MERIDEN
The Meriden Family Programme
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I would like to start by wishing all of our readers a very happy and fulfilled 2018. This is a very significant year for the Meriden Programme as it marks our 20th anniversary. The planning for the Programme actually began in 1997, with initial workshops with managers in West Midlands services taking place in Spring 1998. The first training course in Behavioural Family Therapy was held in April 1998 with the first training course for trainers and supervisors taking place in October 1998.

The Programme expanded its reach and scope over the years, extending from the West Midlands across the UK and into a number of European countries. Over time, we extended further into Australia, Canada, Japan and supporting the development of services for families in Nigeria and Uganda. It is heartening to see after 20 years, the demand for expanding services for families remains high. In 2017 we held two Training Trainers courses instead of our usual annual course due to increased demand.

It will also be a significant year for me personally in that I will be retiring from the Programme and the NHS in July 2018. It seemed a fitting time to leave as the Programme will be in its 21st year! Importantly the Programme will continue to expand and innovate as it has done over the past 20 years – developing new services and resources in an ever-changing healthcare system, and meeting new challenges.

I hope that you will enjoy the reports and information in the current edition of the newsletter with updates on progress in the UK, Republic of Ireland and Canada, and interesting announcements and news items.

The Meriden Programme influenced mental health care in Nova Scotia in Canada and helped to introduce evidence-based family work there.

It is interesting to read the article by Julia Danks on the first family work training held in Ontario, particularly as this was in a forensic setting. The impact of training in the Republic of Ireland is described in the article by Rhona Jennings. This gives a really useful account of what can be accomplished when an area has a clear plan for what they would like to achieve. Clearly, introducing family work is not without its challenges, but addressing these and finding solutions is an ongoing and evolving process.

On the theme of creativity, the article by Martin Atchison describes how family work can be applied in eating disorders services. Tony Gillam's article gives much food for thought. We have found in a number of audits that delivering family work and making a difference to people's lives is a great source of personal and job satisfaction. Tony suggests theoretical underpinnings for this and poses some challenging considerations in working creatively and sources of anxiety in doing this.

Happiness and sadness mix together in this edition. There are the well-deserved awards for Alan Worthington and the Solihull Carers Centre. We were all so saddened in the Programme to hear of the untimely death of Jackie Crowe, one of our trainers in Australia, and feel so much for her family, friends and colleagues.

We are hosting a conference on family work themes on 20th June 2018. We hope that many of you will be able to join us to celebrate with us and to look at the implementation of family services into the next decade. Details of how to register for the conference can be found in the newsletter or on our website. Look forward to seeing you there!

Dr Gráinne Fadden

Fellowship of British Association for Behavioural and Cognitive Psychotherapies (BABCP) Awarded to Dr Gráinne Fadden

To recognise her outstanding contribution to the development and implementation of family interventions for psychosis, Dr Gráinne Fadden, Consultant Clinical Psychologist and Director of the Meriden Family Programme was awarded a Fellowship of the British Association for Behavioural and Cognitive Psychotherapies (BABCP).

Dr Gráinne Fadden has been at the forefront of the development and implementation of Family Interventions for over 30 years. Some of her initial work highlighted the impact of experiencing mental health difficulties on family members at a time when this was overlooked and instead families were often blamed for their relative's relapse. Since then, she has worked tirelessly to promote and implement family work in routine clinical practice, not only in the UK but internationally.

Gráinne established and is the Director of the internationally renowned Meriden Family Programme which has trained over 5,500 people in Family Interventions. The Meriden Family Programme has been pivotal in achieving the ambition to improve access to evidence based psychological therapies for those with psychosis and their families living in the UK and the Programme has been mirrored in other countries around the world including Japan, Canada, Australia and Uganda.

Although Gráinne is renowned for her training role, her focus on the implementation of family work goes far beyond this and spans a wide range of activities including clinical practice, research, writing books and book chapters and, more recently, strategic work to influence organisational change. She is routinely consulted by the Department of Health and NHS England on matters to do with the implementation of psychological therapies for psychosis.

In short, Gráinne has gained the reputation as a world expert and leader in this field. This is demonstrated by the number of awards she has won over the years including the Health Service Journal national award for Mental Health Innovation in 2008 and the prestigious Marsh Award in 2009, a lifetime achievement award for her outstanding contribution to mental health.

Dr Gráinne Fadden with Professor Chris Williams, President of the BABCP

Meriden International Awards

Left to right: Gladys Canikale – Psychiatric Nursing Officer, Namuli Joyce – Senior Principal Nursing Officer, Thomas Walunguba – Director for the BFT Programme in Uganda, Dr Ogwang Alfred Francis – Hospital Director, Stella Olar – Senior Psychiatric Clinical Officer

In our last edition of the newsletter we included details of the winners of our International Awards. We were fortunate enough to be able to present the recipients of two of the awards in person; to Professor Atsushi Sato from Japan and to Ms Rhona Jennings from Ireland. Our third award which was for Thomas Walunguba has made its way to Uganda and Thomas was delighted to receive it.

Thomas, Programme Director for the Behavioural Family Therapy (BFT) Programme in Uganda, received the Meriden Family Programme International Award in recognition of the impact he has had on mental health services across Uganda since his visit to the Meriden Family Programme in the UK in 2012.

We are pleased to be able to include photos from Thomas and his colleagues from Moroto Regional Referral Hospital with the award.

National Award for Carers Trust Solihull

By Peter Woodhams, Carer Consultant, Meriden Family Programme

Many congratulations to Carers Trust Solihull (formerly Solihull Carers Centre) on winning the Young Carers category of the Children and Young Peoples Now Awards for their Peer Mentoring and Befriending Project, funded by Children in Need.

These awards have become the gold standard for everyone working with children, young people and families. Now in their twelfth year, the awards provide a great source of pride and recognition for all those who strive day in, day out, to improve the lives of others. They offer an opportunity to raise the profile of projects and initiatives to funders and the general public

Solihull Young Carers was adjudged the winner by a 15-strong expert judging panel which scrutinised all the entries to produce a shortlist of 6. A panel of young judges examined the shortlisted entries and their marks were added to those of the adult expert panel. The project leads of Carers Trust Solihull together with Gina Ward, Manager of the Young Carers Team were at the Award Ceremony in London in November to receive the award with much jubilation.

