This DYSGU special edition is an opportunity for practitioners from the Family Intervention Team, Action for Children in Caerphilly to offer a window into their creative and rich Community of Practice. This collection of papers have been managed and brought to these pages by the energy and enthusiasm of guest Editors; Leah Salter and Julia Evans.
We are pleased and delighted that this group of practitioners have taken the time [*so precious these days*] and the effort to produce such a variety of gems for us to explore and digest.
This being the first special edition for DYSGU it is fitting that we have such an excellent collection of papers from one small but significant project many of whom are past, present or future students of the Family Institute.
This we hope, may stimulate others to think about collecting some colleagues together and taking advantage of this platform DYSGU to share, ideas, passions and practices which can enrich the practice of others. This also represents for the Family Institute a connection and collaboration with another Community of Practice. If you have felt inspired by this edition let us know, and we may find ourselves working on the 2nd special edition.

Enjoy

Billy Hardy & Kieran Vivian Byrne

This special edition of "Dysgu" has been edited by Leah Salter and Julia Evans with a lot of help from Sarah Holden (business support officer). Leah and Julia are part of the Family Intervention Team [FIT] and this collection of papers represents a rich tapestry of work that connects us to each other within the team, to The Family Institute and to a wider community of practice.
Leah completed her MSc in systemic family therapy at The Family Institute in 2009. Julia is in her final year of her training at The Institute as is Sarah Wheatcroft, another contributor to this collection. Elaine Simpson, the team manager has also completed a clinical supervisor's course at The Institute. Vicky James- Perkins, another contributor has just finished her Doctorate in Clinical Psychology with her thesis focusing on family therapists' experience of change which was in part supervised by Billy Hardy at The Institute.
Others in the team (Matthew Thomas, Jill Lubienski) are also current or past students at The Institute. The relationship with the Institute has developed over time, has been hugely valued, and forms part of the overall story of the FIT team.
This edition marks a period of transition within the team, with people moving on and changes taking place within the team, to which attention needs to be paid. The team's Clinical Psychologist, Dr Liz Richards has recently retired, Elaine has taken up a more senior position with Action for Children, and Leah is due to start a new job as a Systemic Psychotherapist for the States of Guernsey C.I. It felt timely therefore to capture the different components that have to date made up the FIT team, in preparation for any new developments that may come following this transition.
Hopefully, through these papers we have created a small window to the work of the Family Intervention Team and its Parent Therapist service.

Guest editors- Leah Salter and Julia Evans

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51.Title: Referrer perceptions of the Family Intervention Team

Jessica Williams

Abstract:

The aim of this paper is to present data from a service audit into the perceived success and effectiveness of the service by referrers and to reflect on the service's role within the provision of services for children and families in the Caerphilly County Borough.

58.Title: Three year post intervention follow up study of families referred to the Family Intervention Team- What are the outcomes and what makes the difference?

Jessica Williams

Abstract

The paper is focused on the perceived outcomes of clients using the Family Intervention Team, three years post-intervention. Semi- structured telephone interviews were conducted with a parent of a random sample of 15 children and young people referred to the service between three and four years prior to the point of interview.

67.Title: Drama as means to engage with children whose parents experience mental ill health

Leah Salter, Sarah Wheatcroft

Abstract

This paper follows the important phases in the development of practice of 2 therapists/ drama facilitators and the development of the young people taking part in a 10 week drama group. We follow the phases of the group, and of the group's shared learning, from the early joining phases, though the stages of engagement -taking part in drama games and exercises- through to the final performance.

Finding FIT- An exploration of what it means to be a team.

Leah Salter, Victoria James-Perkins and Jessica Williams

Leah is a systemic and family psychotherapist, working as a parent therapist within The Family Intervention Team. Victoria is a trainee clinical psychologist on the South Wales training course and worked within the Family Intervention Team as part of her elective placement.
Jessica held the position of Project Worker within the Family Intervention Team for 3 years until 2011. and is currently working as Assistant Clinical Psychologist at the Action for Children Skills for Living Project in Gwent.

With contributions from- Natalie Davies (project worker); Lisa Dennis (project worker; Julia Evans (practitioner/ therapist); Dr Liz Richards (clinical psychologist); Leah Salter (parent therapist); Mel Senior (project worker); Elaine Simpson (project manager); Matthew Thomas (project worker); Sarah Wheatcroft (practitioner/ therapist)

Abstract

This paper explores some key themes that emerged from conversations within a team, using a constructionist grounded theory approach to "talking with". We will offer some background to the team, how the team developed from it's early days to where it is at now; and what makes up "FIT- Family Intervention Team". We take an idea of team and explore it in more depth by talking with colleagues from within the team about how they perceive what they do, how they do it, and who they are. Through this exploration we used a loose structure of thinking about the levels of approach, method and technique (Burnham, 1992) to formulate 3 questions and to give some structure to the interviews. We then compiled and coded the response to our questions using a constructivist grounded theory approach (Charmaz, 2000, 2006), the process of which is paid due attention in the body of the paper. What the reader should get from this is a multi-voiced representation of what the team is all about, and how families may benefit from this approach.

Introduction

A constructivist grounded theory approach was adopted to undertake four planned group interviews, using a semi-structured interview. Interviewees were guided by 2 of the authors asking 3 key questions; *How do you understand what the team do? (level of approach); What ideas underpin what the team does? (level of method); and What are the interventions/techniques? (level of technique).* The questions were asked of nine current team members, grouped in to four groups, in relation to service specification. There are three services within the one team- Family Intervention Team, Parent Therapist Service and Inclusion and Support- Mental Health Family Support. The interviews were then coded and fed back to the team (triangulation process) to enable a second layer of conversation and meaning making. The paper is framed by an approach that is in line with an appreciative enquiry model. Appreciative inquiry is a form of action research that attempts to create or co-create new theories, ideas or images as part of a developmental change within a system.(Cooperrider & Srivastva, 1987).

