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It has been a while since the last edition of our newsletter, so I hope that all our regular readers were not wondering what had happened. With so much uncertainty in services currently linked with economic factors, there is always a concern that services such as ours will not continue to exist. Fortunately however, we are still rolling along, and you will see from the current newsletter, that the reason for the delay is linked with us having had an exceptionally busy period from January until April.

You will notice a clear international flavour in the articles in this edition. For the second year running, we were pleased to have mental health professionals from Uganda on placement with us under a Commonwealth Fellowship scheme. This year we had two people, Robert and Hasifa. You will also see the amazing range of work that Thomas who was with us on placement last year has done since returning to Uganda. Thomas, Robert and Hasifa plan to continue to work together to develop services even further. It is humbling to see the extent that they are developing services with minimal resources. Next year we hope to have four mental health professionals from Nigeria under the same scheme who are looking to develop early intervention services in psychosis. It is very rewarding for us to be able to support the development of services in developing countries, and this is something that we hope to continue over the coming years.

In March we welcomed a delegation of visitors from Japan. Once again we were really impressed to see that the drive to develop services for families is in fact coming from the family movement and carers groups rather than from professional services. The delegation was keen to see a range of services in practice. They met with families who had received family work and professionals who deliver it. Following the visit they have developed an ambitious plan to adopt the Meriden model within Japan as they feel that the cascade approach will result in large numbers of people trained in family work which is what is needed in such a vast country.

Services for families are also developing well in Nova Scotia as is evidenced by the interesting article from a carer who has seen how services have changed since adopting the Meriden approach. It is difficult to know what to say when Donna touchingly talks about us having made dreams come true as I'm not sure our very small team see ourselves in that way but it is so satisfying to see the real impact of the longstanding relationship we have now had with services in Nova Scotia, and we were delighted to welcome the first therapists on this year's Training Trainers course. The second stream of work that is beginning in June is rolling out the training across the other districts in Nova Scotia so that the approach will be taken up Province-wide.

You will notice that the article on our Training Trainers course this year discusses the wide variety of people on the course – the largest we have had in many years. It is really heartening to see that the interest and commitment to developing services continues both within the UK and also worldwide. Amazingly, we already have people booked onto next year's Training Trainers course!

The other country where there is a real sense that services for families may now begin to develop is Ireland. Two introductory events which were held in Spring this year had an amazing attendance reflecting a genuine interest in the development of services for families. There are also plans in the country to develop early intervention services across the country in the way in which they developed in England. These are badly needed and it is heartening to see that finally things may begin to happen.

On the opposite side to new services developing there are articles from services who like our own have persisted with making family work sustainable for such a long time. The article by Margaret Tulloch and Gail McKillop about the event held Scotland-wide last year, demonstrates the commitment across the country to continue to overcome implementation issues and ensure the widespread geographical availability of services for families in Scotland. In a similar vein, Lina Gatsou's article on developing services across primary care, schools and a whole range of agencies in Leicestershire is full of ideas for how people can look at multi-agency approaches to working with families.

There have been other interesting developments of course in the last while. The launch of the Improving Access to Psychological Therapies (IAPT) Competencies is something that those of us who work in this area have been trying to develop for a very long time, and we're delighted to see that these are now online. The Meriden Programme was heavily involved in the development of the family work competencies and we encourage anyone involved in the area to have a look at these and think about how they can be implemented in the workforce locally. There is also information on the open day which is being held in July in Birmingham, as we are a demonstrator site for bipolar disorder.

I thought it worth reminding people about the Caring for Yourself self-help workbook which we launched last year. We have an article summarising the feedback from the small number of people who have sent feedback in to us. This is a very full resource that is available to download freely either from the Rethink Mental Illness website or the Meriden Family Programme website, so we would encourage readers to make use of this whether individually or in groups or to let others know about it.

Finally, we have published in full the EUFAMI Dublin Declaration. This describes the aspirations for families across Europe over the coming decade. Please distribute as widely as possible.

So as you will see there is lots going on both locally in the West Midlands, across the country and further afield. We will try to have a shorter gap between this and our next newsletter and as always welcome items from people who would like to tell us about their work.

Best wishes to you all for the coming months and for a good summer.

**Dr Gráinne Fadden**

*On Friday, 24th May, over 193 delegates from 21 European countries met in Dublin to discuss the needs of family carers for people with mental ill health. Addressing the conference Dr Tonio Borg, European Union Commissioner for Health and Consumer Affairs stressed the importance of family involvement in mental health care across Europe.*

*The Irish Minister of State, Kathleen Lynch declared at the conference that good mental health was a partnership between government, professionals, people with self-experience of mental ill health and family members.*

*Throughout the day, the audience heard presentations on the importance of family involvement, the need for education, quality information and communication in helping families to cope with mental ill health.*

*Against this background, the delegates unanimously agreed The Dublin Declaration 2013....*



**Left to right:** Bert Johnson, President – EUFAMI, Claire Keogh, Chairperson – SHINE (Ireland), Kathleen Lynch, Irish Minister of State for Mental Health, Gráinne Fadden, Director – Meriden Family Programme (U.K.), Matt Muijen, Policy Advisor (Mental Health) – World Health Organisation

# Dublin Declaration\*

## **EUFAMI's vision for the future for families**

All families and persons affected by mental ill health should at all times be afforded equal rights, entitlements and opportunities that are available to any other member of civil society and should be empowered to participate in the community in which they live.

## **The role of families**

- The central role and rights of family members in the care and treatment of people with mental ill health should be fully acknowledged and provided for throughout Europe. Family carers should be acknowledged as equal partners with professional staff and the person with mental ill health in decisions relating to the planning and delivery of treatment and care.
- Families and individual family members have a right to choose and define the role they are willing and able to play. This must include the right not to be involved directly with their relative's care, or to be involved in planning services, campaigning and monitoring services.
- Families should not be discriminated against or held responsible legally or financially for their family member directly affected by mental ill health. State mental health care should be adequate to enable family members of people with mental illness to make their choice without any feelings of personal guilt.

## **The needs of families**

- The needs of families and carers themselves for support and understanding should be recognised and fully provided for by the state authorities. Families should have a right to the opportunity to state their emotional, practical and financial needs so that they can be empowered to acquire the necessary coping skills to fulfil their caring role.
- Families need to be cared for to ensure that their own physical and mental health is well maintained and supported. Evidence exists widely to show that this is not happening and that family member's health suffers. Depression amongst families is increasing and much is going un-diagnosed. Families should be provided with a statement of their own needs on a routine basis, with written records of these needs, and continuing assessment. Plans for meeting identified needs should be implemented and audited.
- The need for families and carers to recover from the experience and trauma of mental illness must be formally recognised and services provided to help them with their own recovery.

## Public Authorities and statutory service providers

- Resources must be made available to meet those needs to enable family carers to carry out their role effectively. This may involve costs of training, counselling or other emotional help, providing information and financial help (for respite breaks, and travel costs to visit their relative)
- Such resources should be available to meet the family's needs, over time, in a planned way. They may include factual information, training in new skills (identifying signs of relapse, communication and problem-solving skills), support for themselves, e.g. counselling, advocacy, and support for self-help carer groups, help lines, peer support (carer to carer), respite, or help with identifying their role.
- Legislators and statutory service providers must be proactive in providing evidence-based family intervention services. They should not leave this to voluntary groups. The evidence for family interventions has been available now for thirty years, and it is negligent that these approaches are not yet widely available.
- The development of Comprehensive Community based services is seen as both essential and desirable if recovery is to be a realistic possibility. However, it is imperative that mental health care services provide the services outlined above to family members so that they can carry out frontline care, which is essential as a consequence of community care, more effectively. The sharing of information on the wellbeing of the person affected by mental ill health is essential.

★ The Dublin Declaration was unanimously endorsed by delegates attending EUFAMI's special European Family Conference held in Dublin, Ireland on Friday, 24th May 2013 to mark the 20th Anniversary of the founding of EUFAMI under the patronage of his Excellency, Michael D Higgins, President of Ireland. The conference was officially opened by Ms Kathleen Lynch, Minister of State with responsibility for Mental Health. Dr Tonio Borg, EU Commissioner for Health and Consumer Affairs also addressed the delegates, who numbered 190 from 21 European countries.

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Dr Tonio Borg (EU Commissioner for Health)



Ms Kathleen Lynch, Irish Minister of State for Mental Health



Delegates at the conference



Dr Gráinne Fadden, Director – Meriden Family Programme (UK)

# Awareness of Family Work Comes to Mayo, Ireland

**By Veronica Burke**  
**Senior Social Worker, Mayo Mental Health**

On the 14th of February 2013, Mayo Mental Health Service in association with Galway Mayo Institute of Technology (GMIT) hosted a Master Class by Dr Gráinne Fadden on the theme of 'Working Collaboratively with Families in Mental Health: Challenges and Opportunities'. Refocus (a 3 year project aimed at developing recovery oriented practice across a range of settings in Mayo Mental Health Services), Shine (a national organisation dedicated to upholding the rights and addressing the needs of all those affected by mental ill health) and the Mayo Mental Health Association funded the Master Class.

Dr Fadden is Director of the Meriden Family Programme, Consultant Clinical Psychologist based in Birmingham & Solihull Mental Health NHS Foundation Trust, and an Honorary Research Fellow at the University of Birmingham. She also happens to have grown up in Castlebar where the Master Class was held.

The turnout for the Master Class was unprecedented – the training venue had to open two extra rooms additional to the large lecture theatre where the event was relayed to. The keen interest may have been prompted by a frank radio interview given by Dr Fadden the previous day outlining what she thought needed to happen to develop state of the art mental health services in Ireland.

