twenty-three years of caring has taken its toll, many times, on my own health. I have had numerous episodes of severe clinical depression, suffered stress-related digestive disorders and, as a result, have had long periods of sick leave from work. Over the years my own needs have been at the bottom of the large pile of caring and work demands and, as a result, have often been totally neglected. It was only when I started to take my own needs seriously – helped by Family Therapy, a carer assessment, and psychological support and medication for my own depressive illness – that I embarked on my own Recovery.

When your relative or friend is unwell, it’s really hard to think of your own needs – but looking after yourself is vital. As I have found to my own cost, there is a real risk that, if you don’t, you may eventually become physically or emotionally unwell yourself.

If you have travelled on a plane you’ll be familiar with the safety advice – that if the oxygen masks are activated, in an emergency, you need to put yours on first before helping anyone you are caring for. The risk is that, if you don’t follow this advice you may lose consciousness before you can help others – it really is just as crucial for us carers to put our wellbeing first.

When the word ‘recovery’ is mentioned in mental health, it usually refers to the recovery of the person with a mental health problem. When families and friends are mentioned in this context it is generally in terms of how family and friends can support the recovery of the service user. There is now a growing recognition that the concept of recovery is also important for carers, families and friends in their own right.

The recovery for carers, family and friends pages offer a wealth of support, advice, information and research evidence to:

- Carers, family and friends of people affected by mental health issues
- Professionals working, directly or indirectly, with the carers and families of those who access mental health services

The site – www.meridenfamilyprogramme.com/recovery – is a hub of information and advice including a wide range of recovery resources for carers, guidance on carers’ rights and benefits, family interventions, carer wellbeing, confidentiality issues and details of local and national organisations that may be helpful. We’ve also got sections for young carers and siblings and an opportunity to find out about the experiences of other carers.

There is also information on the site for professionals and carers which will be of interest to those who work in research and academic areas or who are involved in developing strategies related to carers, within local authorities, health services or other organisations which may have contact with carers.

Grateful thanks to all of the following:

The new website was made possible by Caring Minds, the charitable trust of Birmingham and Solihull Mental Health NHS Foundation Trust who funded the research and the development of the website material.

To all those who allowed us to use or reproduce their material including:
- The Scottish Recovery Network
- The West Sussex Partnership NHS Foundation Trust
- The Sainsbury Centre for Mental Health
- IMROC – Centre for Mental Health and Mental Health Network, NHS Confederation 2013

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**Behavioural Family Therapy (BFT) Training Trainers Five Day Training Course**

Dates have been set for our next annual Training Trainers course so please make a note in your diaries!

The course will take place from 9-13 February 2015 at the Beeches Management Centre in Bourneville, Birmingham, UK.

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

Please contact Sam Farooq on sam.farooq@bsmhft.nhs.uk or telephone 0121 301 2896 for further information.

More details of what the training involves can be found on our website www.meridenfamilyprogramme.com
The development of family sensitive practice and collaboration continues at a great pace in Nova Scotia. This report details the achievements since the last report in volume 4, issue 1. This work is implementing key actions in the Nova Scotia Mental Health and Addictions Strategy ‘Together We Can’ which details the need for support to be offered to families. This development continues to be supported by the Mental Health Foundation of Nova Scotia and the Nova Scotia Department of Health and Wellness.

A collaborative team made up of Cheryl Billard from Capital Health District Authority (CDHA), Debbie Picco, Family Member from Nova Scotia, Donna Methot, Family Member and Chair of Schizophrenia Society of Nova Scotia, Dr Gráinne Fadden and Chris Mansell from the Meriden Family Programme visited a further three districts within Nova Scotia in July 2014. Consultation visits took place with Mental Health and Addiction Services in South Western Health, South Shore Health and Annapolis Valley.

During each of the consultation visits the team met with groups of local people who use services, their family members, clinical staff, service leaders and associated organisations with a focus on collaborative working and family sensitive practice. This enabled the identification of good practice, barriers to implementation and areas for development. This information is being used by each area to develop their action plans to support family sensitive and collaborative practice.