The centre has now become a member of the Carers Trust network of more than 130 local carers services throughout the UK. It remains an independent local charity but will now be able work in a stronger and wider partnership to further promote the wellbeing of carers of all ages in Solihull. The services will remain the same under the new name and logo.

Staff from the Carers Trust Solihull at the awards event

Pioneering Carer Recognised by the Royal College of Psychiatrists

By Peter Woodhams, Carer Consultant, Meriden Family Programme

Ruth Hannan, Policy and Development Manager, with Alan Worthington, Carers Trust

Never was an award more richly deserved than the Royal College of Psychiatrists' award to Alan Worthington as Carer Contributor of the Year 2017.

Alan is from the South West of England and became a carer in 1989. After quickly establishing local carer support and engagement groups in Exeter he became a major influencer of national mental health policy particularly in relation to the vital role played by carers and families.

He created the now nationally recognised 'Triangle of Care' which has been implemented in 32 Trusts in England and joined the National Institute of Mental Health England Acute Steering Group. He worked with the now retired Paul Rooney from Birmingham and Solihull Mental Health Trust on many of the initiatives related to the implementation of the Triangle of Care in Acute settings. He now advises various organisations including the Carers Trust, the Care Quality Commission and the Devon Partnership Trust.

Meriden has long recognised Alan's outstanding contribution to the profile of carers and families in mental health and he was the invited keynote speaker when the Triangle of Care was first launched in Birmingham in 2011. We send our sincere congratulations to him.

Family Work in Eating Disorders Service

By Martin Atchison, Deputy Director, Meriden Family Programme

My clinical experience of working with families stretches back to 1999, and I have worked with families from a wide variety of backgrounds and diagnoses. During training courses, we talk about the evidence base for family work which is referenced in the NICE guidelines for schizophrenia and bipolar disorder, but we are also aware that BFT has been used within other areas by people across the world that have accessed the training.

Over three years ago, Meriden was contacted by a family who lived a couple of hundred miles from Birmingham, whose daughter was under the care of the eating disorders service in Birmingham and Solihull Mental Health NHS Foundation Trust. They were looking for some support for themselves in relation to their daughter, and were uncertain about how much information they should themselves share with the service, and in turn how much information they should expect to receive back from the service.

They were treading a fine line between needing to express serious concerns about their daughter's wellbeing to professionals, while at the same time not wanting to upset their daughter who was concerned about confidentiality being broken and wondering what exactly was taking place in discussions between her parents and clinicians. Following some negotiation an agreement was reached that Behavioural Family Therapy (BFT) would be delivered to the family.

Following this, relationships developed between myself and staff from the Eating Disorders Service. We delivered a day's training for the whole staff team about BFT and general engagement of families. The team were already engaging well with families (there is a regular structured carers group on the inpatient unit), so the training was more about how to develop these relationships. Throughout this time, I was receiving regular referrals for families, mainly from the inpatient unit.

The NICE Guidelines for Eating Disorders recommends Family Therapy for Anorexia Nervosa (FT-AN) developed by the Maudsley Hospital, so there is some evidence that family interventions are effective. Certainly my experience of using BFT with families in contact with eating disorders services has been that families have generally found the experience to be beneficial, and families would recommend the service. There is scope for a more structured exploration of the effectiveness of BFT with Eating Disorders (ED), which may be something the Meriden Family Programme could introduce in the future.

This article will look at the model of BFT and some of the learning points that I have found over the last few years. I will be writing about the components of BFT in a different order than may be familiar to people, and this is explained as I go on to discuss this.

Engagement

Generally, families have been willing to engage in family work without too much debate. They are quite often bewildered by their relative's experience and keen to find out more about how best to support their relative. While a number of families had received or had been directed to good information about anorexia, families often were unsure about how to translate their knowledge into practical day-to-day methods that would be supportive of the service user in a consistent way. A number of service users I worked with wanted family work to help the whole family to be more honest with each other. This seemed to be an indication that communication had become strained in the family because of uncertainty about whether to discuss what was happening, how to discuss what was happening, and a sense that previous discussions about what was happening had been stressful.

What I found to be important was the need to be clear with the family that family work wasn't being offered because the service was blaming the family for their relative developing an ED, but rather an attempt to get the family moving forward together and managing to reduce stress levels. While this is always an important issue in families, this has been more acute and sensitive within the ED service.

Assessment

Meetings with individual family members have often demonstrated that, as has been mentioned, families have done a lot of reading about ED, and can talk about what they understand about how an ED may have developed and how it is sustained. What is more of a challenge for families is how to create a supportive environment for the service user when the level of concern about their wellbeing creates a lot of stress.

A number of parents spoke about spending a lot of time ruminating about what they may have done when raising their children that may have led to the ED occurring, and talking about how difficult it is not to be constantly observing the dietary intake of their loved one. Family members often talked about mealtimes being a challenging time, particularly when their loved one was starting to have leave from the inpatient unit and starting to eat meals at home. The person with an ED would often be eating meals on their own, to avoid any scrutiny from family members.

While this wasn't an ideal situation, families were focussing on ensuring their relative was eating something, rather than eating together as they normally would. Service users often stated that this seemed to reinforce their ED, that decisions in the family were made based on the ED. A number of service users said that they felt they had too much power within the family, without the resources required to be able to cope with this.

Family assessments have usually indicated that communication and relationships in the family were good, as long as discussion wasn't about the ED.

Planning Ahead With the Family

When considering how to proceed with the family, it has often been the case that we have left the information sharing sessions until the latter stages of the family work. Family members often had a good knowledge of the ED from reading around the subject, but were finding it a challenge to deal with the ED practically on a day-to-day basis.