The Background

The Family Intervention Team (FIT) has been operational in Caerphilly since 2004. Set up as a preventative, early intervention service for young people and children (age 5 to 14) and their families, where there are recently emerging emotional, behavioural or mental health issues, the team has developed it's own model of practice which this paper speaks to from relational (grounded theory) frame.
The team was established with funding from Wanless (preventative health funding) following the Wanless Report (2002) and the review of the original report (2004) which focussed particularly on prevention, the wider determinants of health and on the cost – effectiveness of action that can be taken to improve the health of the whole population and to reduce health inequalities. At a similar time a review of CAMHS services in Wales 2011 (Everybody's Business also highlighted the importance of early intervention and a family approach to mental health.

> *"Mental health problems and mental disorders in young people can devastate the lives of those affected and destroy the quality of life of those around them. Society pays a high price in terms of social disruption, education failure, ill health, anti-social behaviour and hard cash for failure to tackle these problems effectively."*
>
> *"Mental health promotion and prevention of problems and disorders are key to this approach because good mental health in children is a positive indicator of the future wellbeing of the adults they become."* (Everybody's Business 2001)

The team offers 12 week interventions for families who are experiencing emerging mental health needs or emotional/ behavioural difficulties with interventions that include solution focused therapy approaches, systemically informed practices, attachment theories, and behavioural techniques and methods.
The referral routes are varied with most coming from schools (education) or GPs (health). The team has the flexibility to work at times and locations that suit the families and benefit from having more time to give each individual family than is usually the case for social workers and health professionals (New Economics Foundation Report, 2009).
The overall objective is to provide an accessible service for children and their families, to offer a responsive and timely service, and to work within a model that "fits" within a timeframe of a 12 week intervention.

Families requiring longer term intervention would be viewed as more likely to meet the threshold for a CAMHS or psychology service; and be more likely to receive the appropriate service to their level of need from those existing sources.
From 2009 the service has also included a parent therapist who has been able to offer psychotherapy/ counselling to parents of the children referred to the service, as part of a mental health promotion frame. This post has been funded for 5 years by The Big Lottery. Since 2010 this service has also expanded to include a family therapy team and wellbeing groups for adults to support good mental health in Caerphilly.

In addition since 2011 the team also offers mental health family support as part of a wider "Team Around the Family" model within Caerphilly borough and this team's

remit also focuses on the impact of parental mental health on children/ young people and the wider family impact of child and adolescent mental health. The team focus on new and emerging difficulties.

This is the background to the development of the service and from this point on the paper will pay attention to the team's own ideas about what it is that we/ they do,. The paper will also speak to the process which captured that feedback.

Constructing meaning

In considering writing this paper a great deal of thought was put in to how this might look, who would write it and how it might stand as a marker in the evolution of the team. In wanting to capture an "essence" of the team, and also to (in some way) represent the ethos, it was decided by the authors that it needed to be grounded in the matter that makes up the team.
The most useful frame for this (that we had access to) was a constructivist grounded theory approach (Charmaz, 2000, 20006). This fitted with the team in that it pays attention to the richness of experience, and the relationship between the interviewer and interviewee. This has a correlation in terms of the teams' experience of working with families.
We consider that we are continuously in relation "with"- with each other (as colleagues), with families who are referred to us, and with the community in which we operate, in an eco-systemic way of being (Bronfenbrenner 1979). It is also important for a team grounded in systemic ideas to pay attention to the language we use when we make sense of the conversations we have- "the data", and for this reason, where possible we use direct quotes to represent what we think we have heard through the important conversations that took place.

Methodology: Constructivist Grounded Theory

A constructive Grounded Theory approach (Charmz, 2000, 2006) was drawn on to inform the methodology of this research. Informed by a social construction epistemology, this approach is developed from the established qualitative research methodology of grounded theory (Glaser & Strauss, 1969). In its application, grounded theory aims to identify themes from qualitative data in a clear and systematic way. Whilst early grounded theory was criticised for its positivist assumptions (Willig, 2008); that there was a *truth* to be *discovered* in the data, constructivist grounded theory offered an approach that was influenced by a social constructionist epistemology.
Continuing to adhere to the well-established grounded theory guidelines (Strauss & Corbin, 1997; Willig, 2008), constructionist grounded theory redefines the researcher as the *co-constructor* of experience and meaning. Mills *et al.,* (2006), and positions the researcher as an *author* of this co-construction.
This approach was understood to be consistent with the epistemological position of the therapeutic approach under examination, and also offered a method of enquiry that was understood to facilitate a deeper understanding of the issues being explored. This approach therefore understood that emerging meanings would be a *co-construction* of both the researchers and participants.

Semi-structured qualitative interviews were conducted with four components of the current FIT service; managers (n=2), family intervention team (n=3), inclusion and support (n=3), and the family therapy service (n=3). Interviews were conducted by the three authors individually and recorded using DVD equipment.
Each interview was 30 minutes in duration. Interview recordings were initially reviewed and annotated by two of the authors independently before then being drawn together and analysed by all three authors. Informed by principles of grounded theory, a process of 'coding' and 'categorisation' of the data was developed, using a 'constant comparative method' (Strauss & Corbin, 1997). This allowed for codes and categories to be constantly revised, so as to capture the richness of variation within each category, with the overall aim of progressing focus upon an emerging theory, grounded in the participants' experiences (Charmaz, 2006).