Very high numbers turned out for each of these events and the team met extremely motivated and enthusiastic people who were keen to support and develop family sensitive practice.

Following on from the three visits this July, teleconference consultation meetings are being held with the three organisations, to review the recommendations and next steps. Each area is encouraged to develop action plans for progress, developments and good practice.

A follow up event also took place with senior staff and managers from CDHA in Halifax. The purpose of this was to review progress and achievements against the actions that were set during the initial consultation visit. Feedback from this session was incorporated into the proposed plan for 2014 – 2017 for Supporting Families in CDHA.

There are nine trainers and supervisors in Behavioural Family Therapy (BFT) across Nova Scotia including two family members who continue to facilitate training and supervision. There are now 120 people from a range of professional backgrounds and family members trained in BFT resulting in an increasing number of families having access to family work. The BFT trainers continue to manage the time difference between Nova Scotia and the UK and access monthly group supervision with the Meriden Programme via teleconference.

Julia Danks and Paula Conneely from the Programme facilitated the first acute care BFT course in Nova Scotia with Cheryl Billard and Jamelee Liddell who are local BFT trainers. The course was attended by staff from two inpatient units and was a great success. Please see the article written by Julia Danks in this edition for more detailed information about the training course.

The local BFT trainers which included two family members, facilitated their first training course to prepare 15 additional people to deliver the Meriden ‘Caring for Carers Programme’ known in Nova Scotia as ‘Families Matter’. This was a great success. There are now 79 facilitators for ‘Families Matter’ in the Province of which 31 are family members. Over the past 2 years there have been 18 Caring for Carers Programmes delivered across Nova Scotia with excellent feedback and strong community support.

"Nova Scotia is committed to improving mental health and addictions care for families and their loved ones”. The delivery of evidenced based programs, the collaboration with family members and training of clinicians and family facilitators has given this initiative momentum. The on-going collaboration and support of the Meriden Family Programme has been critical as we work to develop new practices and approaches. The implementation of family centered care makes so much sense and yet has been such a challenge. We continue on this journey together with families, people with lived experience and our Meriden partners.”

Cheryl Billard, Capital Health District Authority

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

References
Acute Care Behavioural Family Therapy (BFT) Course in Nova Scotia, Canada

By Julia Danks, Clinical Specialist, Meriden Family Programme

This BFT course was exciting as it was the first acute care course delivered in Nova Scotia and was aimed at building capacity and improving the interface between the in-patient services and community services. In preparing the course, time was given to ensuring the course retained the core skills and components of BFT whilst giving enough consideration of the acute environment for the delegates to feel prepared and able to adapt their current practice to incorporate the new skills whilst retaining fidelity to the model.

Delegates came from two main sites, 7 from an in-patient unit in Truro and 11 from a unit in Capital Health District, Halifax. Each site had the benefit of having a senior manager attend the training. Managers are key in supporting staff with implementation of the model and provided support and guidance to their colleagues.

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<th>Truro</th>
<th>Total</th>
<th>%</th>
</tr>
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<tr>
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<td>4</td>
<td>11</td>
<td>61.1</td>
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<td>Day Hospital</td>
<td>1</td>
<td></td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
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<td>1</td>
<td>3</td>
<td>16.7</td>
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<td>2</td>
<td>5.6</td>
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<tr>
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<td>1</td>
<td>2</td>
<td>5.6</td>
</tr>
<tr>
<td>Recreation Therapist</td>
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<tr>
<td>Total</td>
<td>18</td>
<td></td>
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<td>100.0</td>
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Expectations of delegates at the start of the course:
- Help me and the people I work with
- Families are important support; how community supports the person
- Understand what families need from us
- Better understanding of how to support staff in providing this
- How can this work in in-patient settings
- Improve my practice
- Learn what resources are out there
- How to work with patients who have no connected family
- How to help families stay healthy
- How to make the approach part of our culture.