Dr Fadden spoke about a particular tradition of families not being 'seen' in adult mental health services. In particular she outlined that this is due to models of mental health which focus on the individualistic and intrapsychic rather than the psychosocial. Other factors also contribute to this resistance to include families such as a lack of training of mental



**Front row (left to right):** Joan Higgins – Relative, Ursula Scanlon – Clinical Director, Veronica Burke – Senior Social Worker, Gráinne Fadden – Keynote Speaker, Barry Buckley – National Service Users Executive and Eileen Connolly – Relative

**Back row (left to right):** Cillian Russell – Shine, Corina Keane – Shine, Sean Lynch – Carer, Jacqueline Mangan – Users Service, Brendan Needham – Occupational Therapy, Claire Guerin – Social Work, Michael Tobin – Manager of Mental Health Services, Mary McHale – Nurse Practice Development Co-ordinator, Ken Hogan – Head of Department Nursing, Healthcare & Social Sciences, and Kevin Mangan – Relative

health professionals in family work, an over emphasis on confidentiality in the doctor patient relationship, unequal power positions and a tradition of pathologising families.

Dr Fadden explained her rationale for including families. Research shows that the impact of mental illness in a family can be considerable. Carers of people with mental health difficulties are more prone to depression and stress. Families therefore need to be supported in their role and have their needs assessed. We all live in social contexts and to fully understand the service user and their needs we must understand those who matter to them and who care about them. Dr Fadden argued that contact with the family is essential. Families have valuable information about their relatives, which when shared with professionals can assist their assessment and treatment.

She spoke about a range of approaches around working with families. Carers support groups have been shown through research to be beneficial for the relatives of people with mental illness as they can reduce stress, isolation, stigma and increase skills and knowledge of carers. Family-to-family run programmes fared well, with participants showing reductions in distress and increased acceptance



Part of the large crowd who attended the seminar, GMIT Castlebar Campus

of family member's illness, as well as improved problem solving and a reduction in subjective burden.

Dr Fadden reviewed evidence-based approaches to individual family work. A behavioural psycho-educational approach, which is based on an assessment of the whole family, works best. With this approach the service user and family are seen together, at least for some sessions. This approach has strong educational and information sharing components as well as a focus on skills acquisition such as problem solving and improving communication skills. A collaborative relationship between the service users, the family and the professional, who recognizes the expertise of all parties, are essential for this approach to be effective.

She proceeded to outline some of the numerous studies into the effectiveness of this approach for the treatment of Schizophrenia. The Cochrane Review (Pharoah et al 2006) summarizes the outcomes of over 43 different studies, all of which highlight that individual family approaches reduce relapse and hospitalization rates, improve medication adherence and reduce the cost of care.

She also pointed out that NICE Guidelines for Schizophrenia (2009) recommend that all families of people with schizophrenia who are in close contact with their relative should be offered family intervention. NICE Guidelines (2006) also recommend family focused intervention for people with bipolar disorder.

Dr Fadden talked about the issue of confidentiality and how it can be viewed as a barrier to working collaboratively with families. She referred to the Royal College of Psychiatrists good practice checklist outline in the pamphlet 'Partners in Care; Carers and confidentiality in mental health' (2010). This pamphlet states that all relatives of people with mental illness should have their needs assessed and should be given information about the local and national supports. This good practice guide explains that clinicians need to explain to relatives any confidentiality limits they are under as a result of restrictions requested by the service user.

It suggests that relatives should get both verbal and written information about the mental health diagnosis, what behaviour is likely to occur, the benefits and side effects of medication as well as the roles of the different professionals involved in the care of their relative explained.

There was discussion of the importance of recovery for the whole family. Mental illness in a family usually represents a crisis. Behavioural family intervention facilitates families to use their own resources to find new ways to relate and adjust to the changes that mental illness brings to the family unit. It is not just the family that needs recovery. The mental health services need to adjust and change to a more recovery-based approach to working with families. Dr Fadden pointed to the need for organizational and cultural change in order for the mental health service to begin a more collaborative partnership with service users

and relatives. The Meriden Family Programme offers training in family friendly awareness building as well as training in Behavioural Family Therapy (BFT) worldwide.

The Master Class finished with a celebration of 21 years of the Shine Relatives Support Group, which is facilitated each month by Donie Coleman and Maire Tuohy. Relatives from this group have been trained as facilitators of the Shine Family Education course. They have also contributed to the development of a Family Friendly Services Policy document developed by Shine and have been involved in Mayo Mental Health through the Consumer panel, Stakeholders meetings, Imroc, Prosper and Refocus. Participants on the Recovery modular course in the GMIT then received their certificates from Dr Gráinne Fadden and Mr Ken Hogan, Head of Social Studies, GMIT.

The afternoon session consisted of a workshop on how we can implement change in Mayo Mental Health to insure we work more collaboratively with families. This was facilitated and organized by Claire Guerin, Social Work Team Leader and Mary McHale, Nurse Practice Development Coordinator. Five key areas for change were identified under the headings Access to Services, Family Friendly Service, Care Planning, Information and Education. Some of the recommendations of this workshop were:

- Access to the service is a major issue for families. Current access to the Adult Mental Health Unit through Accident and Emergency Departments is found by relatives and service users to stigmatise them further and to be stressful and difficult to negotiate.
- Relatives and GP's need to be advised of the Authorised Officer's role and how to access it.
- There needs to be a culture in the mental health services that recognises families' strengths, resilience and skills. A culture of avoiding pathologising families needs to be encouraged in the mental health services.
- Family friendly training of staff would help with this, particularly with relative peer supporters co-facilitating the training.
- There needs to be consistent recognition that families have their own need for recovery. This should start at first contact with the service.
- Families should to be directed to key supporters, particularly on admission/discharge, diagnosis and after care.
- Families should be involved in the care planning process, in assessment, treatment and discharge planning with the consent of the service user. A copy of the care plan



Michael Tobin, Manager Mental Health Services, addressing the large crowd, GMIT Castlebar Campus

Photo © Ken Wright Photography 2013

with a named key worker should be given to families. Prior to discharge, families need to be included in a discussion around possible challenges they and their relatives may face.

- The emotional needs of children of people with mental illness also need to be recognised. Possibility of delivery of service for the same in partnership with voluntary agencies.
- Behavioural Family Therapy should be available to all families of people with mental illness as there is a clear evidence base for its effectiveness for reducing service user relapse rates and is in line with NICE guidelines.
- A Relative's Pack should be given to each relative who has contact with the service. Families need easily accessible information.
- Workshops for relatives and service users to explain how the service works, the rights and the roles of the

different professionals and supports in the mental health service and voluntary sector available for them would be beneficial.

## References

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# Working with Families of People with Serious Mental Health Problems: A one day event in Dublin, Ireland

**By Eithne Cusack, Director, Nursing Midwifery Planning & Development Unit  
Dublin North, Ireland**

As part of the implementation of *A Vision for Psychiatric / Mental Health Nursing – a shared journey for mental health care in Ireland* – a report launched by the Office of the Nursing and Midwifery Services Director (ONMSD) that provides strategic direction for the further development of the role of Nursing within the Irish Mental Health Services; a national workshop on *Working with Families with Serious Mental Health Problems* was hosted by the ONMSD on 13 February 2013.

Dr Gráinne Fadden, Director of the Meriden Family Programme in Birmingham, (UK) presented along with a carer John Saunders who is Director of SHINE, a large voluntary agency aimed at improving services for families of people with mental health problems, and Dr Ian Daly from the Health Service Executive (statutory mental health service) on the development of family sensitive, evidence based mental health services with particular emphasis on integrating the principles of recovery and the implementation of family work in clinical practice.

The workshop addressed the different ways nurses can support families and carers; the evidence base for what is effective, the content of family work, recovery for family members and carers, and using carers and family members as consultants and experts.

The ONMSD continue to support the development of clinical skills based education programmes to support staff to develop the necessary skills to ensure families remain

at the heart of our mental health service delivery. As all applicants could not be facilitated on the day due to the degree of interest in the topic a DVD of the workshop was produced and will be circulated to all of the Regional Centres of Nurse Education to support learning and development.

**For further information, contact Ms Eithne Cusack  
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**Left to right:** Ms Allyson O' Brien (Carer), Mr John Saunders (Director, SHINE), Ms Rhona Jennings (Programme Manager, Mental Health Clinical Programme), Ms Sadie Tierney (Director of Nursing, CAMHS Dublin Mid-Leinster), Dr Gráinne Fadden (Director, Meriden Family Programme, UK), Ms Mary Wynne (Interim Area Director, ONMSD), Mr Pat Benson (Director of Nursing, Sligo Mental Health Service) and Ms Eithne Cusack (Director, Nursing Midwifery Planning & Development Unit and ONMSD Lead for Mental Health)



# Realizing a Canadian Dream

By Donna Methot, Family Member in Nova Scotia, Canada

*The Meriden Family Programme is bringing a 40+ year old dream for many to life. Like many families affected by mental illness the world over, the families and consumers of Nova Scotia, Canada have been struggling to be listened to, involved in the mental health care system, and given the education and support they need to promote the recovery of their loved ones and family members affected by mental illness.*

Many mental health systems are in need of development. Consumers, families and many health care providers have known this for a long time. The revolving door syndrome, needless suicides, no to low recovery expectations, consumers disengaged in treatment or untreated, families being left to cope as best they can, providers overworked

and stressed, a system underfunded and fraught with stigma. And of course, all this at great societal and economic cost. We knew what was wrong but no one knew how to fix the system as a whole, the attitudes, the culture, and address the many needs of the mental health community.

Meriden provided a blueprint to achieving our vision of what mental health care should be. They presented the evidence based research to support the benefits; and long term cost effectiveness of working collaboratively with consumers and families as valued partners in mental health care. After meeting with all stakeholders to assess our mental health system they made recommendations that were very clear, practical and achievable.

Meriden has demonstrated their expertise and experience in meeting the challenges of initiating a system-wide change. Their ability to assist in identifying potential barriers and providing solutions that have been proven to work in a step by step approach has enabled us to lay a strong foundation, from organizing the core committed leadership of all stakeholders, to get the support of management, and mental health providers. The Meriden group has provided guidance and training every step of the way,



Peter Woodhams being presented with a gift on behalf of the whole group

answering questions, offering insights, always supportive and available.

A core group of consumers, family members, providers and management have been trying to move the system forward for a long time. It wasn't until Dr Gráinne Fadden, Director of the Meriden Family Programme spoke at a Schizophrenia Society of Nova Scotia's Conference in Halifax in 2008 that the spark for change was ignited. Meriden was invited to return in 2010 to assess our mental health system and to make recommendations.