Evaluative guidelines were drawn on to ensure methodological vigour throughout the research process (Elliott *et al.,* 1999). Specifically, a number of methods were used to check the credibility of the data and initial interpretations made, including triangulation of data and multiple analysts. The process of triangulation was sought through the presentation of emergent categories to a sample of participants, so that feedback and verification could be obtained. Responses from participants of the first analysis were noted and integrated into the subsequent analysis and emergent theory, thus ensuring that the emergent theory was *grounded* in the data.
Researchers are required to specify their theoretical orientations and assumptions throughout the research process so to consider the ways in which they might have influenced the collection and analysis of the data (Elliott *et al.,* 1999). In response to this, the process of 'memo-writing' was drawn on, which forms a fundamental part of the analytical process in a *constructivist* grounded theory approach, where researchers consider their role in both the *co-construction* of the data, and also their *co-authoring* of what emerges. In addition to the above, supervision was accessed by the authors at various stages of the research process, as per the guidelines for good quality research (Elliott *et al.,* 1999).

Our approach/ Design

Through the process of undertaking the interviews a loose structure of thinking about the levels of approach, method and technique was utilised (Burnham, 1992) to formulate 3 questions and to give some structure to the interviews.

The three questions were:

1. How do you understand what the team do? (level of approach)
2. What ideas underpin what the team does? (level of approach)
3. What are the interventions/techniques? (level of approach)

The interviews were grouped for the purpose of capturing as many voices as possible within a limited time frame and were grouped within service design and delivery. Group 1- project supervisors; Group 2- parent therapist service, Group 3- inclusion and support service, Group 4- FIT project workers.

The interviews were recorded using video equipment and watched back subsequently to enable as much accuracy as possible in the coding process. The tapes were played back in 5 minute sections, notes taken and shared between the two "researchers", re-played back if required and then moved on to the next section.

As the interviews progressed themes emerged which led on to the process of "coding", to capture the essence of the responses from the team. The responses seemed to fit more "comfortably" with "Family, Intervention, Team" rather than "approach, method, technique" so this became the framework for the continued enquiry and the subsequent pulling together of data. These 3 themes were kept as headings to which the results speak.

Interview Results

Theme One: "The Family"

Within the frames of we were able to identify 3 sub-categories from the responses of the team. These included ""evolving idea of family systems", "engagement and collaborations" and "language/social construction".

Core Category One: 'Evolving idea of family systems'

All participants described a wide range of systems within which they worked, and how their understanding of 'systems' had developed over time. Whilst their early focus had been on working with the child, this had since developed to working with the family system as a whole; with the parent moving from the "*background*" to the "*foreground*"; and further still to include the wider system around a family. This reflects the principles of systems theory which understands events and occurrences not in isolation but as interrelated and interconnected with the context within which it occurs (Bateson, 1976). Within this broader perspective of family systems were participant's acknowledgements of the FIT within that system, reflecting a position of reflexivity (Palazzoli, *et al.,* 1978). The movement from first to second order cybernetics can be observed here in both the

idea of second order change and also the recognition of the therapist being part of that which is being observed (Jones, 1993). In this way the service provided by the FIT was understood to be "*holistic*" and "*multi/eco systemic*", where the family was understood within a rich context.

> *"Our work is underpinned by systemic ideas..."* (Parent Therapist).
>
> *"Thinking about change in the system is inseparable to what we do..."* (Manager).

Core Category Two: 'Engagement and Collaboration'

'Engagement' was identified as an integral part of working with, and "*getting alongside"* families, which was understood to occur within all contexts. The process of engagement was described as "*really listening*" to what families had to say, with "*unconditional positive regard"* (Rogers, 1961). 'Pace' was also identified as an important component within this process. Participants identified how, being non-statutory, they were able to take a different position to other agencies and work with families who wouldn't normally access mainstream services:

> *"We go to them".*
> *"We're really good at trust, they let us in"* (Project Worker).
> *"We are there because they want us there"* (Project Worker).

This alternative perspective extended beyond access of service, to the construction of the problem within the system (e.g. the perspective of the referrer), thus echoing Anderson & Goolishan's account of the 'problem-saturated' ways of talking within systems (1988). Collaboration was similarly identified by participants as an important part of their work with families*; "doing 'with', not 'to'",* thus echoing the theoretical underpinnings of Anderson and Goolishan's positioning of the therapist as 'collaborator' rather than 'expert' (1992).

Core Category Four: 'Language/Social Construction'

Participants identified language as a representation and construction of reality, reflecting a social constructionist epistemology (Gergen, 1985), constructed *within* relationships, and consists of multiple voices and perspectives (Rivett & Street, 2003). As such, participants described being particularly thoughtful about families' and their own use of language (for example, the language of diagnosis), as well as the stories that families present, which can be understood to be influenced by White and Epson's narrative therapy approaches (1990).
This consideration of the use of language within a system extended beyond that of families to other services also. Participants described the importance of "*meeting with*" the language that any system presented.

> *"It's a cross-fertilisation of language"* (practitioner/therapist).

Theme 2 –Intervention

Within the frame of intervention (which initially fitted most closely with the "technique" level) we were able to identify 3 sub-categories from the responses of the team. These were ""timely", "solution focused" and "specific interventions".