There was much more focus on engaging with families, both in a general sense and also how clinicians might engage families with the idea of working together in a structured way. It stands to reason that in-patient clinicians are likely to be involved with their service users and families for a shorter period of time than their community colleagues, so it is important to find out early on what families would find most helpful in order to best support their relative and prioritise what elements of the model can be offered in that time.

Even though it is unlikely that acute care staff would offer the full BFT intervention to a family, all components of the model were delivered within the 5 day training, with the intention that the staff would have an increased array of skills and techniques to share with families on their units, thus being able to tailor a few sessions based on the assessed needs of the family unit.

We were privileged to hear from a family who had received BFT over the last year and from the staff member who had worked with this family. On the next page is an excerpt from Neil, an Occupational Therapist, who attended BFT training in Truro, Nova Scotia last year…
COMPASS is an awkward but apt acronym for COMmunity Psychosocial rehabilitation And Support Service: providing psychiatric rehabilitation, case management and recovery services to persons with severe persistent mental illness and their families. Service recipients report we help them get a “sense of direction” and “stay on course” in recovery and living.

“BFT has been a wonderful addition to our team’s process and ‘toolkit’ and has very much reinforced our on-going work with caregivers.”

What has worked well:

**In general:**

- Having a family perspective fits well with the ‘working with clients/care recipients circle of support’ that COMPASS has always embraced.
- BFT has provided a useful framework for acknowledging the needs of family and significant others alongside the specific needs of the care recipient.
- BFT opens the door for a timely constructive collaborative, culturally, sensitive attending to the social needs of each care recipient.
- BFT becomes part of the focus for all my work, both individual and group.
- The BFT orientation to the fact that family is an integral part of how COMPASS wants to do its caring for each client is a great relief to family and significant others.
- The evidence for BFT success internationally, alongside our in-depth training, allows us to confidently offer this service to care recipients and their loved ones from the beginning. The conversation “who does the care recipient most value, need and want to be part of their recovery journey?” opens the door appropriately to initial conversations with partners, siblings, parents and all significant others.
- Our young clients with on-going parental contact and early significant other relationships are very ready and open to BFT.

**BFT components**

- The initial individual assessment process is a very powerful engagement process for all the significant others identified by the care recipient. It allows for a deeper understanding of the family culture, everyone’s experience of the clients illness experience and a preliminary understanding of the coping strategies that are working or not working. It is an authentic opportunity for family members to be truly heard and experience being listened to in an in-depth individual way. The acknowledgement of individual goals and aspirations validates the ‘okayness’ and rightness of each family member continuing their own life alongside the care recipient.
- The regular format for conducting sessions gives a structure, which the family quickly gets used to. It’s a familiar social space with a time limit of one hour that allows for a very tolerable learning of new skills.
- During BFT the spotlight is shared in turn by all family members with the care recipient thus it reduces intensity of focus on the individual client.
- The graded sequence of how the communication skills are taught is a powerful way to allow families to discover and rediscover their capacity to connect with each other respectfully and meaningfully.
- The process of eliciting individual family member rationales for the value of each skill engages each person more fully.
- The concept of the family meeting formalizes a sharing of important issues and concerns that are often dealt with by being squeezed into the spare moments of busy lives.
- The encouragement of the practice of the skills between sessions holds the family responsible for using what they learn.
- BFT has reduced stress in the household I’ve worked with e.g. “we’re not as stressed now…” Quote from family after 4 communication skill sessions.

**BFT challenges**

**In general:**

- When clients are older and had a longer illness journey which has estranged them from family and
significant others it has been difficult to offer this service.

• Single adults who have lived on their own for years without partners have limited or modest social networks which make BFT challenging.

• Engagement: COMPASS is still building how to effectively invite families to participate in BFT. We aim to make this core to our approach with every client.

• System change: how best to engage all mental health services and psychiatry in this mode of practice.

• Scheduling: need to be very flexible in accommodating the timetables and the activities of the family e.g. end of the day, early evening, respecting child care, respecting work schedules.