By June 2011, under very strong management leadership in our local service, we acted on five key recommendations. One was to address our greatest barrier to collaboration which was the systems over-zealous view of confidentiality. There were no guidelines so all information was private, even to the point that concerned parents of suicidal adult children would not be told if their child was in hospital. A working group of consumers, family members, providers and legal staff developed the Information Sharing Guidelines.

Meriden provided the training and guidebook to roll out the Information Sharing Guidelines to staff across our service. Interestingly, this roll-out implemented by a team of three representing the collaborative group, provided an opportunity for providers at large to be introduced to the collaborative approach and its benefits.

Simultaneously, a second collaborative working group was asked to provide the Mental Health Program with recommendations to identify the gaps in the system and the educational and support needs of consumers, family members and providers. This was accomplished by meeting with stakeholder focus groups and producing a report of 107 recommendations in June of 2011.



Paula Conneely being presented with a gift on behalf of the whole group



The Meriden facilitators on the Caring for Carers course held in Nova Scotia, Canada 2012. Left to right: Paula Conneely, Peter Woodhams and Julia Danks

The third and fourth initiatives were to include two consumers and two family members on all the Mental Health Program Quality Teams. This was well underway by September 2011. Feedback and experience evaluation forms for families and consumers were developed and completed in June 2012.

The fifth initiative, the Family Work Training Program offered in June and September 2012 by skilled trainers was, as one of the 50 participants reported, 'phenomenal'. Training sessions modeled the program. Each concept was modeled and practiced. Participants came away with a user friendly, step by step, comprehensive guide. The same is true of the Family Education and Support Program offered in September 2012 to 18 providers and 9 family members (carers). The trainers were 'brilliant', fun, engaging and very supportive. It was a truly exceptional experience.

The population of Nova Scotia is 922,000 with 350,000 being in the Halifax region where the Meriden Programme model has been initiated. We will be extending the program throughout the province of Nova Scotia beginning in June 2013. There has already been a province-wide three day introduction and training event in October 2012 with representatives from all districts.

We are very fortunate to have a number of committed and enthusiastic individuals. It is a very exciting time. Our numbers may be small but our drive and energy is powerful. We have come a very long way in a very short time under the guidance of the Meriden Programme.

We still have a long way to go and there are still many challenges to overcome but we are confident that our dream of being truly valued partners in mental health care will be realized in the not too distant future.

Thank you Meriden, for showing us the way.

# Taking Family Work to Japan

By Peter Woodhams  
Carer Consultant  
Meriden Family Programme

*The Meriden Family Programme welcomed a group of visitors from Japan for a week-long visit in March. A delegation of six was led by Professor Atsushi Sato, a Social Worker Researcher at Kyoto Notre Dame University.*

Their visit was primarily to learn about Meriden's family work training programmes and to discover how family work and carer education is embedded into our work in Birmingham, with a view to promoting a similar model in Japan.

Professor Sato was joined by representatives from Minna-Net, the largest network of family carers and patients with mental health disorders in Japan. The delegation included Vice Presidents Yoshiharu Kimata and Yoshikaxun Honjyo, and Administrator Yoshinoro Suzuki. Chihoro Ito, a Research Social Worker from Shukutoku University and Dr Mirai So, a London-based Psychiatrist – and the group's translator – also joined the group. Minna-Net is a not for profit organisation, run by family carers, which campaigns for better mental health services across Japan. It also provides training for carers to help empower them to advocate for better services.

Training mental health professionals and social workers in family work is seen as key to their campaign to promote the importance of involving and supporting families within the community. This is why the organisation is talking with Meriden about planning a consultation and



The delegation meeting Peter Woodhams and Gráinne Fadden on the first day of their visit

training programme and this is now scheduled to start in March 2014 when 3 Meriden staff will be visiting Japan to introduce family work to several large audiences of family members and professionals.

Dr Gráinne Fadden, Director of the Meriden Family Programme, met the delegates to outline Meriden's cascade approach to training and implementation before introducing them to the team of family therapists.



The delegation with staff from Solihull Carers Centre

The visitors' programme also included a trip to Lyndon Clinic in Solihull to see how family work is built into our service, where they also met families who have benefitted from family intervention and carer education programmes. The visitors were impressed that staff were very committed to involving families and providing general information to families at an early stage. They also commented later that the concept of the triangle of care really 'struck a chord strongly' in that it encouraged service users, professionals and family members to co-operate together.

Time was also spent at the Zinnia Centre in Sparkhill (one of Birmingham & Solihull Mental Health Trusts in-patient units), Solihull Carers Centre and BITA Pathways

workshop in Digbeth where the visitors were able to see some of the services available in helping adults to explore pathways towards employment, training, education and community services. The visitors also enjoyed some of Birmingham's cultural attractions, including a concert at King Edward's School, Edgbaston and the art gallery at the Barber Institute at Birmingham University.

Professor Sato said: "Services for families are highly developed in England, compared to Japan, and we are keen to use the Meriden model." He added that "people in Birmingham are very friendly – just like Japanese people."

At the end of a busy but rewarding week, Dr Fadden said: "It was both humbling and inspiring to see the commitment and aspiration of Minna-Net, a voluntary family movement funded solely by individual subscription, to developing improved services for families."



The delegation with staff from BITA Pathways and members of the Meriden team

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# Social Values Which Present a Care Burden for Japanese Families

By Mari Higuchi

Ph.D. Student, Graduate School of Human Sciences, Osaka University, Japan

*“Because it is us, the parents, who give my son ‘home nursing service’ every day, we don’t need the Assertive Care Treatment service for the moment.”*

It was at the First European Conference of Social Psychiatry in Geneva in July 2012 where I met Mr. Chris Mansell (Deputy Director, Meriden) and it was my unexpected good fortune that I came to know the Meriden Family Programme and was given an opportunity to write this newsletter article.

First of all, I would like to introduce myself; after I obtained a license to practice as public health nurse and psychiatric social worker in Japan, I went to the Graduate School of Human Sciences at Osaka University to learn sociology in medicine, particularly both quantitative and qualitative social research methods. There I have been working on investigating societal factors which adversely affect the quality of life of people with schizophrenia and their families in Japan.

In this article, I would like to present some of my research, which investigates how Japanese social values affect interactions among three groups – medical professionals, mental health service users and their families – by focusing

on the families' understanding of inherited predispositions to develop schizophrenia and the stress-vulnerability model.

## **The difficulty of sharing ‘Taboo Information’ between professionals, service users and their families**

Knowledge about the genetic component of schizophrenia is considered to have an influence on social values which relate to social acceptance of people with mental illness and their families. Recent research has revealed that biogenetic causal attributions do not contribute to reducing social rejection of people with schizophrenia (Angermeyer et al., 2011).

Some families of people with schizophrenia have a tendency to have genetic testing carried out (DeLisi & Bertisch, 2006) although they have worries about “being unable to cope with knowledge of their genetic fate.”(Lawrence et al., 2011:315).

Concerning the situation in Japan, there are few social science studies on the attitudes of families towards biogenetic explanations of the illness, though attitudes are related to the family's understanding. Most of the families have difficulties in reconciling their ordinary life tasks and their role as a 24 hour caregiver as is obvious from the earlier quotation given by the father of a service user. In spite of the difficulties, they tend to think that taking care of a family member is a family's 'natural' duty. In these families' situations, talking about the genetic component of schizophrenia has been seen as a taboo among medical professionals, service users and their families.

Most psychiatrists tend to avoid referring to the information on hereditary predisposition which relates to illness in clinical fields. The families and the service users don't tend to ask psychiatrists, even though they want to get further information.

But why do these groups feel awkward with this information? How does the biogenetic explanation of schizophrenia affect family members' prospect of marriage? Is there any relationship between having a biogenetic perspective on the illness and families undertaking intensive care for the person with a long term mental illness?

To investigate these questions, I conducted semi-structured intensive interviews from July to August 2012 in urban areas in Japan with 13 family members of people with schizophrenia. There were 2 fathers, 7 mothers, 1 set of both parents and 1 sister. I adopted the 'Grounded Theory Approach' (Glaser & Strauss, 1967) as a methodology for the qualitative data analysis.

### **Biogenetical explanations of illness: Influence on caregiving behaviour of Japanese families, and on their social lives**

In Japan, psychiatrists do not encourage families to discuss their concerns about the genetic component of the illness, as in this society there is a lot of social blame on families for genetic factors as the cause of the illness. Psychiatrists worry that the families, especially parents, would blame themselves if they knew about the genetic component, so they try to console the parents by emphasizing that schizophrenia is not unusual but a common illness. However, families are aware of the genetic effects as a possible contributory factor because they perceive similarities between their own and their child's personality. Families also found that they have relatives with psychiatric problems in either the maternal or paternal family. The interaction between the psychiatrist and family members is explained by the following comment of two mothers in their seventies:

*“The doctor denied the relationship between heredity and the nature of my son's illness. But I know that he would just try to console me because I have a similar personality to him, and this relates to the illness.”*

*“The doctor had never mentioned that...about the hereditary predisposition of my son's illness. But I know it because I have noticed it by looking around my husband's family line. My husband's brother also has schizophrenia.”*

On the other hand, we observe the families' sense of valuing the positive aspects of blood relationships from a father's comment:

*“The blood relationship has a special value and it is not a substitute for any other human relationships. ...I think that it is a fundamental role of families that they take care of their blood relatives. Other people may help the families only when they cannot absolutely continue to care themselves.”*

This family's sense of values leads them to think that taking care of blood relatives is the most natural type of care for the person with schizophrenia. In addition, awareness of the hereditary predisposition of family members and the importance placed on blood relationships by the family contribute to the family feeling responsible for their child's illness. In families, this sense of responsibility and the family's ideal image of 'care' result in the family undertaking most of the care of the person with the illness.