Core category One - "Timely"

"Timely" seemed to encompass considerable reflection on the "brief" nature of the intervention, the "pace" of the intervention, the "early" onset of intervention and the "intensity" of the intervention. So, for example it seemed important to those being interviewed that the service is identifiable as a "short term" intervention but within it that there is a sense of pace and momentum that the family "co-opt" in to, over the time of the intervention which then equips the family to "go on" after the intervention is over.

> *"(we are) looking to build momentum and then the family carry on. We are here for a short period of time to build enough momentum to enable families to do it."* (project worker)

Core category two- "solution focused"

"Solution-focused" emerged as its' own sub-category as more than just an intervention/ technique or model but as an approach. The team strongly identified with being "resilience and strengths based" rather than being "problem or deficit led", and there was value placed on a context of health promotion rather that about ill health.

> *"(at assessment) we are thinking 'what have we got here that we can build on?'"* (Service Manager)
>
> *"helping families to be in the driving seat"* (Project Worker)
>
> *"valuing what each member of the family brings"* (Project Worker)

This fits with the ethos of solution focused brief therapy, (De Shazer, 1988, 1991) but also with the team feeling a fit with the idea of being a" resilience" or "strengths based" approach which fits with the overall systemic ethos of the team. This also fits well with the underlying principle of the original Wanless Report (2002) and the review that followed in 2004.

> *"Our health services must evolve from dealing with acute problems through more effective control of chronic conditions to promoting the maintenance of good health."* (Wanless review, 2004)

Core category three – "techniques/ interventions"

When coding the question that speaks to "technique" or "intervention", there was (as expected) a list of "things we do" and/or "resources we utilise to do what we do", and the list was comprehensive. This fits well under an eco-systemic umbrella where

workers are responding to individual need, by carefully selecting an appropriate way to engage with children and families and to encourage positive outcomes; whilst being flexible to the ever changing needs of individuals, families, and communities. (Bronfenbrenner,1979).
Some of the key "methods" of doing what we do include a list of service provision- individual work, family work, family therapy clinic, wellbeing groups, schools counselling. It also included a list of evidence based interventions such as solution focused brief therapy (SFBT) (De Shazer, 1988, 1991; O'Hanlon et al, 1989), cognitive behavioural therapy (CBT) (Beck, 1979; Lazarus, 1971), positive parenting (Solihull Approach, (1996); Webster Stratton, (2005); Triple P programme (2008); mindfulness (Mark Williams, Jon Kabat-Zinn, 2007).

More specific interventions were also noted in relation to family therapy which included the "Milan model" (Palazzoli et al 1978), narrative therapy and the importance of witnessing stories to encourage re-storying or re-authoring of people's lives (Michel White, 1990), non-violent resistance (NVR) (Omer, 2004; Jakob, 2011) as a response to family violence (also fits well under a multi-systemic approach) managing safety (Goldner, 1990) and supporting relational responsibility (Jenkins, 1990) in response to intimate partner violence.

Other words in the list referred more to the approach as well as at a technique level, for example being "creative, "using play", "arts and crafts" and being informed by theory such as attachment theory (Bowlby, 1951) and attachment therapy (Hughes, 2007) and using a psycho-social model (Erikson, 1950), using psycho-education (particularly in relation to wellbeing groups).
Underlying this was a firm idea that "how we do it" is as important as "what we do", and that techniques need to be selected with thought, clarity and also with flexibility.

> *"sometimes it's taking bits from all of it, and customising it for the family"* (Project Worker)
>
> *"It's not a factory line of psychological interventions. I hold an idea of where (the intervention) comes from, and where I am going with it."* (Project Worker)
>
> *"the project workers are extremely creative in how they work, but it is underpinned by evidence base"* (Clinical Psychologist)

Theme Three- Team

Three core subthemes emerged from the data which fit the broader theme of 'Team'. These were: "Team approach", "process and structure" and "professionalism".

Core category One- "Team Approach"

All participants spoke to the idea of a team approach in their work with families. *Practicing 'not as an isolated practitioner but as part of a wider team'* emerged as a key ingredient of the FIT model which reflects the 'more heads are better than one' philosophy posited by McGregore et al (1964). It was seen as particularly important that

this team were *'multi-disciplinary'* in nature with a '*happy marriage between disciplines'* identified as significant to the functioning of the team as a whole.

> *"Different skills mix of psychology and family therapy means that the work speaks to both models. It's a 2 edged sword idea- same implement but different uses."* (Project Worker)

It was also suggested, however that the fact that this sense of multi-disciplinary was not manufactured was an important detail and that the 'idea of growing as a team' was valued. It seems then, that the natural evolution of a team with individuals from diverse backgrounds rather than, what participants described as, a prescriptive approach to the team make-up is seen as important.

The idea that 'multiple is key' was linked to a '*reflecting team approach'*. The work of Tom Anderson (1987) underpins this approach to utilising the team and participants elaborated on this theme to discuss the reflecting team as a way of taking multiple-perspectives towards an '*emerging understanding*'. This fits with the whole team, using layers of supervision (both live and retrospective) and joint assessments as well as with the family therapy team, working together as a team in each session.

> *"It's useful to have someone else to offer a broader perspective, to stand back a bit and re-appraise."* (Clinical Psychologist)

The idea of '*difference'* was also identified as part of this approach, both in terms of valuing difference within the team and noticing difference between FIT and other teams. It seems that this idea of difference may be important to the team identity. Participants identified the concept of '*team mind'* and spoke of '*holding the team in their head'* whilst working individually with families. This is consistent with the work of Matteo and Mara Selvini (1991) who spoke of 'collective mind' in relation to ideas of team. Matteo and Mara Selvini also spoke of the need for the team to value one another, a theme which was echoed by participants.
This was best conceptualised as a 'team ethos' which encapsulated the importance of support within the team, and the sense of both a valuing of self and a valuing of team simultaneously. The benefits of a team approach to working with issues of safety were also highly regarded by participants.