• Delays and complications: it took six months for this family to actually begin; changes in sessions when cancellations were needed.

• The initial assessment: tape recording can feel quite awkward for both the provider and the family. Careful orientation to the privacy of the recorded information and its ultimate erasure is required.

Tips

• Let the family do the work! Listen, encourage, give regular succinct and clear feedback to acknowledge successful skill practice; balance with gracious coaching to fine tune skill performance through re-practice; sprinkle with modest demonstration and even examples from your own social experience – a wry sense of humour goes a long way.

• Stick to the hour: avoid historical emotional patterns or revisiting of old issues or personal beefs.

• Stick to the format and process in the here and now.

The power of having a family address the group

Following Neil’s presentation to the group, a family sat with the delegates and shared their experiences of receiving BFT. The service user described his experiences of becoming unwell, hospital admission to different units and the help he and his family had received.

The family had been involved to a greater and lesser degree on different units and were thankful for any information shared with them by staff. This was a new experience for the whole family and after initially being left out of the loop and feeling overwhelmed and frightened, they were then included and offered BFT.

This was a key turning point for the family and it has made such a difference to their understanding of what happened and what to look for in the future. Their relationship with each other also improved and they both attribute this to the communication skills they learnt, the key feature of these was giving each other eye contact when they spoke to each other – a simple thing but one they had let go in all the distress and worry. The family members were very anxious about talking to the group but really wanted to give something back. If they could convince even one person of the merits of BFT and that staff member went on to help another family, then it was worth it.

It was particularly poignant for me to listen first to Neil describing his experiences of implementing the work, then to the family he had helped and hearing how things have changed for them. I have delivered training in Nova Scotia several times over the past couple of years. Cheryl and Jamielee who trained on the first BFT course we delivered in Halifax in 2012 were now my fellow trainers along with my Meriden colleague, Paula Conneely. Neil completed the training in Truro 2013.

We don’t often get the opportunity to see first hand the influence our training makes and knowing that services, service users and families are benefitting in this way is tremendously encouraging when we are away from our own families to deliver training. We get a sense of this through supervision but hearing it first hand from the healthcare provider and the family brings it home and completes the circle.

Feedback/comments from course participants on completion of the training:

“Please keep reminding ‘acute care’ of the usefulness of new skills learning”.

“A change to practice is needed and this BFT training was well done and will go towards the work ahead of us.”

“Thanks for increasing our awareness and giving us confidence to move forward.”

“Really enjoyed the course. Look forward to implementing it on our unit.”
Acute In-Patient Pilot – An Update
By Julia Danks, Clinical Specialist, Meriden Family Programme

Further to the article in the June 2014 edition of our newsletter I would like to update progress on the acute in-patient pilot running on a unit in Birmingham. The context of the pilot being offered came about earlier this year as part of Birmingham & Solihull Mental Health NHS Foundation Trust’s commitment to implementing The Triangle of Care – a government initiative aimed at developing relationships between service users, families and providers in in-patient settings.

Recap of pilot:
- Identify service users
- Engage service users and family
- Complete pre-intervention measures and brief assessment with each person involved.
- Three sessions
  - Session 1 – Information sharing
  - Session 2 – Recognising early warning signs of relapse
  - Session 3 – Problem solving
- Discharge as appropriate
- Post-intervention measures
- Report results

What went well?
The service users and family members found the sessions helpful and would recommend it to other families. Feedback was given after completion of the family work, e.g. in response to being asked how having the family work had helped, the following feedback was received:

“Having agreement that I can be involved in her care without going round the houses and having the data protection act quoted at me was helpful.”

“Written information was useful, I was able to ask her questions about the illness, I haven’t been able to do that before.”

“She is more open, she tells me when the voices are bad and when she doesn’t feel good. I have an increased awareness of symptoms.”

“Mom more aware of signs but also helped me understand my early warning signs more.”

One particular service user was quite anxious at times but was able to tolerate all sessions and participated fully. After four previous admissions this year this was the first time mom had been involved in her daughter’s care, and the relief was obvious.