The idea of a family meeting was often helpful to try and help the family minimise any discussion about the ED in everyday family life. Having a weekly (or twice weekly on some occasions) family meeting helped the families to talk about their views on progress at a time when everyone was focussed and expecting this discussion to happen, rather than this being mentioned at unexpected times during the week.

Ground rules have occasionally been a challenge to negotiate. Some service users have said that they don't want their ED to be mentioned constantly during the family work, but families have been unwilling often to agree to this being a ground rule. It has been important to be clear with the family when planning ahead that there will be time to discuss this, but certainly when looking at communication and problem solving skills, the focus should be on the skills rather than the ED and it is important that the ground rules reflect this and are reviewed on a regular basis.

Problem Solving

This has usually been the first session following the assessment and planning ahead. The process has been helpful for families to enable them to start talking about how to manage the day-to-day issues that have proved difficult to discuss. With a number of families, we used the problem solving process to get the family to explore the issue of mealtimes. Re-framing the problem of 'mealtimes are stressful' into a goal of 'how to make mealtimes more enjoyable' was helpful for families to start to think in a more positive sense, and to enable the family to talk through what could be a sensitive area.

Social occasions such as christenings, family birthdays and weddings have been other topics that have been discussed by other families. Planning ahead has been helpful so that everyone contributes ideas about how to respond in a consistent way to any potential challenging situations. Without the problem solving approach in place, families would often struggle to know how to hold these discussions.

Communication Skills

Anyone working in mental health will appreciate that families are often under a great deal of stress, which can change how a family communicates with each other. This is certainly the case with families in contact with ED services. Often, families find themselves in a position where communication is strained, where a routine conversation is clouded by the potential mention of the ED or behaviours related to the ED, which can add tension to relationships. Families have also said that they found it difficult to hold discussions about the ED, that family members have, with the best of intentions, said things that they have learned over time to be unhelpful for their relative. This has led to reluctance to discuss how the service user is doing, out of concern for saying the wrong thing. This then leads to the service user feeling that the family need to talk about a serious issue, without the arena in place for this to take place.

Families have generally found that the communication skills have been useful in resolving some of these tensions, by having an agreed way that the family communicate. Families have been surprised at times when asked to say something positive to each other for example, and have commented that tackling the family's situation 'from a different angle' was unexpected, but understandable once the family had started to implement the communication skills in day to day life.

Personal Goals

One of the interesting factors has been the influence that family members working on personal goals has had. It is quite common that family members with a relative with a mental health problem will put their own lives on hold while they focus on their relative's wellbeing. What has been more noticeable has been the impact of this on the person with the ED, who often will observe their family reducing their social contacts, which can make them feel guilty and start to exacerbate their eating disordered thinking. When family members have started to achieve personal goals, the person with the ED can feel under less scrutiny and the family moves towards a more 'normal' way of life.

Information Sharing

Often this has been planned to take place towards the end of the family work. As has been mentioned previously, families often have read a great deal about anorexia, but find it challenging to know how best to respond to stressful situations, particularly mealtimes. A number of family members have said that, with the best of intentions, they have said something that hasn't been helpful or made things more stressful, which subsequently has made mealtimes for example, more stressful. Service users, who often find mealtimes stressful, have said that their family's uncertain silences and tentative attempts to encourage them to eat often tend to encourage their eating disordered thinking.

While some of these challenges may have been partially dealt with through the use of the problem solving process, it has been useful to have had some discussion with families about understanding the personal experience of the service user, about what statements the family make which are interpreted as positive, and what statements have a negative impact. It has also been helpful to have discussions about moving towards achieving the right balance between the family expressing their concern that their child is eating sufficiently, and the service user not feeling that they are being constantly observed.

Staying Well Planning

Family work has usually started while the service user has been an inpatient, and continued after they have been discharged. Obviously, the inpatient environment is very different from the home environment, and service users have to adapt to the home environment while maintaining improvements to their wellbeing made on the unit. Families, following discharge from inpatient services, have reported the challenges in being consistently concerned for how their child maintains their wellbeing, but being uncertain about when to be sufficiently concerned to mention this to their relative.

They may be worried about the response they may get, fearful that it may make things worse or worsen their relationship with their child. There is also some concern that saying the wrong thing will make it more difficult to express concern in the future.

The benefits of having a clear and specific staying well plan for families are obvious. Identifying specific signs of changes in the following areas has been beneficial:

- Food
- Activity
- Mood
- Sleep
- Concentration
- Communication

Having a written plan ensures the family have clarity about what specific signs they should be looking for and have an agreed plan as to how everyone will respond if they notice these things happening. Family members have used the plan in a supportive way, helping them to respond to concerns more clearly and positively.

Some service users have said that this was the most difficult part for them to complete, as it seemed to restrict the opportunity for the eating disordered thinking to influence behaviour, since families were clearer about specific signs to look for and there was an agreed plan in place to respond to these signs.

It is hoped that the relationship between the ED service and Meriden continues in the future.

Further articles about this work will appear in future editions of the newsletter.

Behavioural Family Therapy Training in Ontario

By Julia Danks, Clinical Specialist, Meriden Family Programme

Ontario Shores Centre for Mental Health Sciences in Canada, is a public hospital providing a range of specialised assessment and treatment services to those living with complex and serious mental health difficulties. It is based in Whitby, Ontario about an hour from Toronto.

In 2016, Dr Elizabeth Coleman, Medical Director at the Ontario Shores Centre for Mental Health Sciences contacted the Meriden Family Programme to enquire about our model of family work and the training process.

Dr. Coleman was really keen to embed family work into clinical practice and they wanted to have their own trainers and supervisors so that they could develop a critical mass of skilled clinicians, so a plan was developed to support this vision.

The proposed training was supported by the new standards, which were developed within Ontario Shores Centre for Mental Health Sciences. These are:

- The Clinical Care Standards in Recovery-Oriented Mental Health Practice.
- Quality Standards for Schizophrenia '*Schizophrenia, Care for Adults in Hospitals*' which is the Ontario–wide document. This quality standard addresses care for people aged 18 years and older who have schizophrenia – whether they are in an emergency department or admitted to a hospital. It also provides guidance on care that takes place when a person is between settings, such as when they are discharged from a hospital.