"It makes what we do safe. An individual worker is held by the team. It helps families feel safe" (Project Worker)

'Strong ideas' within the team about working with violence and child protection were identified by participants and the idea of '*being held'* by he team was important. The team also highlighted the importance of being '*unique, yet part of a whole'* with the metaphor of individuals as separate parts of the body and the team as the body as a whole. This gives the sense that no individual part can function to full potential without

forming part of the whole and is reminiscent of ideas of 'the whole is greater than the sum of its parts' first discussed by Aristotle.

> *"A team approach echoes through everything"* (Project Worker)
>
> *"I really value what I do and that I am valued"* (Project Worker)
>
> *"We're the team together when we're with families"* (Project Worker)

Core Category Two- Structure and Process

Many ideas emerged relating to structure and process around the team. Central to this seemed to be the notion that FIT was *'structured yet flexible'*, allowing for *'clarity'* and *'focus'* as well as '*fluidity'* and *'openness'*. Participants identified that they felt FIT avoided being *'pigeon holed'* and was *'not wedded to any one approach'* whist still being '*underpinned by an evidence base'.* This speaks to ideas of structure in Integrative Psychotherapy models and Beutler's (1999) ideas of 'manualising flexibility' which suggest combining the benefits of flexible approaches with the benefits of more structured manualised approaches. Participants echoed this theme in terms of referral pathways.

> *"The team have a good sense of their remit, of what they can and can't do (within the time limit) and clear boundaries about how they do it."* (Project Manager)
>
> *"we are always looking to do things better (and).. be creative."* (Project Manager)

Clarity around referral criteria was identified as important for providing a remit and ensuring focus however it also emerged that the *'team are not organised by this'.* The process of assessment, formulation and mid and end review through the course of an intervention with a family was also identified as a key part of how the team works. Balanced with this was the idea of an *'open door'* for families into the team, and an '*open door'* for colleagues to talk with one another and the supervision structure..
Time dedicated to a space for team meetings emerged as an integral part also. Participants were clear that time was prioritised for team meetings and that they were a valued part of the structure around the team. In addition to diarised team meetings it also became apparent that '*softer*' processes within the team such as having lunch together were also important to its functioning.

Supervision emerged as a dominant idea related to structure and process. All participants placed a high value on the availability of a range of supervision opportunities within the team. This included management or organisational supervision as well as clinical supervision and peer supervision.

> *"Supervision must enable and support workers to build effective professional relationships, develop good practice, and exercise both professional judgement and discretion in decision-making.... Supervision should improve the quality of practice, support the development of integrated working and ensure continuing professional development. ...It is therefore at the core of individual and group continuing professional development".* (Skills for Care 2007)

As with team meetings the idea of valuing and protecting time for supervision emerged and supervision was also described as consistent. The idea of both *'live'* and '*retrospective'* supervision was identified within the context of the family therapy clinic. Ideas of the need for informality at times were also discussed in terms of opportunities for informal supervision within the team.

> *"Supervision is embedded in everything the team does."* (Project Worker)

> *"The model is one of disseminating skills to project workers and maintaining close supervision. It's a cascading effect."* (Clinical Psychologist)

Core category Three- "Professionalism"

All participants spoke to the value of the '*skill base'* each individual brought to the team from their professional background. In part this reiterates the ideas of multi-disciplinary working discussed earlier but goes further with the suggestion that the team '*work to individuals' own strengths rather than to a model*'. This is consistent with Selvini and Selvini- Palazzoli's (1991) view that teams function at their best when individuals have space to develop their personal style. Participants identified the '*sense of safety working with their strengths in the team'* created whilst highlighting the team's '*ability to question models and continue to look for ways to do better'*.
A value base of commitment to ethical practice and striving for excellence emerged with the idea that the team is '*forward thinking'* and '*continuously evolving'*. The team is seen has highly skilled, qualified and experienced with continued professional development integral to this value base. Participants identified that the team had all undertaken a level of systemic training and so it seems that although individual skills are valued, shared, team skills also form part of the model.

> *"It's a professional outfit, and the expectations are quite high"* (Project Manager)

Discussion

The format of the interviews enabled the authors to be part of meaningful conversations with colleagues from within the team and the results of those conversations, as discussed in the results, suggest a richness to practice that speaks both to development and to experience. Therefore though this is an established team, it is also a team that is innovative and positions itself positively in relation to change and development.

It is also suggestive of a service that has a strong identity as a team, and that the very essence of the word "team" is multi-dimensional and grounded in relationship beyond the linguistic domain. This could also be said for other key words such as "systemic", "supervision", "intervention", "family", "engagement" to name a few. Much more could be said about linguistics and the wider theme of social constructionism, more than the structure of this paper allows, but the use of language and the team's relationship to language/ the meaning of language could have been a theme in and of itself.

Conclusions

This paper has followed three authors attempts at utilising a grounded theory approach to have meaningful conversations with colleagues within a team with which the authors are connected. The use of the method (constructivist grounded theory) has enable the authors to continuously check out their own positions and ground the data back in to the relationship between the authors and their colleagues and the relationship between the words and the people saying them.