Concerning social blame of the families for genetic effects, we can consider that the families, as well as the psychiatrists, perceive discrimination towards schizophrenia on genetic grounds. Two mothers explain their experiences by the following comments:

*“There still exists the social prejudice that mental illness appears only in certain families.”*

*“When my daughter married, we tried to hide the fact that her brother has a mental illness from her spouse's family because we thought it would be an obstacle for her marriage.”*

This social discrimination seems to be related to Japanese society's sense of values which attaches special importance to blood relationships. This social blame of families leads family members to link up with other persons in similar situations. This pattern was especially observed in relation to marriage, for example, the siblings of someone with schizophrenia tend to marry a person who also has a relative with mental health problems. Both the parents and siblings often get together with other family members and sometimes they reveal their worry about their children's marriage which they cannot share with other people. It can be said that families getting together in this way helps them to avoid being accused by society for the genetic component as one of the causes of mental illness. At the same time, this cohesion can increase the family's burden of care.

*“My husband also has problems with his two sisters. They seem to have a mental difficulty, too.”*

*“My daughter had a boyfriend and he visited us twice from Tokyo. He told us that his mother had suffered with depression. My daughter then thought that he would accept her brother (who has the illness.)”*

### **Families’ ambivalent awareness about evolution of biogenetic technology and families’ needs**

Because of the excessive care burden of the families and of the parents’ sense of responsibility for the genetic component of their child’s illness, as the following case show, most of the family members strongly hope the development of technology will result in better treatments or prevention. They also express their wish that the new technology will clarify the nature of the illness and thereby modify the social image of this illness:

*“Genetic discrimination has certainly existed...it has convinced people that the nature of the illness is related to hereditary factors. So I hope this knowledge will help treatments to be developed.”*

On the other hand, families perceive social genetic discrimination toward the illness, so that at the same time, they fear the risk that the development of genetic technology will lessen the social acceptance of the persons with the illness and of their families. To solve this ambivalent awareness, the families think that not only researchers, psychiatrists and other concerned parties but also the public should discuss the direction of the research and of genetic information.

### **Conclusions**

These data suggest several important observations concerning the relationship between families’ burden of care and social values for family blood relations in Japan. First, family members assume that a genetic component which relates to the stress-vulnerability model definitely influences the cause of schizophrenia. As family members avoid facing discrimination because of the illness by spouses and spouse’s relatives, this awareness about genetic effects on schizophrenia increases the number that marry and associate with persons in similar situations. Second, because family members, especially parents, feel responsible for the genetic component, they also tend to be the main people taking care of the person with the illness. It seems that these tendencies are greatly influenced by Japanese society’s sense of values, which acknowledge the importance of blood relationships. Third, the care burden of persons with schizophrenia and sense of responsibility of parents for the genetic component cause most families to approve of the advances in genetic research, hoping for new and better treatment and prevention. However they also have fears that the research might make discrimination on genetic grounds stronger. To solve the conflict between hope and fear, some of them think that public discussion about the direction of research is necessary.

### **Future Directions**

The present study was intended to be exploratory with a limited sample of Japanese family members. Most of the interviewees in my sample are parents who are over sixty and their children with the illness are more than thirty-five years old. Thus these hypotheses about the link between families’ behaviour on undertaking care, and the social values of blood relationship in the family should be examined and elaborated more comprehensively. For example, the families’ negative attitudes toward the information about genetic influences on the nature of the illness have to be tested to see whether this is a characteristic of Japanese families or if this tendency exists in other societies. In addition, it will be necessary to inquire how younger generations of families view their role in caring for the person with the illness.

In order to contribute to the development of effective care for families, we need to understand also the social values by which the service users, their families and the professionals are influenced consciously and unconsciously. For further studies, I am conducting fieldwork research in France. I hope that sociological research and the practice of medical professionals can corroborate much more frequently to promote improved quality of life for the person and their family.

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# Behavioural Family Therapy and Family Work in Masaka, Uganda

**By Thomas Walunguba  
Senior Psychiatric Clinical Officer**

*Following a successful Commonwealth Professional Fellowship award undertaken at the Meriden Family Programme and funded by the Commonwealth Professional Scholarship Scheme from February to March 2012, I am delighted to report on the progress of family work in Masaka, Uganda.*

A training course for six mental health workers – five from our mental health department and one from Kalungu district was organized. The training took place in August 2012 at Masaka Regional Referral Hospital.

The purpose of the course was to enable participants to develop awareness of the need to deliver family work to families and to build on existing skills to be able to deliver evidence based family work to those families requiring it.

We were able to have a Carer who gave a moving speech about her experience with mental illness. She noted that carers need to be educated, they need support from mental health workers, and they need to be welcomed and involved in the treatment plans for their relatives who are mentally ill.

Participants were very happy and promised to put what they had learnt into practice. The participants suggested that:

- Clinicians should refer families to family workers.
- Start with those who are from nearby.
- Have monthly individual supervision.
- After 3 months we all come together and share ideas.
- Start with inpatients.

One participant commented that *“the topics were very good and I am sure they will be very helpful to me in my day to day life and activities”*.

The Principal Hospital Administrator who was the chief guest at the closure gave his remarks in which he expressed happiness with the initiatives the mental health department had come up with. He emphasized that the roles of families cannot be down played, therefore the hospital was willing to work with the mental health department to see that this important initiative develops and progresses.

## Caring for Carers Better programme

A Carers' Education and Support training course was organized. The training took place in September 2012 at Masaka Regional Referral Hospital lecture room. One of the major purposes of the training was to develop a knowledge base for sharing information with carers and help them to develop a range of coping strategies, develop an overview of the programme to be delivered to carers and consider how the programme may need to be adapted to meet the needs of specific carers and communities.

15 carers participated in the training. The majority were caring for relatives with severe mental illness and some were working with Masaka Hospital. Some were health workers outside Masaka Hospital; we had one religious leader and a recovered patient who was at the same time a carer. During the sharing of information, some participants could not hold back their tears initially. However at the end they became more empowered.

The training encouraged teamwork and openness. One participant on behalf of all the participants remarked that he was very happy about the workshop which was the



Thomas Walunguba (far left) and Robert Tigawalana (far right) with participants of the Caring for Carers Better course held in September 2012, Uganda

first of its kind in Masaka and that there had been no involvement with carers whatsoever until then. They have been empowered to take responsibility for caring in the best way and would be able to empower others.

#### Participants resolved to:

- Encourage family meetings.
- Train other family members.
- Encourage community members to give support to people affected by mental health problems.

I am so grateful for the support from Peter Woodhams, Carer Consultant with the Meriden Family Programme and Masaka Regional Referral Hospital for making this initiative possible.

#### Caring for Carers Better for inpatients

In an effort to reach a large number of families, we have introduced a Carers' Education and Support initiative to train carers and inpatients in relapse prevention and crisis management, problem solving, communication skills and information sharing.

In January 2013, we were able to train 17 participants of whom 10 were carers and 7 were patients. The training was about relapse prevention and crisis management and was organized by Nakiseka Hasifa, Tigawalana Robert and Walunguba Thomas.

#### Lessons learnt

- We noticed that carers and patients were very willing to learn about mental health issues and develop skills in caring.
- It improved the relationship between mental health workers and patients and carers.
- We were also able to become aware of things which were not going well for the carers and patients on the ward.
- We need to get patients who are about to be discharged for trial leave to participate in the sessions.

#### Comments from Participants

One member commented *"I am very happy I have learnt a lot I did not know about what early warning signs and symptoms are"*

Another one commented that *"Everything was so relevant, it was as if it was relating to my relative. I have learnt that as a family we can sit down together and discuss things."*

We continued with the next topic which was problem solving. This time it was Hasifa who introduced the topic to the participants. Afterwards participants went into groups and did an exercise to practice the skill.

All said *"It is a good method, because family members work together in solving problems."*

#### Behavioural Family Therapy (BFT)

I have been able to visit four families and introduce BFT to them, but it has been difficult to have all the family members present at a session. I have also done telephone supervision twice.

#### General challenges

##### We lack funds:

- To buy writing materials, pens, books, refreshments for the inpatient sessions.
- To reimburse travel expenses for participants, writing materials, pens, books, meals and refreshments for outpatient programme.
- Transport for health workers to communities to do family work.

#### What we intend to do in the next 12 months

1. To offer family work to 3 families each month.
2. To offer Carers' Education and Support training to 15 carers of outpatients for 3 days.
3. To intensify the Carers Education and Support Programme to carers of inpatients at least 2 sessions per week for 2 hours per session and we shall make sure that a patient has a carer before discharge. The carer must have undergone the Carers' Education and Support sessions.
4. Train another 6 staff in the mental health department in family work.

#### The long term goals are:

- To train all mental health workers in the Masaka Region
- To train psychiatric clinical officers at Fellowship level from other districts
- To follow up trained families and health workers.

We are appealing to any organization to support this noble programme so that our patients and carers get the best service. I thank very much Martin Atchison from the Meriden Family Programme for the monthly supervision which has kept me energized to be able to produce this amount of work. I am excited in that my two colleagues will soon be leaving for Birmingham to undertake similar training.

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*National Chairman, Uganda Schizophrenia Fellowship  
General Secretary, Uganda National Association of  
Psychiatric Clinical officers*

## Commonwealth Professional Scholarship Scheme 2013

### **Introducing Robert Tigawalana and Hasifa Nakisekka Masaka Regional Referral Hospital, Uganda**

*Robert and Hasifa wrote about their hopes and expectations prior to coming on a Commonwealth sponsored placement with the Meriden Family Programme in February/March 2013.*

We are Robert Tigawalana and Hasifa Nakisekka, a Psychiatric Clinical Officer and a Registered Psychiatric Nurse respectively. We have worked at Masaka Regional Referral Hospital since 2007. During our time of service, we have seen changes taking place in the mental health department. First as a small unit with two rooms and now a big department with both male and female wards and housing different offices for the different types of staff working in the department. During this period, we have interacted with patients, carers, fellow workers and other people from the community.

We have also worked with organizations such as the Uganda Schizophrenia Fellowship (USF), Epilepsy Support Association of Uganda (ESAU), and the Uganda Society for Disabled Children (USDC). All these organizations are geared towards helping people with mental health problems where there is some impact on those who provide care to them. However despite these interactions, we felt we lacked knowledge and skills in family work.