Another family was involved from the outset as this was their daughter’s first episode of psychosis and first admission, and they were very grateful for the information and support they received. It is never too late to start involving families in a more thorough way, it might mean hearing and holding some criticism e.g. “Why was this not offered two years ago?” but being more involved enabled the family to provide more effective support for the service user.

I was able to be flexible within the three sessions and deliver them according to need of the family, not sticking to a set order. For example, with one family, information-sharing was delivered first as mom needed to understand more about what was happening, but the planned early warning signs work was moved to facilitate problem solving in response to an issue regarding accommodation post discharge.

There are designated family rooms within the ward to see the family in private, which was very helpful as the ward environment is busy and often very noisy. It provided a tranquil space for the family to focus on their issues.

The ward manager was supportive of the pilot and some staff appeared interested in the work. When allocated by the ward manager, they were happy to sit in on the family sessions. I spoke with most staff prior to the pilot starting, during their handover periods to talk through the pilot, the aims and what the family work would involve and how they could be part of the work.

Issues raised during pilot
Several service users who met the criteria declined the intervention. This raises questions about how the service users were engaged with the idea of working with their families. As I wasn’t a member of the ward team I couldn’t pick the ideal moment to speak to service users about family work, I only had the time I was there to try and engage with service users and family members if they happened to be on the ward at the time.

Having inclusion criteria seemed a good idea at the start of the pilot, but was it too tight or even necessary? Having to have a previous admission precluded many service users and their families and so the decision was taken to remove
it. The only thing stipulated was that there was a support network around the person who visited the ward.

Staff were not always available to sit in on sessions and if a member of staff was available they were different each session, they might be regular ward staff but often were agency staff. This meant there was no consistency for the family and no learning or no overview of how the intervention progressed for the staff.

How families were identified for family work was an issue. Staff were not routinely identifying families that might need support. I didn’t get to meet all eligible service users as by the time I came across them, some were close to discharge. When families were identified through the staff, they were often the most challenging service users or families. Those that came and went quietly were not identified as needing extra support or information.

**Lessons learned**

Training in-patient staff to deliver the intervention may be key in supporting them to do the work rather than Meriden staff doing it. Historically, where psychosocial interventions have been offered in in-patient care, it is generally as part of a research programme rather than something delivered by ward staff and this has been replicated within this pilot. This will always be a challenge for ward staff where the environment is busy and sometimes chaotic. It has highlighted that for change to happen there needs to be a consistent approach and an understanding of the need for change. This has helped us re-think further training for other units.

When identifying families, the criteria although loose, was constrictive. In hindsight it may have been better to offer to all families for a set period of time or to a set number e.g. ten families.

Following the lessons learned we have gone on to deliver training on two other units within BSMHFT. Below is a summary of the units involved and the differences in training delivery:

- **Acute Adult In-Patient**
  Staff aware of pilot but the intervention was delivered by Meriden staff

- **Mother and Baby Unit**
  All staff attended one day training and are delivering pilot intervention themselves

- **Eating Disorders Unit**
  All staff attended training (3 x 2.5 hour sessions) and are delivering pilot intervention themselves

Early results during supervision with the staff on the mother and baby unit indicate that they are now using aspects of this approach in their everyday practice and are offering the brief intervention currently to four families.

The training with the staff on the Eating Disorder Unit is ongoing at the time of writing.

It is fair to say that although the initial results were not what we hoped for, it has proved a valuable experience in understanding the challenges for staff working in an acute environment, but also allowed for thought to be given to required changes for future training. There already seems to be a positive result from the more recent training where the staff are trained to deliver the pilot family work themselves and have taken ownership for the work.

A further update will follow in the next edition.

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**Launch of ‘Understanding Psychosis and Schizophrenia’ Report**

On 27 November 2014, the Division of Clinical Psychology on behalf of the British Psychological Society launched the revised version of the ‘Understanding Psychosis and Schizophrenia – Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help’ document edited by Psychiatry and Complex Mental Health Faculty (PCMH) member Anne Cooke.