In January 2017, two members of the Meriden team and a colleague from our previous work in Nova Scotia, Cheryl Billard, went to Whitby to train 15 clinicians in Behavioural Family Therapy (BFT). This was the first training within the province and this is always exciting and challenging at the same time.

Delegates and trainers on the Behavioural Family Therapy course held in Ontario Shores

The delegates were made up of Social Workers and Occupational Therapists and worked within Forensic In-Patient Services. The training was delivered over five days within the hospital setting.

Feedback

'Very appropriate to our work. Definitely an important piece we have been missing'.

'Overall very well presented. Very clear. Facilitators did a great job of answering questions, addressing concerns, giving examples and feedback.'

'This is an excellent course, practical and the delivery is appropriate, fun and balanced.'

'This is what our families need!'

To support the implementation, the plan involved regular supervision with the delegates. Two sessions a month are facilitated via teleconference for delegates by staff from the Meriden team.

Following the initial BFT training, three of the delegates came over to the UK in March 2017 to complete the Training Trainers programme and after successfully working with families using the model are now planning their first roll out of training.

In the following article one of the newly trained trainers, Sujeetha Kulasingam, talks about her experiences so far:

My Journey with BFT by Sujeetha Kulasingam

I recall being extremely sick during the 5-day training program that was being offered to me and my colleagues at Ontario Shores Centre for Mental Health Sciences in Ontario, Canada during the end of January 2017. Despite being very unwell, I stuck through the week long training as I was intrigued by this model and the impact it could have on families and people that I see in the hospital.

My experience has been very interesting, as I am working with people who have lived with Schizophrenia or Schizoaffective disorder for most of their lives. This means the family who are often involved with their care also learn about the illness along with their own means to cope. Often, the families I have spoken to express that they would have loved to have received support and work with a professional in this manner when they first experienced the illness within their family.

There are challenges in a geriatric setting, such as cognitive impairment which can sometimes affect learning of new skills. However, for every problem there are many solutions which we do not see. We must find ways around the challenges to reach the end goal of supporting people and their families. I have provided more handouts, binders and checklists to people who have cognitive difficulties as a way to compensate for their difficulty with recalling new information.

Supervision has been very helpful in learning about other clinicians' experience, as well as keeping me on track with implementing the model correctly. Needless to say, I am a strong believer of BFT and have seen how useful it can be.

I had the opportunity to attend the Training Trainers course offered in Birmingham during the Spring of 2017 with two of my colleagues. We are in the final stages of preparing our first course for other Occupational Therapists and Social Workers throughout the hospital. The course will be offered in January 2018. I feel very prepared with the Training Trainers course to guide my colleagues through the BFT model and workbook. Being the first organization in Ontario to offer BFT, I hope we are looked upon as a gold standard for the care that should be offered to people and their families in our province.

Family Work, Creativity and Wellbeing

by Tony Gillam, Senior Lecturer in Mental Health Nursing, University of Wolverhampton (U.K)

Tony Gillam

This article discusses the connections between family work, creativity and wellbeing. It explores, firstly, how family life is central to the wellbeing of service users and carers and how working with families enhances the wellbeing of mental health practitioners. Secondly, it highlights what can be learnt about creative practice from family therapy research, how this can help us identify the characteristics of creative mental health care in practice and how more creative mental health practice – including family interventions – might benefit services users and carers.

The importance of relatives, carers and family life

Family life is an important aspect of our wellbeing yet wellbeing is itself an ill-defined concept. Wellbeing has been described as "a complex, confusing and contested field (with) competing and contradictory definitions" (McNaught, 2011, p.7-8). The term is used imprecisely in various contexts (for example in the phrases *physical and emotional wellbeing, mental wellbeing, health and wellbeing*) and often used in conjunction with, or as a synonym for, health and/or happiness.

In its ubiquity it risks meaninglessness hence, in my new book *Creativity, Wellbeing and Mental Health Practice* I have gone to some lengths to explore the meaning of wellbeing in order to help understand the links between creativity, wellbeing and mental health practice (Gillam, 2018).

In my research into wellbeing and mental health nursing most of the literature reviewed concerned not physical but psychosocial wellbeing (including mental, psychological, social, emotional, individual and organisational wellbeing). I make a distinction between the psychosocial wellbeing of service users (as a service delivery issue) and the psychosocial wellbeing of Mental Health Nurses (MHNs) themselves. I describe these two types of wellbeing as psychosocial wellbeing **for** MHNs and the psychosocial wellbeing **of** MHNs.

When considering psychosocial wellbeing for MHNs, I identified several subthemes which suggest new roles or new interpretations of the role of the MHN. These subthemes are:

- facilitating flourishing
- the importance of relatives, carers and family life
- general health and psychological wellbeing
- recovery and wellbeing.

Family intervention as a means of facilitating flourishing

The findings of my research strongly suggest that MHNs need to move beyond focusing on symptom reduction or amelioration towards positively promoting resilience. Along with an appreciation of the impact of poverty, social exclusion and inequality, this also calls for skills in supporting the welfare of children and families, for greater use of solution-focused approaches and self-management resources and for an ability to identify and mobilise strengths in the community to bolster resilience (Blakeman & Ford, 2012; Ruddick, 2013). Family interventions are a very effective and efficient way of supporting children and families, promoting the use of the families own resources and skills to solve problems, achieve goals and manage difficulties. They are also an excellent way of bolstering resilience and focusing on – and mobilising – service users' and carers' own strengths.

In order to facilitate flourishing, MHNs need to work not only with individuals but with families and communities. While Ruddick (2013) calls for MHNs to have skills in supporting children and families, the importance of relatives, carers and family life emerges as a subtheme in itself. Several authors stress the value of assessing the wellbeing of families and carers and developing therapeutic relationships with the relatives of service users (Jormfeldt, 2014; Saarijarvi et al., 1998; Minardi, Heath, Neno, 2007; McGuinness & McGuinness, 2014). A structured approach to providing family interventions, such as that provided by behavioural family therapy, enables nurses and other mental health practitioners to systematically assess the strengths and needs of families, carers and service users and, through active and purposeful engagement, to develop therapeutic relationships with families.