We appreciated Thomas Walunguba's contribution when he came back from the UK and introduced knowledge to our departmental staff about family work/Behavioural Family Therapy (BFT) which he had acquired from the Meriden Family Programme early in 2012. We are very delighted to have this opportunity to be sponsored by the Commonwealth Commission to enable us to undergo the same set of training.

During our time in the United Kingdom, we expect to gain the following:

- Gain more knowledge and skills about family work, and on Carers Education Programmes from a renowned international organization that has trained many others i.e. the Meriden Family Programme.
- It is our hope that during the training, we shall acquire facilitation skills that will help us to carry out the role

of co-facilitators with our fellow colleagues and health workers, and when we are offering Carers' Education and Support Programmes to carers.

- We expect to share experiences of how mental health services are provided by our colleagues in the United Kingdom (UK) and other areas of the world.
- Interact with other people from other parts of the world and meet new friends.
- Learn more strategies on how to work with people affected with mental health problems and their families.

We also hope that after this training, it will boost the training potential of our organization as myself and Hasifa will be able to work alongside Thomas as trainers.

We also hope that it will impact much onto the carers of those who are mentally unwell and also help in supporting carers as they play a big role in the recovery of patients i.e. to prevent relapse and stigma among the families where one person has a mental health problem. This will help in the reduction of hospital expenditure as there will be reduced re-admissions of patients.

We also hope to:

- Participate in the identification of health workers/carers for training in family work.
- Follow-up the trained health workers/carers in family work.
- Work hand in hand with Thomas and be guided by the Meriden Family Programme in terms of training and evaluation of family work.

#### **Robert and Hasifa can be reached by writing to:**

Masaka Regional Referral Hospital, PO Box 18, Masaka, Uganda, East Africa.

**Email:** Robert: [tigawalanarobert@gmail.com](mailto:tigawalanarobert@gmail.com)  
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# Update

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



Robert Tigawalana and Hasifa Nakisekka visiting Stratford upon Avon whilst in the UK

*Since writing this article, Robert Tigawalana and Hasifa Nakisekka have now completed the Commonwealth Professional Fellowship with the Meriden Programme in the UK. Robert, who is a Psychiatric Clinical Officer, and Hasifa, a Registered Psychiatric Nurse, have undertaken the three key Meriden courses (Behavioural Family Therapy, Caring for Carers and Training Trainers) and are now able to work fully with Thomas in implementing Family Work and Carer Support in Masaka, Uganda which is a great step forward for families and service users there.*

*Since completing this training, Robert and Hasifa are now able to work as co-facilitators, to identify and engage with families for whom BFT might be helpful and deliver an education and support programme to caregivers. In the longer term they plan to identify and train professional colleagues in BFT and to provide supervision to family workers who are delivering BFT to families.*

*In addition they are keen to promote BFT and Caring for Carers at seminars, meetings and workshops across the region particularly as the initiative is supported by the Principal Medical Officer for Mental Health in the Ugandan Ministry of Health.*

*Recently they have been able to work with Thomas in conducting three further courses for caregivers in inpatient unit and there are plans to run a similar course for those in an outpatient setting. Thomas also tells us that the Assertive Community Treatment (ACT) Project is shortly to begin which will be a very big boost in implementing BFT in Masaka.*

## Masaka Referral Hospital

Adapting the Meriden Caring for Carers Programme for carers in Uganda



Doctors instructing caregivers

Masaka Referral Hospital is working hard in caring for people with mental problems though some clients don't recognise that they have a mental illness.

Recently Dr. Thomas Walunguba and Dr. Robert Tigawalana held a seminar of three days to provide support to those who take care of people with mental illness. These two doctors answered a number of questions from the participants. Common questions included:

**Q: What could be the cause of these mental illnesses?**

**A:** There are a number of causes for mental illnesses among them are the following: severe malaria, AIDS, serious disappointments in relationships and people not realizing their expectations.

**Q: Is there a specific time that mental illnesses occur?**

**A:** There is no specific time. Some become mentally unwell in childhood due to severe malaria and other factors while other people become mentally ill in old age.

**Q: How can one care for people with mental illnesses, especially those who are violent?**

**A:** The first thing to note is that a carer has to understand the person who is ill, and then be patient with him or her.

A carer has to show love to the person with mental illness. Someone who is ill in this way knows when a person loves them and also recognises those who don't.

A carer has to listen and not just instruct the person. These

mentally ill people want to feel that they are valued and respected but not undermined. It is also important that doctors advise those caring for people with mental illnesses to ensure that they approach hospitals for medicine and treatment that is available to them, as sometimes carers are reluctant to do this.

Finally, in a recent development, Dr Walunguba Thomas, a consultant on mental health issues at Masaka Referral Hospital, has started a rehabilitation centre at Kijjabwemi where those who are recovering from mental illnesses and those who have recovered learn how they can be self-reliant. He is encouraging others to join him in this venture so that the centre continues to develop.

## YoungSibs – Exciting New Online Service for Siblings

# Sibs

**By Rubina Jhadray**  
**Psychology Research Assistant, Meriden Family Programme**

**Sibs, a UK charity for brothers and sisters of disabled people has launched an innovative service for siblings who live in the UK and who are under 18. The new service YoungSibs aims to provide online support for siblings who have a brother or sister who is disabled or has a serious or life limiting illness. For some time, siblings, parents and professionals have been asking Sibs to provide this service and they are now very pleased to be able to offer it. YoungSibs is supported by the True Colours Trust, Esmée Fairbairn Foundation and The Rank Foundation.**

YoungSibs aims to support siblings in a number of ways:

**Providing Information:** The website has information about dealing with feelings; dealing with guilt, anger, happiness and further provides tips for coping with difficult situations. Information on dealing with different aspects of family life, such as communicating, helping your sibling behave well and attention from parents is also available.

**Get Help:** Siblings can write letters to YoungSibs with problems that they want help with. They will receive a personalised response from an experienced member of the Sibs' team. They can also choose to have the responses to their letters published in the YoungSibs letters page for others to see.

**YoungSibs Chat:** This is a forum that allows siblings across the UK to talk to each other. It is moderated by Sibs' staff to ensure that it is used safely and appropriately.

**Sibling Group Chat:** This allows for local sibling groups to keep in touch.

**Sibs are keen to publicise and promote this new service to families. A flyer for YoungSibs is available to download and forward to families from the charity's website. Postcards about YoungSibs are also available on request from Sibs to pass onto siblings you may know and that may benefit from this valuable service. Sibs need your help to let young brothers and sisters know about it.**

**Further information can be obtained by visiting [www.sibs.org.uk](http://www.sibs.org.uk) or calling 01535 645453.**

# Launch of the new “Competence framework for psychological interventions for people with psychosis and bipolar disorder”

by Paula Conneely  
Clinical Specialist, Meriden Family Programme

*The competences described in this article are designed to be accessed online and can be downloaded via the CORE website. CORE is the British Psychological Society’s Centre for Outcomes Research and Effectiveness. [www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/). They were prepared by Dr Anthony D. Roth and Dr Stephen Pilling, Research Department of Clinical, Educational and Health Psychology, UCL*

## Background

May 2013 saw the launch of a new competency framework for those working with individuals with bipolar disorder and psychosis. Developed as part of the Severe Mental Illness (SMI) initiative of the Improving Access to Psychological Therapies programme (IAPT), the descriptive report and e-framework are designed to guide the user through the clinical competences linked with best practice in the field. The framework describes the various activities which need to be brought together in order to carry out effective clinical work with service users experiencing more severe or enduring mental health issues and builds on some of the work undertaken as part of the earlier IAPT frameworks (for the delivery and supervision of Psychological Therapies). It is an extensive framework, but is not intended to prescribe every aspect of what a clinician should do; it makes suggestions about best practice in the light of current knowledge of the effectiveness of approaches and interventions.

The framework uses 5 “domains”, each of which represents a broad area of practice. This helps those using the tool to see how the various activities associated with work in this area fit together. The domains are:

- Core underpinning competences for work with people with psychosis and bipolar disorder
- Generic therapeutic competences required for managing clinical sessions and any form of psychological intervention
- Assessment and formulation competences
- Specific interventions (including evidence based family interventions)
- Meta-competences – over-arching, higher-order competences which practitioners need to use to guide the implementation of any assessment or intervention.

The competence framework is designed to be relevant to staff across all clinical settings and defines a range of core clinical

skills and knowledge relevant to a wide range of professions (including psychologists, psychiatrists, psychotherapists, nurses, occupational therapists and social workers).

In terms of accessing the material, the CORE website hosts a hyperlinked “Map of competences”. By downloading the map, the user is able to click on each of the domains to reveal a more detailed breakdown of the competences involved. For example, by clicking on Family Interventions in the “Specific Interventions” domain, the user is directed to a detailed section covering competences and best practice in relation to family work.

## Family Interventions

The section relating to family intervention is an 18 page document which references and relates to those evidence-based interventions cited within current NICE guidelines. The Expert Reference Group (ERG) overseeing the work included such names as Christine Barrowclough, Frank Burbach, Gráinne Fadden, Elizabeth Kuipers and Fiona Lobban. Five of the major texts were reviewed (see References) and core competences extracted. As such, they do not refer to one specific model of family intervention but span all of the evidence-based psycho-educational models. As experts in the field, The Meriden Family Programme were tasked with pulling together the document which was then edited and refined by members of the ERG and peer reviewed, among others, by our Carer Consultant, Peter Woodhams and by professionals such Professor Jo Smith.

### The document itself is divided into 3 main sections:

- Knowledge of the rationale for family intervention
- Engagement and Assessment
- Specific components of family interventions.

Each section is then divided into several themed areas, with these broken down further to describe the specific competences required in each. This follows through from engagement to disengagement, referring to the clinical

skills and knowledge required at each stage. Further reference is also made to aspects such as supervision and audit/outcome measurement.