This report describes a psychological approach to experiences that are commonly thought of as psychosis, or sometimes schizophrenia. It complements parallel reports on the experiences commonly thought of as bipolar disorder and depression and is intended for service users, their friends and families, journalists, policymakers, mental health workers and the public.

The report can be downloaded from The BPS Shop: (www.understandingpsychosis.net) or you can get a free hard copy by emailing: memberteamservices@bps.org.uk with ‘psychosis’ in the subject line.
Family Work Training in Ireland 2014

By Martin Atchison, Deputy Director, Meriden Family Programme

The Meriden Family Programme’s training programme for the newly established Early Intervention service in Ireland has continued during 2014. Following four training courses in 2013, supervision for trained staff has taken place across the country to support the implementation of family work. A large number of families have benefitted from family work since these training courses took place and it has been pleasing to hear from clinicians about the success that they have had in supporting families effectively.

In March of this year, six clinicians from Ireland who have trained in family work attended the training the trainers course. Since then the family work supervision has been delivered alongside local trainers to support them to be prepared for the time when they will be delivering training and supervision independently. This has also been extremely beneficial to the members of the Meriden team in providing some awareness and knowledge of local issues to ensure that supervision is done in a way that relates to the experiences of clinicians working in existing services.

During May and June this year, four more family work training courses were held. The recruitment and selection process was carried out by the local trainers with support and guidance on the process being offered by Meriden staff. These were facilitated by local trainers alongside one member of the Meriden Family Programme team. This allowed the recently trained trainers to get some experience of delivering a family work course for the first time, whilst having the benefit of a more seasoned trainer being present.

It was a positive experience for the Meriden Family Programme team to be part of these courses, in that we were confident that the future roll out of training and supervision is in the hands of some very confident, capable and enthusiastic people who have positive beliefs about working with families and who clearly value the model of Behavioural Family Therapy.

The courses took place in Cork, Castlebar, Dublin and Kilkenny, with 64 people being trained. The overall total of people trained in BFT in Ireland currently stands at 164. The table below outlines the professions trained in family work, which is compared to the percentage of people trained from different professions in the UK.

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<th>Profession</th>
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<th>% of total trained staff (UK)</th>
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<td>46%</td>
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<td>Community Psychiatric Nurse</td>
<td>31%</td>
<td>31%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
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<td>47%</td>
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What is interesting about this is the much higher percentage of people trained in Ireland from a social work background, which indicates that services in Ireland are structured differently from the UK, a factor that will need to be taken into account when considering the implementation of family work.

Moving forward, supervision will continue to be delivered by a combination of local trainers and Meriden staff. In May 2015, a Training Trainers course will be taking place in Dublin, the first such course outside of Birmingham. Twenty-five people will be trained as trainers, with the aim of having two trainers from each county in Ireland in place to sustain the training and supervision that will be necessary to ensure that more families will go on to receive the benefits of family work.
Meriden Behavioural Family Therapy Training in Castlebar, June 2014

By Veronica Burke, Senior Social Worker,
Health Service Executive West Mental Health Services, Ireland

Behavioural Family Therapy is an evidence-based approach for working with families of people with mental health difficulties. There is over 30 years of research that shows working individually with families using a psychoeducational approach reduces relapse rates for people with mental health difficulties to less than 10% at 9 months, to between 30% to 40% at two years post intervention (Tarrier et al 1988, Hogarty et al 1986). The Cochrane review (Pharoah et al, 2006) highlighted that individual family approaches resulted in reductions in relapse rates, hospitalisation rates, and better adherence to medication for service users and reduced cost of care.

In particular, with regard to early psychosis, individual family intervention has been shown to be particularly effective (Bird et al). The NICE guidelines 2014 recommend offering “family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user”.

As part of the early intervention in Psychosis Clinical Care Programme, Meriden have been tasked with the job of training up the mental health teams nationally in Ireland using a cascade model to provide family intervention to families affected by mental health difficulties.