How family work can enhance the wellbeing of mental health practitioners

If family work is an important means of promoting the psychosocial wellbeing of service users and carers how might it impact on MHNs themselves? This, I argue, relates

to the psychosocial wellbeing of MHNs – if MHNs are to address effectively the psychosocial wellbeing of service users they may need to attend to their own psychosocial wellbeing. Within this, two subthemes are critical to the discussion: occupational stress/satisfying professional practice and individual/organisational wellbeing.

Much of the literature I reviewed explored the quest for satisfying professional practice in the face of considerable occupational stress. Several papers highlight evidence that MHNs experience higher levels of stress and burnout compared with both other nursing specialties and other mental health disciplines. Cole, Scott and Skelton-Robinson (2000) find organisational factors a greater source of stress than service user-related factors. Stressful organisational factors identified include lack of role definition and lack of support. Seeing the provision of family intervention as a key part of the job could help MHNs to be clearer about their role whilst, at the same time, receiving support from a network of family-work trained colleagues and supervisors. This, in turn, could increase the wellbeing of nurses, knowing they are engaged in satisfying professional practice, and bolstering the self-esteem of MHNs by providing greater clarity about what their particular contribution is to care.

Learning about creative practice from family therapy research

Family work can provide MHNs and other mental health practitioners with an opportunity to be more creative in their day-to-day work. I argue that being able to be creative and to regard mental health practice as a creative activity in itself are important to the wellbeing of mental health workers (Gillam, 2018). Healthcare professionals often want to be more creative in their work but have anxieties about this. Happily, in developing a model of creative mental health care and trying to identify the characteristics of creative mental health care in practice, family therapy research is able to provide some helpful ideas.

An illuminating study into therapists' perceptions of the role of creativity in family therapy and couples therapy was conducted by Carson, Becker, Vance and Forth (2003). This surveyed 142 marriage (or couples) therapists and family therapists in 36 states in the US. While these therapists may represent a somewhat different group to MHNs, Carson et al's findings provide another rich perspective, highly relevant to our understanding of creative mental health practice. They argue that creative thinking in family work often leads to real and lasting breakthroughs and that creative energy promotes families' own problem-solving efforts, imagination, flexibility and playfulness. The study explored:

- the meaning and role of creativity in couples and family work
- the characteristics of a creative family therapist
- interventions believed to yield the most novel and helpful experiences
- barriers to creative practice.

The meaning and role of creativity in family work

Carson et al (2003) found an important part of creativity in family therapy was "the ability to apply traditional treatment modalities in novel ways" (p.102). The respondents in their study mentioned the centrality of taking risks with clients and of improvising. My book explores the impact that risk-aversion has in mental health nursing (Gillam, 2018). Risk-taking is an important factor affecting organisational creativity (Ekvall, 1996).

Stickley and Felton (2006) express concern that a risk-averse climate inhibits recovery and autonomy while MacCulloch (2009) identifies the burden of complex risk as a major stress for community MHNs. Carson et al helpfully clarify that risk-taking in family therapy does not mean engaging in dangerous activities but responding intuitively to a client in a session.

Further examples of creative work in Carson et al's (2003) study were the ideas of being "in the moment", of "thinking on one's feet" and of "connecting with the intuitive and creative parts of our clients and ourselves as therapists" (p102-3). "Thinking on one's feet" links with improvisation (which, in itself, involves risk-taking on the part of the practitioner).

Characteristics or qualities of creative family therapists

The respondents in Carson et al's (2003) study identified three qualities of a creative family therapist (which could, perhaps, equally serve more generally as characteristics of a creative mental health practitioner). These are:

- flexibility
- risk-taking
- humour.

While few would argue with the value of flexibility in clinical practice, we have already acknowledged that a willingness to take risks can be challenging in a risk-averse climate. The use of humour is also potentially controversial. Many might recognise that a sense of humour can be a valuable asset to any mental health practitioner, helping them to maintain a sense of balance and perspective in the face of often difficult situations and painful emotions. Yet, using humour in clinical practice is a more contentious area, since, as Carson et al recognise, the concerns and difficulties of service users are hardly something of which to make light.

Using humour as a therapeutic tool, then, is risky but we cannot be creative without being playful. As Weston (2007) observes, "creativity can require a certain kind of playfulness (...) but it does not mean just letting go" (p.3). Playfulness is part of creativity but it must be combined with discipline; to qualify as part of creative mental health care, the use of humour must be ethical and effective (Cropley, 2001).

Creative interventions

The list of creative techniques and interventions generated by respondents in Carson et al's (2003) study is interesting because many of them involve attempts to use techniques derived from the creative arts. These include role play, role reversal and psychodrama, drawing, collages, art therapy, stories, poems, films, songs, letter writing and narrative therapy. This suggests that the therapists surveyed strongly associated creativity with the arts. Andreasen and Ramchandran (2012) highlight the general tendency among lay people to associate creativity more with the arts than with the sciences while Schmid (2005) reminds us that connecting creativity solely with the arts may diminish its significant role in other activities. I would argue the association limits the possible meaning of creative mental health practice hence, in my book, I deal with applying concepts of creativity and incorporating creative arts as two distinct areas (Gillam, 2018).

Barriers to creative practice

The fourth aspect Carson et al (2003) investigated was perceived barriers to creative family therapy. As suggested above, these barriers – if they apply to family and marital therapists – are likely to apply just as much to mental health practitioners in general. The obstacles identified by the respondents were:

- **time constraints** – finding time to contemplate, learn and implement creative techniques and interventions;
- **client resistance** – a reluctance to take part in more creative tasks;
- **managed care** – duration and methods of therapy prescribed or mandated;
- **personal limitations of the therapist** – lack of confidence, inhibition.