## Summary

This is a comprehensive and well-structured tool which describes a method for identifying competences for staff working with people with psychosis and bipolar disorder. It organises the competences into five domains, with an over-arching domain which identifies the 'therapeutic stance, values and assumptions' for work in this area. This framework will provide a resource for both clinicians, supervisors, managers and commissioners by setting out competences in a way which clarifies the activities associated with skilled and effective practice in the psychological treatment of psychosis or bipolar disorder. The hope is that this will, in turn, promote better outcomes for both service users with bipolar disorder or psychosis and the families and friends that support them. The competency map can be found at [www.ucl.ac.uk/clinical-psychology/CORE/competence\\_mentalillness\\_psychosisandbipolar.html](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_mentalillness_psychosisandbipolar.html)

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## Staff Changes

***Some of you will have had the pleasure of speaking with Kuljit Heer who was our Psychology Research Assistant until last year. We were very sorry to say goodbye to Kuljit who left us in August to move to London and is continuing her career at Kings College London. She was a valuable member of our team and is a much missed friend and colleague. We wish Kuljit all the very best in this new phase of her life.***

***Since then, we have successfully recruited to the Psychology Research Assistant post and are delighted to welcome Rubina Jhadray as our newest team member....***



Rubina Jhadray

I studied BSc Psychology at the University of Leicester. I thoroughly enjoyed my undergraduate study and developed a keen interest in Clinical Psychology and the development and implementation of psychological interventions. After obtaining my degree, I started an internship as a Research Assistant for the

University of Leicester Counselling and Psychotherapy Research Clinic. My duties as Research Assistant included managing and analysing data, conducting client interviews, administration tasks and supporting therapists and academic staff. I was also involved in

completing a research project for the BACP looking at the evaluation of supervision competences, and also assisted on a project for Birmingham City Council looking at providing supervision to social workers. I enjoyed the post as it allowed me to participate in clinical work alongside various research responsibilities.

I then went on to work as an Activity Co-ordinator for South Staffordshire and Shropshire NHS Foundation Trust. I worked across two older adult inpatient wards, with service users suffering from organic and functional disorders. My role was to promote activity on the wards; to develop an activity timetable to engage service users and make their stay on the wards more stimulating.

Alongside other staff I started a number of different groups including music, arts and crafts and gardening. I aimed to provide a sense of enjoyment through celebrating cultural events, such as the Queen's Jubilee, and working with organisations such as Arts for Health, to develop activities and projects across the two wards. I enjoyed working as part of a multi-disciplinary team and working with service users in an inpatient setting.

Having obtained the post of Psychology Research Assistant with the Meriden Family Programme, I am happy to be a part of the team as I am very interested in the process and implementation of family work. I look forward to furthering my knowledge in Behavioural Family Therapy and to my time here.

# Behavioural Family Therapy (BFT) Across Scotland

## Stirling National Day

**By Margaret Tulloch, Senior Psychological Therapist, Coatbridge Psychological Therapies Team and Gail McKillop, Senior Psychological Therapist, East Kilbride Psychological Therapies Team**

In February last year, the BFT trainers from Lanarkshire, alongside NES (NHS Education for Scotland which is responsible for supporting NHS services in Scotland by developing and delivering education and training for those who work in the NHS) held a national event for those interested in the implementation of psychological therapies and BFT was used as an example. It was felt it would be a good idea to bring together people across Scotland to discuss progress and share common implementation issues and solutions. Gail McKillop and Margaret Tulloch, both BFT trainers within NHS Lanarkshire, describe the events of the day and how this has been productive in approaching the longstanding issue related to the implementation of psychological therapies.

BFT was first introduced to Scotland in 2001 when 10 clinicians from NHS Lanarkshire were trained, locally, by Meriden. In October of that year, 3 clinicians from the original 10 then attended the Meriden Training Trainers course in Birmingham. Due to the enthusiasm and commitment of the new trainers, BFT quickly grew throughout Lanarkshire, supervision was up and running and the process of engaging families began. Feedback was very positive from both therapists delivering BFT as well as the families who were receiving it. It became clear that the implementation of family work was crucial.

This was confirmed by, three evaluations of BFT within Lanarkshire, with implementation being a focal point. The recommendations from each of these evaluations have been consistent and suggest that in order for family work to be implemented, support for training needs to be endorsed and encouraged at management level. As well as training being supported, staff attendance at supervision sessions also needs to be agreed with management.

Since 2002, there have been 16 cascades of BFT training in Lanarkshire with 145 therapists trained. Over the years, using the cascade model, the Lanarkshire trainers have assisted Meriden and training has been provided across Scotland funded by Health Boards and more recently by NES. By February 2012, the number of BFT therapists and trained trainers had increased significantly across Scotland and stood at 518 therapists and 35 trainers and supervisors.

The lead up to the national day in February began in the autumn of 2011, when Padhraic Dolan, one of the first cohort to be trained, was approached by NES to arrange a national day on Behavioural Family Therapy (BFT).

The possibility of holding a national day on BFT was met with enthusiasm by the other Lanarkshire trainers and arrangements and preparation for the day began.

The BFT national day was held in Stirling Management Centre and was attended by 40 people from the various Health Boards across Scotland. There was a selection of presentations throughout the morning from a variety of people. Emily McIntosh, another BFT trainer within Lanarkshire, introduced the background to BFT and a summary of the evidence base to date. This was followed by an explanation of the evolution of BFT in Lanarkshire and how this was cultivated across Scotland. Geraldine Bienkowski, from NES set the context of the day by describing increasing access to psychological therapies (IAPT). Geraldine is a Clinical Psychologist and Associate Director of NES. We were also delighted to be joined by Steph Allan who gave her unique insight into her positive experience of family work. Dr Gráinne Fadden, Director of the Meriden Family Programme ended the morning session with a very helpful perspective on the Implementation of Psychological Therapies, using BFT as an example. This very nicely set the context for the afternoon session around planning the next steps in relation to issues around implementation.

The afternoon session provided us all with the first chance to sit together as BFT Therapists and share our common experiences of working with families, and implementing BFT in our own areas. This was an excellent opportunity to hear about the issues across Scotland, and there was acknowledgement that many of us were experiencing similar difficulties with implementation. It was, however, very evident that there was great commitment and ongoing enthusiasm to consider together what needs to be done in specific Health Boards to improve implementation in BFT, particularly in the challenging current climate. The focus of the group work was to draw on the experience of others and generate ideas which could move us closer to finding solutions to ongoing difficulties with the aim of improving implementation throughout Scotland.

Following this national day, a report has since been compiled and recommendations have now been made. The recommendations cover topics such as training, clinical governance, supervision, efficiency of cascades of training amongst other issues. These recommendations are being considered by NES. For full information on this document and how to access this please contact Padhraic Dolan, by emailing: [padhraic.dolan@lanarkshire.scot.nhs.uk](mailto:padhraic.dolan@lanarkshire.scot.nhs.uk)

# Training Trainers Course 2013

**By Martin Atchison  
Deputy Director, Meriden Family Programme**



Participants and facilitators on the 2013 BFT Training Trainers course

The annual Training Trainers course is one of the most important training courses that the Meriden Programme deliver in that people attending this course go back to their own organisations and start to train and supervise their colleagues in family work. The cascading of training that is carried out by people attending this course has led to the high number of people trained in family work across the world, and it is essential that people completing the trainers course feel equipped to take on the challenging role of being a trainer and supervisor in family work.

The course in 2013 took place from the 4–8 March and was attended by 31 people, the highest number of people that has attended the trainers course in several years. As always, the evaluation of the course by attendees was very positive, with numerous comments about how much people had learned and developed during the week.

## Comments from participants

*‘A week FULL of content that was skilfully organised to maintain attention and promote learning. All content backed up with written material to allow for post-course consolidation.’*

*‘Very relevant, practical and immediately useful.’*

*‘I love the way the training models the way the work is organised in families.’*

*‘The course is well structured and strikes just the right balance in allowing us to practice enough to gain confidence and not so much that it is death by role-play!’*

*‘The course was extremely well-facilitated with all presenters offering a high standard of professional, informative presentations’.*

*‘Meriden training continues to be the best training I have ever been on.’*

The range of organisations represented at the course was varied, and the circumstances in which people would be starting their role as a family work trainer were very diverse also. This helped to add an additional element to the learning that took place during the week, with people from different organisations, which were at different stages of implementing family work, being able to share experiences and learn from each other.

The first family work trainers from the American continent were present, with 5 people from Nova Scotia adding

a Canadian flavour to the week. The Meriden Family Programme has been out to Canada several times to consult with Capital District Health Authority in Halifax on how to progress services for families within their organisation, and two family work courses and a Caring for Carers course were delivered in 2012. The Meriden Family Programme will continue to further relationships with other organisations in Nova Scotia, with the programme beginning to be rolled out across the Province in 2013, and more people attending the trainers’ course in 2014. Endorsement of the Meriden model appears in the first Nova Scotia Mental Health plan that was developed in 2012.

The second and third trainers from the continent of Africa were also present, with 2 people from the Masaka region of Uganda on the course, who had spent 7 weeks with the Meriden Family Programme on a Commonwealth Fellowship Scheme. Their colleague had done a similar placement in 2012, and work was already being undertaken to develop services for families in Masaka (see article in current newsletter). Now, with 3 people who have done the trainers course, and with some innovative work already taking place in the Masaka Regional Referral Hospital, it will be interesting to see how families from that area will be supported in the future. The Meriden Family Programme continues to provide support and supervision to the trainers in Uganda, and there will continue to be articles in the newsletter in the future about how they will be taking this work forward. There were others on the course who were from organisations that already have trainers in place who have been delivering training. It is pleasing that family work continues to be supported strongly and developed by numerous trusts across England and Scotland.

There were also others on the course who were the first people from their UK organisation to become trainers; these include West London Mental Health NHS Trust, Fife NHS Trust and Derbyshire Healthcare NHS Trust. With the addition of trainers in Fife NHS Trust, this means that there are family work trainers in place in the vast majority of all NHS trusts in Scotland, due to the commitment of those involved, and of National Education Scotland (NES) who have been very supportive of the Meriden approach.

The next Training Trainers course takes place from the 10–15 February 2014. We look forward to another intense and satisfying week.