From the results (or more accurately the responses) drawn out from interview some dominant themes emerged. These were- "Family", "Intervention" and "Team", within those three broad themes three sub groups were identified in each theme. Under family the sub groups were "evolving ideas of family systems", "engagement and collaboration", and "language/ social construction". Under "intervention" came "timely, "solution focused" and "specific interventions". Under "Team" were "team approach", "process and structure" and "professionalism." The coding process supported the complexity of the conversations and captured the richness of the narratives that were recorded using video equipment.

The primary conclusion that can be drawn from the interview process is that the team has a strong identity, grounded in ideas of team, systems thinking and evidence based interventions. The values that can be drawn out from the data include ideas of "working with" as opposed to "doing to", recognition of strengths and resilience factors that are already present and engaging with families to bring about change. These ideas were dominant throughout the interviews and speak to a coherence that the interviewers were struck by when talking with this team about who they are and what they do.

Recommendations

This paper and the interview process fits with a number of evaluation and audit processes that the team have undertaken in the years that they have been working with families. The authors would recommend that further audit of what the team does, alongside audit of the outcomes that are achieved (a critical factor) would provide a more comprehensive view of the effectiveness of the service. This alongside previous reports (NEF report 2009) that highlight the cost effectiveness and social return this team provides would form a robust platform for the service to develop.

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A small scale audit of satisfaction with a Parent Therapist service: The Caerphilly Model

Julia Evans, Leah Salter, Billy Hardy

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Introduction

This paper offers a discussion of a small scale audit of the parent therapist service's "family therapy" provision as one intervention in the range of options open to the clientele of this service. The parent therapist provision is the only such service in the 3rd sector providing services to both adults & families but placed within a children's service context.

The audit took place in May 2011 and involved a telephone survey of clients who used the services of a therapist over the previous year (June 2010- May 2011). The audit involved 20% (n10) of the service users who used the therapy offered within this timeframe. The audit suggests high level satisfaction with the services offered and provides a platform for further investigation of the appropriateness and effectiveness of the parent therapist service.

Background

The parent therapist service sits within The Family Intervention Team in South Wales (an Action For Children Project), set up to support emotional wellbeing in children and families.

The post of "parent therapist" is funded by the Big Lottery, to offer counselling and psychotherapy to parents. The service developed from identification of a gap in service need highlighted by the team in previous research and service audit. (NEF report, 2009)This is the first of this kind in the organisation and in this part of South Wales and as such is an innovative addition to the pre-existing services on offer from an established team. This paper presents some feedback from clients from an audit of views about the services and was undertaken during the summer of 2011.

The Family Intervention Team

The Family Intervention Team (FIT) has been running in Caerphilly since 2005. It was set up as a preventative, early intervention service for young people and children (from age 5 to 14) and their families, where there is recently emerging emotional, behavioural or mental health issues.

The team works on the basis of brief, intensive interventions, usually limited to 12 weeks. The ideas which support the interventions include solution focused therapy approaches, systemically informed practices, attachment theories, and behavioural techniques and methods.

The referral routes are varied with most coming from schools or GPs. The team has the flexibility to work at times and locations that suit the families and benefit from having more time to give each individual family than is usually the case for social workers and health professionals. (NEF Report, 2009)

The overall objective is to provide an accessible service for children and their families, to offer a responsive and timely service to families, and to work within a model that "fits" within a timeframe of a 12 week (early) intervention.

Families requiring longer term intervention would be viewed as more likely to meet the threshold for a CAMHS or psychology service; and be more likely to receive the appropriate service to their level of need from those existing sources.
All the practitioners have had formal training in brief solution focused techniques and further enhanced with systemically oriented skills development in assessment, team working, reflecting team approaches , life cycle approaches. There has been ongoing skills-based team development programme created and designed by the Team Manager.
The markers of success for this service are based on several ideas. However, the most significant is that of social return theory. Most services espousing an early intervention ethos would be operating out of an idea that prevention is better than cure. This team also operates out of that ethos.
This team have a strong driver toward the social return theory in social and economic terms. The evaluation by NEF in 2009 highlighted the success of this team in using this predictive modelling of social return; the area for prediction fall into broad categories such as: *NEET, Obesity, crime, teenage births, substance misuse, mental health problems[psychopathology] domestic violence, child abuse and neglect* and *wellbeing*.
This fits with a social pedagogical approach consistent with a European wide position which includes the following principles of *whole child thinking ,body, mind, feeling spirit and creativity* with the main ingredients are *feeling good about self, my inner resources, doing well and the context of relationships* an important intervention in the community. *This is further elaborated in the European social survey and includes the following specific domains of emotional well being, satisfying life vitality resilience and self esteem positive functioning, supportive relationships and trust and belonging* NEF [2009]
It is estimated that by using this formula the "Caerphilly model" can save the Local Authority funds and target services to more effective and sustainable processes for change and stability. It is estimated using the model that for every £1 invested in this team alone generates £7.60 worth of benefits to society [social value].

Parent Therapist Service

The parent therapist service offers a range of therapy services which includes a family therapy clinic. The "family therapy" service was established in 2011. Initially it was one full time systemic psychotherapist, but now the parent therapist service includes 1 full time psychotherapist and 2 part time therapists. Collectively they offer a therapy service to parents who have identified mental health needs (with or without a diagnosis) and/ or parents who feel that therapy would be useful for them.

The service is also a resource for systemic consultation and therefore project workers meeting with children and their families have access to consultation; liaising with other professionals in both contexts of adult and child mental health.
The parent therapist service has the flexibility to continue to meet with parents/ a family beyond the 12 weeks if that is best suited to the families they are working with. This however is considered by the whole service and not an ad –hoc event as the measure for funding have to be adhered to.