Commenting on this, Carson et al. point out that if the therapist is inhibited about trying out a more creative approach, whether due to time or other constraints or their own self-doubt, then this is likely to lead to reluctance on the part of the client. Those of us who practice and supervise family work are familiar with the impact of therapists' inhibition on family engagement. The moral seems to be that, if we are convinced of the benefits of a more creative approach to mental health care, as practitioners we have to act as positive role models and offer creativity in such a way that it is likely to be embraced.

Conclusion

It is beyond the scope of this article to fully develop the model of creative mental health care alluded to but, hopefully, it has provided some insights into the connections between family work, creativity and wellbeing. Family life is central to the wellbeing of service users and carers and, indeed, to us all, and family work has the potential to enhance the wellbeing of practitioners through providing more opportunities for satisfying professional practice. Valuable lessons can be learnt about creative practice from family therapy research which can help us identify the characteristics of creative mental health care in practice. Family work can simultaneously facilitate flourishing in families and provide mental health practitioners with an opportunity to be more creative in their day-to-day work. Such everyday creativity is essential to the wellbeing of practitioners, services users and carers.

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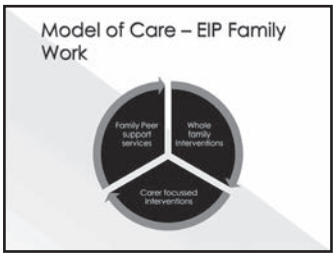
National Clinical Programme for Early Intervention in Psychosis Dublin, Republic of Ireland

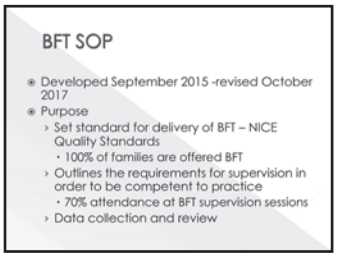
By Rhona Jennings
Programme Manager, Mental Health Clinical Programmes Clinical Strategy and Programmes Directorate, Health Service Executive

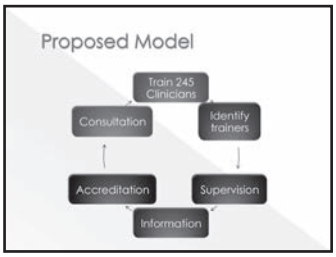
In October 2017, the National Clinical Programme for Early Intervention in Psychosis facilitated a one day conference entitled* Implementing Behavioural Family Therapy in Local Services – the opportunities and challenges in Ireland.** ***The conference brought together over 120 people including service users, family members, voluntary agencies, academic institutions and clinicians in mental health services to reflect on the achievements to date and look forward to developments in family work.

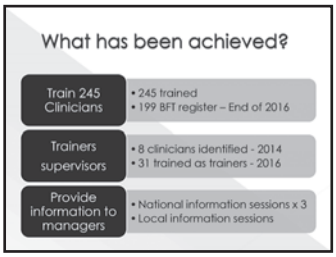
Behavioural Family Therapy (BFT) was first introduced in Ireland as part of this National Clinical Programme in 2012. At the end of 2016, 199 clinicians were registered as BFT clinicians from all services across the country. There were 29 BFT trainers/supervisors in place.

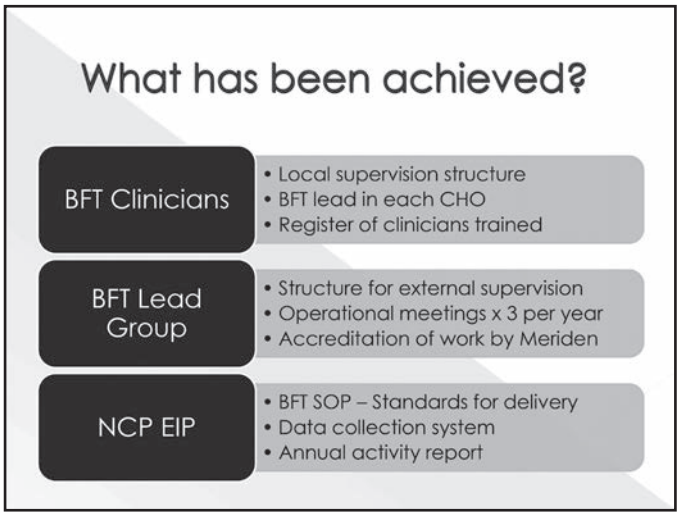
The conference partly was a celebration of the achievements to date and also to hear from families and service users who had engaged in the BFT process.











The conference was opened by Dr Philip Dodd, National Clinical Lead and Clinical Programme Advisor from the Health Service Executive (HSE). Dr Dodd is a member of the senior management team within the Mental Health Division (MHD) of the HSE. Mr Liam Hennessey, Head of Engagement within the MHD of the HSE, spoke about the role and function of his office, which was recently created.

This was followed by Ms. Rhona Jennings, Programme Manager who gave a review of the work planned and achieved over the previous five years.

Left to right: Rhona Jennings, Katherine Brown, Gráinne Fadden and Chris Mansell

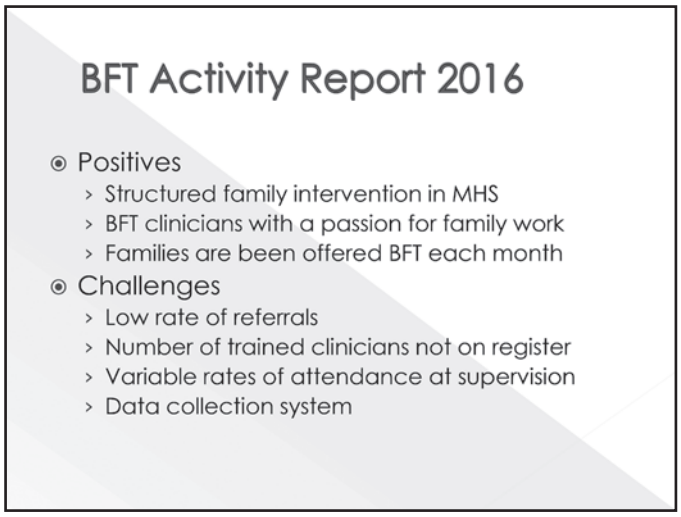
Sean Boland presenting on measurement of outcomes in BFT