# ‘Caring for Yourself’ Self Help Workbook

## The views of a sample of carers

By Rubina Jhadray, Psychology Research Assistant  
& Gráinne Fadden, Director  
Meriden Family Programme

Launched during Carers week June 2012 by the Meriden Family Programme and Rethink Mental Illness, ‘Caring for yourself’ is available to carers and organisations nationwide through the Meriden and Rethink websites. The self-help workbook was designed to help carers, family and friends who support someone with a mental health problem; to help them develop new skills, ways of coping and to think about looking after themselves. The workbook can also be a helpful resource for health professionals to refer carers to. Those using the resource are invited to provide feedback on its use and whether or not they find it to be beneficial.

So far, feedback has been received from 9 people who were predominantly female, with only one male, and all of whom were the primary caregivers. The majority of carers were over 45 years of age, and only two lived with the service user. Data were provided for nine service users; they suffered from a range of difficulties, with some having more than one disorder. These can be seen in Table 1 below. The length of difficulty that service users were experiencing ranged from six years to over thirty years.

**Table 1. Difficulties experienced by service users**

Service User (N=9)	Difficulties
Service User 1	Psychosis
Service User 2	Psychosis, Anxiety and Asperger’s Syndrome
Service User 3	Psychosis, Depression, Anxiety and Personality disorder
Service User 4	Bipolar Disorder and Anxiety
Service User 5	Eating Disorder
Service User 6	Psychosis, Depression and Anxiety
Service User 7	Psychosis, Schizophrenia and Anxiety
Service User 8	Schizophrenia
Service User 9	Anxiety and Post traumatic stress disorder

### First Impressions

Initial impressions of the workbook appeared to be mixed amongst the carers. The positive comments seemed to focus around the content of the workbook: **‘Excellent, very informative’**. Positive impressions were further highlighted as it was mentioned that prior to the publication of the workbook, there has been nothing similar available for families. There appeared to be a sense of relief, that there is now a source of help and support for carers: **‘At last the sort of resource I needed so badly 20 years ago!’** However there were some areas of concern relating to the size and amount of information provided in the workbook. Many felt that it is too large in size: **‘Large, bulky format’**. In summary, just under half of the carers held the opinion that to look at, the workbook appeared to contain too much information, and for some appeared ‘off-putting’. For the others, first impressions were positive and the workbook ‘looked very good’.

### Most and Least Helpful Sections

Carers were asked to highlight which parts of the manual they found to be the most helpful and which parts they found the least helpful. Responses can be seen in the table below.

**Table 2. Most Helpful Parts**

Which parts did you find most helpful?	No. of Carers (N=9)
1. Introduction	
2. Being A Carer	
3. Information	
4. Communication Skills	2
5. Problem Solving	1
6. Relapse management and staying well	2
7. Recovery and hope	4
8. Taking care of yourself	3

Not surprisingly, parts that were seen as most relevant to the carers' current situation were seen as the most helpful. Interestingly, those who responded were not using the manual primarily as a source of information; rather they were focussing on learning skills to help them in their role. Only one carer from the nine mentioned specific parts they found to be the least helpful. These were the 'Introduction', 'Being a carer', 'Information' and 'Relapse management and staying well'. This may be because they were familiar with these topics already.

Further, carers were asked to comment on how helpful they found the exercises and activities within the manual. Carers appeared enthusiastic about working on the activities and comments were positive overall. It was felt that the exercises were 'relevant' to carer situations and highlighted specific skills they needed to focus upon: **'These are exactly what I need and I will work on them.'** Carers appeared to find the exercises helpful and interesting and some commented on using the exercises in support groups; **'These will be helpful at my support group if appropriate to those attending'**. This would give opportunity for discussion among carers around the exercises, to give feedback to one another and promote learning within groups.

Carers were asked which parts of the workbook they had completed at the time of providing feedback, seven of the nine carers provided responses which can be seen in the table below. The 'Introduction', 'Taking care of yourself', 'Information' and 'Communications skills' were the most frequently endorsed sections.

**Table 3. Parts Completed**

Parts completed at time of filling in this form	No of Carers (N=9)
1. Introduction	7
2. Being A Carer	4
3. Information	5
4. Communication Skills	5
5. Problem Solving	4
6. Relapse management and staying well	4
7. Recovery and hope	4
8. Taking care of yourself	6

When asked if they planned to complete all eight sections of the workbook, five carers answered 'yes' and one answered 'no'. Further, carers were asked to rate how helpful they found the workbook overall on a scale of 0 – 10, with 0 being 'Not helpful at all' and 10 being 'Extremely

helpful'. Five of the carers responded all of whom rated the workbook highly as scores ranged from 6 to 10.

### Was There Anything Missing?

In response to whether the workbook could include any other useful topics, the majority of carers answered 'no'. Of those who did respond, 'validation' was a recommended topic, but it was not clear as to what they meant by this term. It may perhaps refer to validating their roles as carers. Another topic that was suggested was recognising how other family members or friends who support the carer may be affected by the service user's difficulties, as this may influence the level of support that they can provide to both the service user and carer. Further information and guidance on how to access educational resources and how to deal with the perceptions of others were also mentioned as topics that would also be useful.

The workbook is seen as an important resource that may be ideal to work from in support groups and carer groups, where carers can learn and develop skills together. Thus, encouraging the use of the workbook in such groups may be one effective way to utilise the resource, and may be a good platform to raise awareness of the workbook among carers.

### Using the Workbook as a Resource in Carers' Groups

The size of the workbook might need to be considered, as for some it appeared overpowering initially in terms of the amount of information. A smaller and shorter edited version was recommended by one carer. Alternatively it may be useful to have clear guidance about the different ways in which the workbook can be used and to make it clear that only certain booklets may be relevant to an individual. Further, it may be useful to highlight that the parts are stand-alone booklets in themselves and do not need to be used collectively. The workbook may then appear to be less overwhelming. Other comments regarding the workbook were positive with carers expressing how useful it had been to them and how it may be of benefit to other carers. Further, the clarity of information and support the workbook has provided has been helpful to them and their family members.

The manual is free and available to download from the Meriden Family Programme and Rethink Websites. Please log on to either:

<http://www.meridenfamilyprogramme.com/> or  
<http://www.rethink.org/carers-family-friends/caring-for-yourself-guide>

Fadden, G., James, C., Pinfold, V. (2012) Caring for Yourself – self help for families and friends supporting people with mental health problems. Rethink Mental Illness and Meriden Family Programme.

## How can we improve services for people who live with Bipolar Disorder?

**Date: Thursday 11 July 2013**

**Venue: Colmore Gate, 2-6 Colmore Row, Birmingham, B3 2QD**

**Time: 10am—4.15pm (Registration from 9.30am)**

**FREE EVENT**

**Tea/ Coffee and Lunch Provided**

### Agenda

9.30 – 10.00am	Arrival and registration
10 – 10.10am	Opening address
10.10—10.35	The demonstration site so far – improving recovery for people with a diagnosis of Bipolar Disorder
10.35—11am	Current practice and pathways with service user perspectives
11.00 – 11.30am	Tea/coffee break
11.30—12pm	National initiatives in the development and delivery of psychological approaches for Bipolar Disorder
12– 12.30am	The Mood on Track programme and family interventions
12.30 – 1.20	Lunch
12.45 onwards—	Display tables (Meriden, Spectrum, Mood on Track, and Experts by Experience) with staff available for discussion
1.20—1.30	Plenary – views, comments and suggestions for the project team
1.30—2.45	Workshop 1, 2 or 3 Coffee
2.45—4pm	Workshop 1, 2 or 3
4.00 – 4.15pm	Close and questions



Birmingham and Solihull  
Mental Health NHS  
Foundation Trust and The  
Spectrum Centre for Mental  
Health Research at  
Lancaster University are  
working in partnership to  
facilitate the Improving  
Access to Psychological  
Therapies (IAPT) Severe  
Mental Illness (SMI)  
Demonstration Site for  
Bipolar Disorder.

**We Look Forward to  
Welcoming You at Our  
Open Day**

# Think Family/ Whole Family Approach:

## Improving Outcomes for Mentally Ill Parents and Their Children

**By Dr Lina Gatsou, Leicestershire Partnership NHS Trust (LPT)**

**Dr Gráinne Fadden, Meriden Family Programme, B'ham & Solihull Mental Health NHS Foundation Trust**

**Dr Scott Yates, De Montfort University (DMU)**

**Mr Nigel Goodrich, De Montfort University (DMU)**

**Mr Daniel Pearson, Leicestershire Partnership NHS Trust (LPT)**

### Background

Mental Illness is a family matter, particularly where a parent with dependent children has a mental illness. The presence of a parent with mental illness in the family may lead to many alterations in its system, such as changes in family structure and interpersonal relationships (Rose et al., 2002). These changes can cause both obvious and subtle effects on the family (Cooklin, 2006).

Although many parents with mental illness and their children can be remarkably resilient, adverse outcomes for children are associated with parental mental disorder. Several studies indicate that children where a parent has a mental illness may be at twice the risk of developing a mental illness diagnosis compared to other children (Black et al. 2003; Park et al. 2003; Cunningham et al. 2004; Leschied et al. 2005; Edwards et al. 2006). Other studies highlight the range of behavioural, interpersonal, academic and other difficulties that children of parents with a mental illness might face (Rutter & Quinton 1984; Farahati et al. 2003; Maughan et al. 2007; Reupert & Maybery 2007; Reupert et al. 2011).

The links between poverty, mental ill health, discrimination and social exclusion are compelling and any attempt to improve the life chances for patients who are parents and their children must consider the family context of adults with mental illness and must be based on a good understanding of the needs of children and their mentally ill parents (Falkov, 2011).

The issues surrounding living with a parent with mental illness emphasize the need for programs that assess the whole family, even when just one family member is ill (Oscouie et al. 2011). Such programs have benefits for both, the parent with mental illness and the children; in addition, they reduce the costs to the health care system (Mihalopoulos, Magnus, Carter, & Vostanis, 2004). Implementing such programs can improve medication adherence and reduce symptom relapse (Reupert, Green, & Maybery, 2008; Fadden et al, 1998); in addition, by having the child interact with the parent, such programs can reduce the child's burden and eventually improve their functioning

(Miklowitz, George, Richards, Simoneau, & Suddath, 2003) and prevent further decline in their emotional wellbeing.