Two Social Workers in Adult Mental Health Vincent McHugh and myself and one in CAMHS, Breege Moran, completed the first training course in Behavioural Family Therapy in Galway and Mayo in 2013. Breege Moran and I went on to complete the Training Trainer’s course in Birmingham in February 2014. With the support of Meriden we were tasked to organise and facilitate a course in Behavioural Family Therapy for mental health professionals from the west of Ireland, an area stretching from Donegal in the North West to North Tipperary in the south – a very wide area.

In total, approximately 40 professionals from a range of disciplines applied to do the course for a total of 14 places. Two places were also allocated to carers from Mayo as we hoped to introduce a model of involving carers in the provision of BFT as is done currently by Meriden in the UK.

The course was held in the Centre for Nurse Education from 16-20 June and was co-facilitated by the Deputy Director of Meriden, Chris Mansell and Dr Gráinne Fadden, Director of Meriden. An evaluation of the course highlighted that participants found it a positive learning experience that gave them skills to work more effectively with families.

The course had some didactic elements but was mainly skills-based experiential learning where participants had the opportunity to practice skills as the family worker at different stages in the training and get feedback. This is done through role-play in small groups, through observation of tutors and DVD material, and through large and small group discussions with a 1:5 tutor to participant ratio throughout most of the course.

Particularly helpful is that each participant gets to practice taking on the role of the family worker, and gets feedback from peers and the tutor around what they did well as the family worker and what they might do differently.
The main areas covered in the course were:

- Mental health difficulties and their impact on families
- Families’ experiences of services and family sensitive practice
- Evidence base for family work in mental health
- Information sharing, confidentiality and diagnostic uncertainty
- Staying well planning
- Communications skills
- Problem solving skills
- The needs of siblings.

It is hoped that another course will be run in 2015 in Mayo with an equitable distribution of places from across the western region. Any participant who does the course is expected to begin working with a family using BFT straight away and to attend monthly supervision in Galway or Castlebar.

For further information, please contact Veronica Burke Social Worker 00 353 86 8533801.

References


Hogarty et al. Family Psychoeducation and Social Skills Training and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia, Arch Gen Psychiatry, 18986, 43 (7), 633–642


Black Dog

The black dog slinks off once more, and I am left to weave over the torn places in my soul. Aching with tears, stupefied with pain, I turn out my mind, eagerly discarding the impossible ghosts that haunt me….

They scratch and scrabble like rats at poisoned bread – I am confounded. What shall I say? God be thanked! They are dead for a season, and I will not contemplate the anguish of their return.

Switch on the light! Let the warmth bring love and healing before the darkness comes again.

By J. R. Harmer

New Films on YouTube

‘Psychosis’
Film by South Essex Partnership University NHS Foundation Trust

This powerful film made with young service users shows the effect that psychotic episodes can have on young people and why the need for Early Intervention Services is so vital. The service users do a lot to dispel prejudice about what psychosis sufferers might be like. These young people are very passionate, articulate, and more importantly, on the road to recovery.

To view the video, log on to: http://youtu.be/O-FYNNq4uMI

‘Simon Says Psychosis!’
Film by Sussex Partnership NHS Foundation Trust

In a new film made by Sussex Partnership, a number of young people recount their personal stories of psychosis. The film explains the kind of help and understanding they received from the Early Intervention Service in their area.

To view the video, log on to: https://www.youtube.com/watch?v=GXh9hPzHHi4

or Google Simon Says Psychosis!

Obituary – Frances Gair

Dr Gráinne Fadden, Director, Meriden Programme

In August we learned of the untimely death from cancer of Frances Gair, Occupational Therapist who was in the first group trained in the Behavioural Family Therapy approach in the West Midlands when the Meriden Programme started in 1998. She then went on to train as a trainer/supervisor, and organised several training courses in Coventry where she was working at the time. She provided supervision for those trained, and through her management links, worked at implementing family work in that area.