The audit process.

This audit of satisfaction was conducted by a short telephone interview. We asked 10 service users who had accessed individual, couple or family therapy from within the service. It was decided to use telephone follow up as it presented a reliable and relatively easy way of gaining feedback, and also was felt that there would be greater "return" than by using a traditional feedback form.

A member of the team (not the therapist who had seen the clients) telephoned all service users who had received therapy over the previous 12 months. (June 2010 – May 2011).

Most of the clients we were able to contact (some had changed numbers or were no longer contactable) were prepared to take part in the audit. It is recognised that the world of satisfaction surveying is contentious and discussed by many in the field and across different contexts of care provision such as: Lasek, [1997] Williams [2009] and Gribble, R K. Haupt, C [2005].

All of the feedback here is subjective and therefore should be treated with caution in terms of how it may or may not influence service quality and provision. As a service though there is a limit on both time and resources to elaborate on further tests of the client position. Therefore the team took the position that the clients' comments and meaning placed upon that is the best reflector of satisfaction of service at this time. It is also important to be aware that this audit is only specific, relevant and local to this therapist in this context and in this frame.

Design

This audit was designed to gather initial feedback which would touch on the following areas-

The therapeutic relationship
Goals and topics within therapy
Effectiveness toward helpful change
Confidence and self esteem
Family relationships and levels of stability
Method and approach of therapist
Mental health and well being

Themes

The key element in therapeutic relationships

We chose these areas as they seemed to be most important for audit of feedback , they are key areas of enquiry for evaluation of therapeutic services. In this new service and, in the wider context of therapeutic practice the broad thematic approach touched on not only the clients goals within therapy but the relationship to and with the therapist. It also touched on the wider context of family life, given it was a family intervention team service based on early intervention approach.

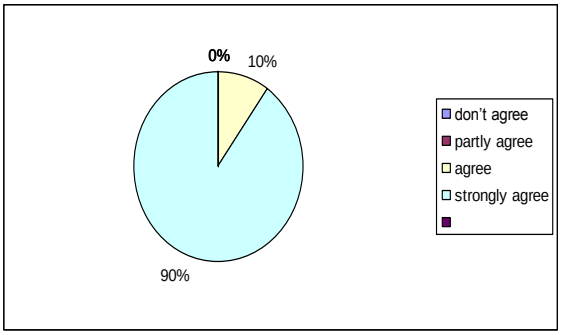
The following is a distillation of feedback for this audit and hopefully provides a flavour of the work being undertaken within the service.

Therapy Relationship

1. *I felt heard, understood and respected-*

Overall 100% found this to be true and below are some of the words expressed by clients following family therapy.

90% Strongly Agreed 10 % Agreed



Feedback relating to family therapy

- *"It was helpful to talk to somebody without a clipboard and a pen and to have the feedback from the 2 other people behind the screen who were able to give ideas and were able to think differently."*

- *"It didn't feel set up, it felt quite natural. It didn't feel like there were people eavesdropping. The most useful part was the mirrored glass."*

- *"We were each battling with our own emotions It gave them (children) a chance to speak, it gave them space and time to talk. It wasn't rushed and was at a good pace for the children."*

- *"Since family therapy I have been able to talk to my mum and tell her how I was feeling and why I had stayed in a relationship where there had been domestic violence. She had never understood why I had gone back and now I think she understands the control he had over me."*

- *"Family therapy changed so much for us. I was nervous but it opened other possibilities and unlocked some understanding for the way forward for us. The 4 sessions changed my life and changed how I didn't think that things could be improved."*

Focusing on the definition of the problem

It could be argued that a key element of successful therapy in any modality is defining what is the "problem" is and what to do about it. The clear explicit therapeutic agenda would be a good aide to successful outcome for therapy. Where it is defined by the client the chances of success are greater Selekman [2007], De Shazer (1991) Anderson H, Goolishian.H [1988] Stoolmiller, M Duncan, T Bank, L Patterson, G R.[1993] White [2007],Ray and Keeney[1993]

With this in mind we noted that 100% of the clients reported that the therapist focused on the important issues for them, with 80% strongly agreeing.

Goals / Topics

One of the central questions for any therapist is often

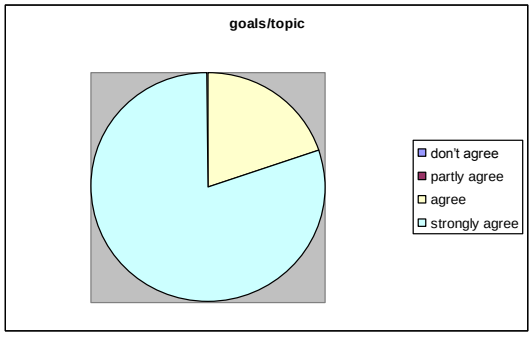
"Am I effective in what I do?".

It seems that this question is the primary preoccupation of many studies such as, Cottrell & Boston [2002] Kraus et al [2011] to highlight a few in the field. This team is also interested in this question, significant within a developing service. In this instance 100% of clients expressed satisfaction with the effectiveness of the therapy.

80% strongly agreed that the service was effective.