### HIEC Think Family Training Programme and Family Intervention

Currently, there are no unified UK training packages for all health, educational and social care sectors in an evidence based family intervention for families affected by parental mental illness. The literature review suggests that of the interventions targeting family relationships and parenting in families, behavioural family interventions founded on social learning models have the greatest empirical support.

The aim of our project was to train 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', 'Think Child, Think Parent, Think Family' and 'Children of Parents with Mental Illness' guidelines and principles. The joint training of multi-agency staff had the goal of promoting joint working across services and developing a consistent approach to families experiencing parental mental illness.

The training programme was tailored to the specific areas of need of the multicultural and diverse community of Leicester, Leicestershire and Rutland aimed at timely, effective, accessible and acceptable care to the vulnerable families affected by parental mental illness.

The main objectives and goals of the project were to increase practitioners (family workers) understanding of the impact of Parental Mental Illness (PMI) on children's outcomes; to identify Children Of Parents with Mental Illness (COPMI); to undertake family mental health assessments; to provide appropriate care management and family sensitive intervention and to enable practitioners to work collaboratively with partner agencies from health, education, social care and voluntary sector when supporting families experiencing PMI.

The family work described throughout our programme refers to the Meriden Family Programme and is based on the Behavioural Family Therapy (BFT) Approach, developed by Professor Ian Falloon in the USA and further refined by Dr Gráinne Fadden, Director of the Meriden Family Programme. It is a practical, skills based, psycho-educational intervention that focuses on here and now issues and on ways of coping with day-to-day difficulties. The family worker and family members attempt to reach a shared understanding of the service user's mental health issues and the best way of managing these. Family members also complete work on recognising early signs of relapse and develop clear plans for staying well and working towards recovery. This approach promotes positive communication, problem solving skills and stress management within the family thus leading to stress reduction. Individual family members are encouraged to identify and work towards clear goals. The concept of 'family' is understood in broader terms; family meetings include those most important in the life of the service user (including members of the extended family, close friends and neighbours).

The 'Think Family' Training/ Family Intervention Programme was developed in response to the competing demands of accessibility (making the training as available as possible to the greatest number of practitioners possible, from the widest pool of services) and rigour (providing sufficient training in skills and knowledge to equip each participant with the requisite attitudes and skills to undertake the work). In order to achieve this and enable freeing up workforce time in the current difficult financial climate, we have decided that our training is going to take up a form of a 2-day training package, as an adaptation of the Meriden Family Programme (BFT), which comprises a 5-day programme.

Moreover, in order to support better mental health outcomes for our specific population of children and families affected by parental mental illness and multi-agency professionals supporting them, BFT principles/modules used in the Meriden Family Programme needed to be adapted for the needs of the families where the parent suffers from mental illness. After the extensive literature review and recommendations from both clinicians, service users and young carers, additional elements (principles of the SCIE guidance "Think Child, Think Parent, Think Family", Cooklin's and Beardslee's cognitive and psycho-educational elements as well as Falkov's principles of joint collaborative practice of working across agencies) were incorporated within the training programme, while retaining a number of fundamental BFT elements as used in the Meriden Family Programme.

The Think Family Training was provided to 100 frontline professionals (family workers) from more than 15 different services from health, education, social care and voluntary sector. This training enabled them to acquire family focused intervention skills and necessary knowledge and awareness regarding mental illness in the family. The project was

developed and delivered by the core Think Family Project Group with members from LPT, DMU and the Meriden Family Programme, in six stages:

- Stage 1:** Development of "Train the Trainer" Programme/ Package of Educational and Training Skills (September – October 2012)
- Stage 2:** Development of Evaluation Strategy (e.g. questionnaires, matrix) and Development of Resources for the 4-day knowledge and skills event (October – November 2012)
- Stage 3:** Delivery of 4-day Think Family Training/ Family Intervention Programme to 11 trainers – "Train the Trainer" Programme (December 2012)
- Stage 4:** Roll out of the 2-day Think Family Training/ Family Intervention Programme to 89 frontline professionals/family workers (January and February 2012)
- Stage 5:** Intervention with the families and supervision (February – July 2012)
- Stage 6:** Project evaluation and write up (July – September 2012)

There was an expectation from the trained family workers that they will practically implement the acquired knowledge and skills, within the 4 months following the training. Family workers agreed that they would complete the family intervention with one pre-chosen and prepared client (family) already on their caseload; this agreement formed part of the specific criteria for the appropriateness of the chosen family for this programme.

The Family Intervention comprised of 8 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, unmet needs and ongoing needs. When working with the families, both trainers and frontline professionals followed a specifically developed manual, which was adapted from the existing Meriden Family Programme manual for the purposes of our programme.

During the work with the families, family workers were receiving supervision and additional support in the way of regular email contact, on-line resources and blog. Reflective meetings were arranged regarding progress and planning of further roll out of the programme and intervention.

## Future work

The collection and analysis of quantitative data is completed, and we are in the phase of collection and analysis of our qualitative data to evaluate the project in more detail. Focus groups and 1:1 interviews with professionals, parents and young people were completed at the end of May 2013; once all the data have been collected and analysed, the project team intends to publish papers in appropriate journals to publicise the Think Family/Whole Family Approach in supporting families affected by parental mental illness.

This project has generated further ideas from the in-depth exploration of issues that came up from the training of the family workers and direct work with the families. It could be argued that it functioned as a catalyst for informing current policies such as Think Family Strategy (health, local authority and voluntary sector), as well as for the development of further training (informed by the recommendations from this project) and research into the workforce development in adult mental health.

The team is currently investigating the possibility of obtaining further funding to adapt the approach for application to Adult Mental Health Services and Health Visitor Services within the LPT.

It is important to regard the 'Think Family Project' to date as a starting point for further training in this field in our locality and region. Further single-agency training is planned in the near future e.g. for Schools, GPs etc. However, for the investment (financial and workload) to be meaningful it is essential that these practices become embedded in routine clinical practice. That will require, in particular, commitment to further training, clinical supervision and supported clinical time within the work setting.

The work on the dissemination of the project has started – through internal workshops/ lunchtime presentations, and through the promotion of the LPT Think Family Strategy; two recent regional conferences (November 2011 and March 2012) and a presentation at the World Conference of Child Psychiatry and Allied Professions in July 2012 and at the Mental Health Conference, London in November 2012 were all excellent opportunities for national and international dissemination of our project and findings. We continue to work with all relevant agencies to embed 'Think Family' principles into policies and protocols.

This report suggests that the initiative has been successful. Continued progression of the approach will need further training of involved staff, in order to sustain and develop

these new skills. Ideally a menu of alternate trainings would be required to address the variable responses of different staff groups to the first course.

With regard to clinical supervision, anecdotal information suggests that the highest uptake of work with families was linked to attendance at supervision sessions by participating staff. This relationship appears to have been reciprocal – staff regarding supervision as more valuable when they had their own clinical work to discuss, and supervision acting to inspire staff to more clinical investment. It will be essential that extensive and robust supervision is provided over an extended period to give assured foundations to those clinical staff electing to take this forward.

Finally, 'Think Family' work will only progress where there is organisational enthusiasm and investment. There continue to be services or organisations within the Leicester City, Leicestershire and Rutland Health and Social Care Community in which commitment to 'Think Family' is less well rooted. It will be important over the forthcoming year to invest in further 'awareness-raising' presentations across the locality. Milestone for this future work is the Think Family Strategy and Action Plan (in which Think Family Training is one of the core strategic goals), which has been developed by the Think Family Lead, Dr Gatsou and number of senior safeguarding leads, frontline professionals, commissioners, and services users and was signed up by the Leicestershire Partnership Trust in 2012; a multi-agency sign-up of this strategy is currently in progress. This will ensure that the project and its findings are embedded in the clinical practise and service delivery of LPT and multi-agency partners within the local authority.

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## Notes

1. Think Family / Whole Family Approach is an approach promoted by Government based on co-ordinating the support provided by adult and children's services to a single family in order to secure better outcomes for the children through the use of targeted, specialised and whole-family approaches to addressing family needs (HM Government, Working Together to Safeguard Children, 2010)
2. 'Think Child, Think Parent, Think Family', SCIE, 2009
3. COPMI, Reupert et al., 2005
4. Meriden Family Programme (Fadden, 1998a)
5. Kidstime Workshops Intervention (Cooklin, 2002)
6. Family Talk Intervention (Beardslee et al, 2006)
7. Crossing Bridges Workforce Training (Falkov et al, 1998)



## 5-Day Behavioural Family Therapy Training Course

21st - 25th October 2013

**Venue: Uffculme Centre, Queensbridge Road, Moseley, Birmingham**

Training in an evidence based psychological approach proven to reduce relapse rates. Learn more and feel more confident about:

- Policy and research around families and carers
  - Working with carers and families
  - Carer and family assessments
    - Early Warning Signs
    - Communication skills
    - Problem solving

There are limited places available for the above course.

**If you are interested in attending please ring Nadine Berry on 0121 301 2896 or email [nadine.berry@bsmhft.nhs.uk](mailto:nadine.berry@bsmhft.nhs.uk)**

## Behavioural Family Therapy 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 of the dates now!

10th - 14th February 2014

**Venue: Beeches Management Centre, Bournville, Birmingham**

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](mailto:sam.farooq@bsmhft.nhs.uk) or telephone 0121 301 2896 for further information.**

**More details of the training we can offer can be found on our website [www.meridenfamilyprogramme.com](http://www.meridenfamilyprogramme.com)**

### MERIDEN CONTACT DETAILS

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		<b>Email Addresses:</b> <a href="mailto:firstname.lastname@bsmhft.nhs.uk">firstname.lastname@bsmhft.nhs.uk</a>	

**Website:** [www.meridenfamilyprogramme.com](http://www.meridenfamilyprogramme.com)

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

**If your details have changed please let us know. Email [sam.farooq@bsmhft.nhs.uk](mailto:sam.farooq@bsmhft.nhs.uk) or telephone Sam on 0121 301 2888**