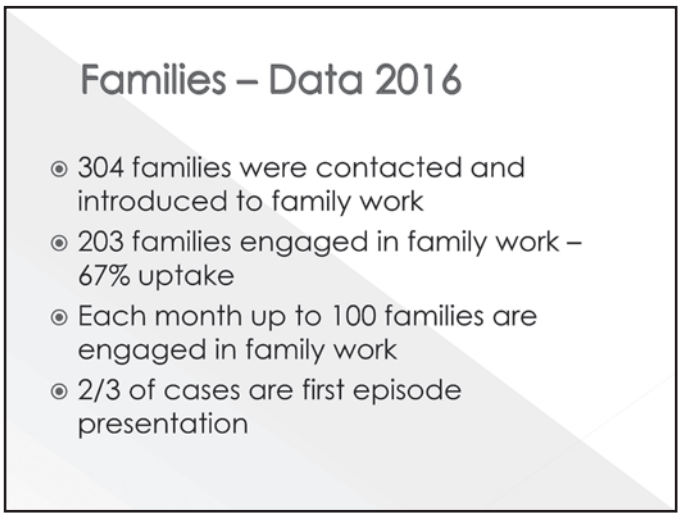
A key part of any reflection is to listen to those who have engaged with BFT. We heard from a family on this and they stressed the importance of clinicians not giving up and engaging with the family even when the first response may be to decline the offer of family work.

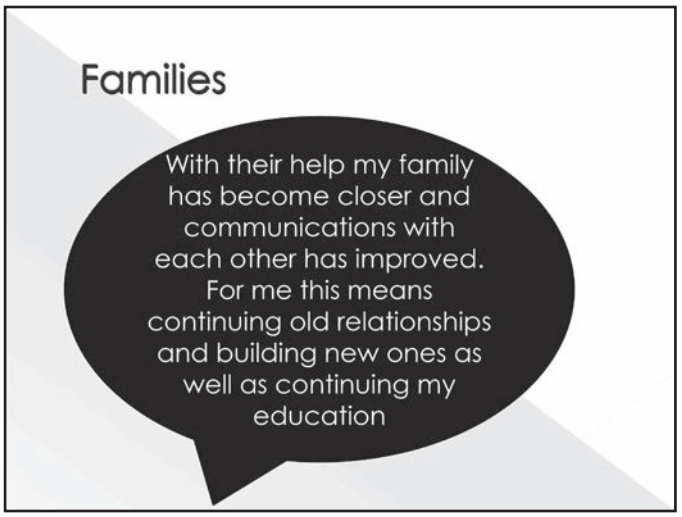
Left to right: Martina Kilcommins, Bridgeen McAlister and Chris Mansell

A service user spoke about her experience and how helpful the process was for her but also her family and their need to achieve gaols and understand what was happening and how they could help. This was a very moving session and reaffirmed the need to actively listen and also continue to develop BFT in clinical practice.

Dr Gráinne Fadden gave the key note address – **The importance of the family in mental health recovery – past and future**. She spoke on the history of family work and cast an eye on where this will take us into the future.







Tanya Harris presenting on the promotion of BFT along with Caroline Kavanagh (not pictured)

The afternoon session comprised of a series of short presentations from services across Ireland on relative peer support workers, promoting BFT in teams, measurement of outcomes and BFT in Child and Adolescent Services (CAMHS). Chris Mansell, Deputy Director from the Meriden Family Programme spoke on multicultural family work, an emerging challenge for services in Ireland.

In conclusion Dr Katherine Brown, National Clinical Lead for Early Intervention in Psychosis acknowledged that the day was an important celebration of the work achieved; it also set out some markers for the future and ways to overcome challenges to implementation in real life settings. She thanked clinicians for their contribution to getting this far and looked forward to conferences in the future.

Breege Moran presenting on BFT in CAMHS

Poster designed by Rowana Wood, Clinical Nurse Specialist, North Dublin Mental Health Services

Jackie Crowe – A Tribute

By Chris Mansell, Deputy Director, Meriden Family Programme

In October we were saddened to learn of the untimely death of Jackie Crowe from Victoria, Australia. Gráinne and I first met Jackie when we visited Ballarat Mental Health Services in Victoria to facilitate training in Behavioural Family Therapy (BFT) in 2006. Jackie took an active role in the training as a Carer Consultant. She was extremely generous with her experience to help facilitate other people's learning and development. I will always remember how welcome she made us feel and how she made sure we were well looked after, including bringing us hot cross buns from her husband's bakery.

Jackie trained in BFT and then travelled to the UK and completed our BFT Training Trainers and Supervisors course and participated in our International Family Work conference. Jackie was a wonderful advocate for families and carers and was instrumental in developing family sensitive practice in Ballarat, across the state of Victoria and country-wide in Australia. She held the role of Mental Health Commissioner from 2012 which involved her flying to Sydney and beyond for committee meetings. Jackie was a member of the Family Advisory Committee in Ararat for many years and facilitated a community based Mental Health Awareness Program. She also helped run the Regional Youth Advisory Network in Ballarat and other local towns.

Jackie will be greatly missed by all the people who knew her and our thoughts are with her husband, children, friends and colleagues at this very sad time.

MERIDEN
The Meriden Family Programme

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Meriden Family Programme 20th Anniversary

One Day Conference

Family Interventions in Mental Health – Future Directions

Wednesday 20 June 2018
Venue: Ramada Birmingham Solihull Hotel, The Square, Solihull, B91 3RF

Since 1998, the Meriden Family Programme has worked to improve services for families. To mark the Programme's 20th anniversary we are hosting a one-day conference exploring the challenges of family work implementation.

Come and join us to shape the future direction of services for families!