Frances also supported us in delivering training further afield in Ireland and Scotland – she joined me in training the first group of ten people trained in Glasgow. She also worked half time with the Meriden Programme for 18 months as part of a European research project with colleagues from 5 other European countries. This involved her travelling to different sites around the country delivering training and supervision.

Some years ago, Frances made a decision to move back to Scotland where she was from originally to be closer to family. It was extremely touching for me that more than once in the 6 weeks before she died she got in touch with us through her sister when she was unable to communicate directly to say how much being involved in all of the family work and its implementation had meant to her. Because of the nature of the cascade model of training, her legacy will live on, and we are thinking of her family as they try to come to terms with the untimeliness of her death.
The Meriden team was delighted to be asked by a team of researchers from Kobe Women’s University in Japan to organise and host a 5 day study tour for them here in Birmingham. All six members of the team had been impressed with Meriden’s work when they had attended one of the conferences that three of us from Meriden had spoken at in Japan back in March 2014 and their team leader, Professor Katsuyo Ueno, felt that we could help them understand the culture and environment in which families and friends provide support here in the UK.

The six members of the team that visited included specialists in architecture, housing for life and well-being, as well as mental health and social care from a social work perspective. Accompanying Professor Ueno were Ms Noriko Mano, Ms Megumi Yoshimura, Dr Ikuko Murosaki, Dr Chie Murosaki and Ms Yasuko Maeda. Translation throughout the week was undertaken by Ms Misako Takahashi (a postgraduate student at Birmingham University) who was supported for two days by Dr Mirai So, already known to Meriden from a previous visit. The visitors were interested to hear about the kind of support available to those people who live in the community and to see the environments in which support was provided including housing. They asked if they could see examples of inpatient units, supported housing, independent living environments and places where support is provided. Other topics the visitors were interested to learn about included benefits and how information is provided on mental health in schools.

The wider community in Birmingham and Solihull was extremely helpful in assisting us in arranging an extensive, informative and interesting range of visits which all took place during week commencing 22 September 2014.

A number of people with specialist knowledge were good enough to meet the visitors and provide information on their particular speciality including Terry Plant, an Architect with The Design Buro and Bram Scott, a Benefits Specialist working in the community. Staff from within our own Trust who met with the visitors included John Short, Chief Executive, Alan Kenny, Director of Infrastructure and Asset Management and Dr Paul Patterson, a Psychologist with the Youthspace team who has done a lot of work in school in relation to reducing stigma.

A wide range of visits were arranged to units within the Trust including the Ardenleigh and Tamarind Forensic Units, Hertford House Rehabilitation Unit, the Melissa inpatient ward and the Street Triage team at the Barberry Centre. One of the visits that impressed them most was visiting a service user in her own flat. The visiting team were surprised that someone could recover sufficiently from a severe mental health problem to live independently, as this rarely happens in Japan.
Thanks also go to other organisations that provided very interesting and relevant visits: Stonham Homegroup was able to show a model of a new supported housing facility under construction in Solihull and the team at Park Lane Garden Centre demonstrated how horticulture can help in the recovery process. A full morning was spent at the interesting accommodation units called Old Snow Hill and The Foyer which are run by Midland Heart in Central Birmingham and they also visited The Factory, a very modern and interesting activity centre for young people.

Solihull Citizens Advice Bureau also made time in their busy schedule and kindly facilitated our visitors who had specifically requested a tour of a Citizens Advice Bureau in the UK.

At each of these places the researchers not only showed great interest in the support services provided but also the environment itself in terms of its design and room sizes. On the final day the visitors met with two families who were able to explain from their own personal experiences how Behavioural Family Therapy had helped each of their families in different ways which was a very appropriate ending to a varied and interesting week.

The Meriden team is very appreciative of all the assistance given to projects like this by local teams both within Birmingham and Solihull Mental Health Trust and also by other agencies and it is really encouraging to find that there is such a wide range of supportive services available across Birmingham and Solihull.