Confirmed Speakers

Dr Alison Brabban ▪ National Clinical Advisor for Severe Mental Illness (NHS England) ▪ ***The Future of Family Interventions in Mental Health***

Dr Frank Burbach ▪ Consultant Clinical Psychologist (Somerset Partnership NHS Foundation Trust) ▪ SW EIP Programme Lead (NHS England) ▪ Family Interventions Lead (University of Exeter) ▪ ***Integrating Behavioural and Systemic Approaches in a Service Context***

Dr Gráinne Fadden ▪ Director, Meriden Family Programme (Birmingham & Solihull Mental Health NHS Foundation Trust) ▪ **Twenty Years of the Meriden Family Programme**

Ms Rhona Jennings ▪ Programme Manager, Health Service Executive Mental Health Services, Republic of Ireland ▪ ***Implementing Behavioural Family Therapy in Ireland – The Opportunities and Challenges of Introducing a National Programme***

Mrs Shelagh Musgrave ▪ Carer Co-Chair, Recovery Programme Committee and Carer Experience Lead (Birmingham & Solihull Mental Health NHS Foundation Trust) ▪ ***Carers and co-production***

Prof Jo Smith ▪ Professor of Early Intervention and Psychosis (University of Worcester) ▪ ***Evidence for different modalities of family interventions***

Mr Peter Woodhams ▪ Carer Consultant, Meriden Family Programme (Birmingham & Solihull Mental Health NHS Foundation Trust) ▪ ***Reflections of a Carer Consultant***

BOOK YOUR PLACE NOW – DETAILED PROGRAMME TO FOLLOW

To register your interest or to book a place, please contact Sam Farooq:
Email: samfarooq@nhs.net Tel: 0121 301 2888

The cost of attending this one-day event is £125 (Limited free places are available for service users and carers)

Training Trainers Course – Autumn 2017

By Julia Danks, Clinical Specialist, Meriden Family Programme

In recent years the demand for places on our annual Training Trainers course has meant that we have been oversubscribed and have had to place people on a waiting list for the course in the following year. This year the team took the decision to run a second course in the Autumn to ease the pressure on the Spring 2018 course.

17 delegates from around the country met together for the week in October. The group included Nurses, Clinical Psychologists, Family Therapists and staff from Early Intervention teams.

Most were from NHS Trusts in England with one family work clinician attending from Hywel Dda University Health Board in Wales and another attending from 'Forward Thinking' in Birmingham – the organisation which now has the contract to provide Early Intervention Services from 0-25 years of age in Birmingham.

This is only the second time we have delivered two courses in one year. In 2015 we delivered a course in Dublin in Ireland as part of the family work implementation contract that we were rolling out across the country for the Health Service Executive in Ireland.

As usual most of the delegates stayed at the training venue during the week and this provided them with networking opportunities with others in the group.

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

'Very useful, increased my skills and knowledge of training.'

'Confidence has increased, feel able to deliver training and also how to manage difficult situations if they arise.'

'Supervision was also valuable.'

'Intense course with good outcomes – lots to learn but leaves you feeling more confident to deliver BFT.'

The Spring 2018 Training Trainers course is now full and is a very big course again, with 40 delegates attending. So, it looks like another course may take place later in the year – watch this space!

Delegates and trainers on the Autumn 2017 Training Trainers course

Developing Guidelines for Family Interventions

There is often a lack of clarity in services about what constitutes evidence-based family interventions; what they should consist of, and what approaches should be offered to families. A new group has been established which aims to develop guidelines on family interventions that are intended to be a support for practitioners and managers in services.

The guidelines will be published through the British Psychological Society (BPS) and supported by the Psychosis and Complex Mental Health Faculty of the BPS. The group is co-chaired by Jo Allen and Steven Livingstone, both of Kings College Hospital and has representatives with expertise in family work from across the UK.

The first scoping meeting of the guidelines group took place at the end of January 2018 in London. There was representation from across the country, and an extensive discussion of who the guidelines are for and what the content should be, as well as a time frame for writing, consultation and publication.

Please get in touch with either Jo Allen or Steven Livingstone (Co-Leads of the Family Intervention Network) if you would like to be part of the consultation process.

Jo Allen – jo.allen@slam.nhs.net
Steven Livingstone – Steven.livingtone@kcl.ac.uk

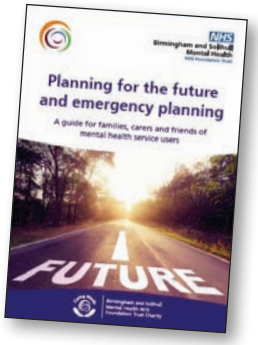
I heard a bird sing

You sang to me as I stepped outside
Into blue skies instead of grey
I know it was you, no other would it be
Just to say you are not far away
Your song was so pure it filled me with awe
That you can produce such a tone
Thank you for making me smile today
Just a song but for me pure joy.

A Carer

Planning for the Future

A guide for carers and families who are thinking about the future



By Peter Woodhams, Carer Consultant, Meriden Family Programme

Gordon Percival is a carer from Solihull who has realised for some years that there has been a gap in information and support available to carers and families who are looking to plan for the future in case there comes a time when they are unable to provide support for their relative with mental health difficulties. Whilst information is available it is not always easily found in one place.

For many years Gordon strove to find an organisation that he could work with in producing such guidance. Finally with the help of Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) and thanks to funding provided from the Trust's 'Caring Minds' Charity, the guidance booklet he initiated was finally published in 2017.

Gordon seated at the launch ceremony whilst Sandra is pictured second from the left

The guidance was developed by a working group set up and managed by Sandra Baker, Family and Carer Engagement Lead for BSMHFT and was led by carers and included representatives from Meriden, Stonham Mental Health Carer Support together with Carer Leads from within the Trust.

The booklet includes:

- How to start the planning process
- Help with planning
- Making financial plans
- Emergency planning
- Useful signposts and checklists

Planning for the Future has no age restriction. There is something in the booklet that may apply to carers of all ages from young carers to those who are caring for someone in their later years.

Well done to Gordon and Sandra and the working group members for producing this much needed free guidance bookle. Copies are available by emailing Evie Hogshaw at evie.hogshaw@nhs.net or by downloading it from the Trust website by logging to: **http://www.bsmhft.nhs.uk/service-user-and-carer/carers-families-and-friends/planning-for-the-future-and-emergency-planning/**

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