2. We worked on issues that were important to me.

80% Strongly Agreed 20% Agreed

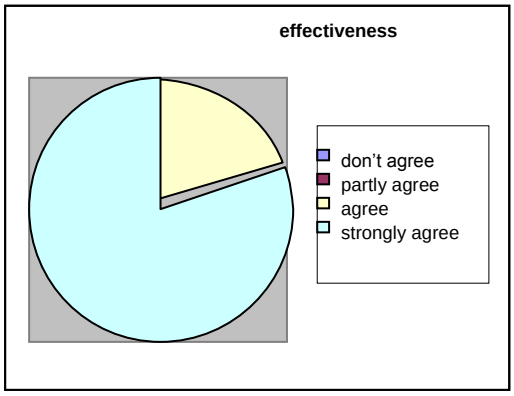


- *"(The therapist) let us guide our own therapy."*

Working closely with the client.

3. The therapist helped me achieve change.

80% Strongly Agree 20% Agree



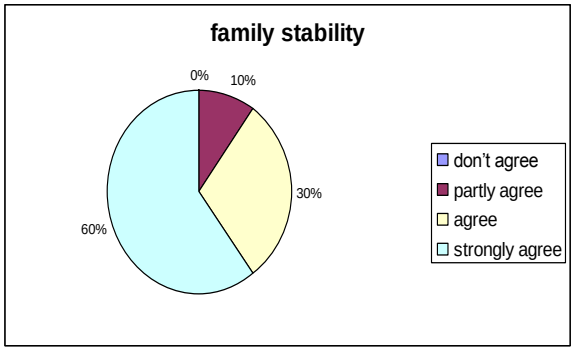
- *"sic: I go out more. I use tactics that (the therapist) has taught me."*

The wider constellation of relationships

It interesting that when someone engages in therapy we might ask how is it impacting on others family members or kinship groups. Here 90% suggested that family life was more stable.

4. Family life feels more stable

60% strongly agreed 30% agreed 10% partly agreed



Here we captured some of the words of participants.

- *"....Without looking after myself I couldn't look after a small child. Having help has made me able to get in contact with the right people."*
- *"My partner was able to get something out about how I was feeling at the time."*
- *"Sometimes parents are forgotten and it is good to have a service for them. It means that a parent's instability isn't then causing a child's instability. My children are more confident now."*

- *"I have had problems since the service has ended and (my son) is now living with my mum. But my relationship with him is more understanding, and he knows I am not well. It has helped me to make the choice for him without it being forced on us, which I think will be better for him."*

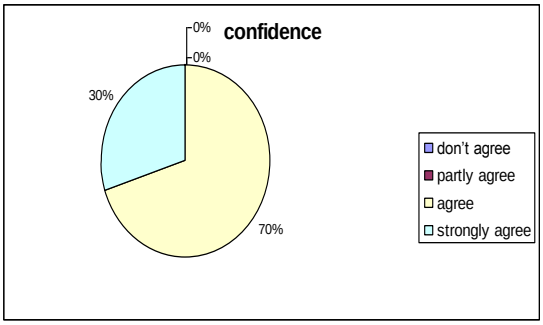
The self of the client

The self of the individual in therapy can sometimes be overlooked in favour of the wider family dynamics. We asked our clients to comment on their own self confidence.

Confidence Self esteem

5. *I feel more confident in myself.*

30% **Strongly Agreed** 70% **Agreed**



Here a 100% feedback of increase in levels of self confidence is captured by the above graph and the words of the clientele.

- *".....I have been more confident in myself and have been less unsure of myself and more confident about my decisions".*

- *"I am out and about now. I do still doubt myself though."*

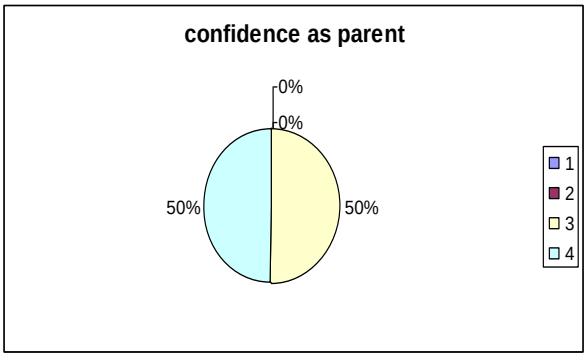
COMPETENCE AND CONFIDENCE AS A PARENT

As a service the team's approach is to work with the whole family and, indeed many of the interventions are focused on working with parents or significant adults in the child's life. We do not offer parenting interventions and the role of parent therapist is clearly defined as being a therapist FOR parents, however our hypothesis is and experience suggests that allowing parent's space to talk about their own experiences enables an in increase in perceived competence as a parent to emerge. When asking about confidence in parenting we had the following feedback.

Confidence as a parent.

6. *I feel more confident as a parent.*

50%Strongly Agreed 50% Agreed



- *"It was the first time I was able to talk about me."*
- *"Over time I have been able to recognise that I have a problem and I had forgotten to look after myself..... "*

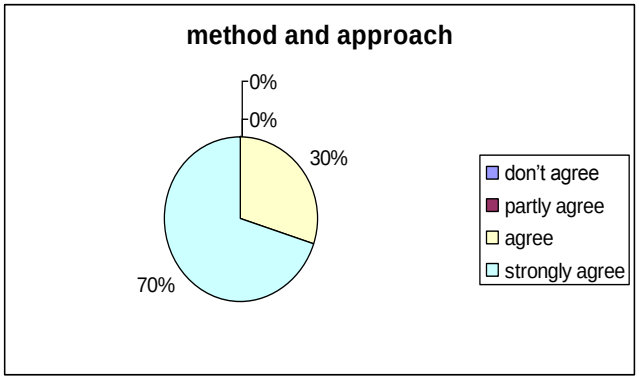
Is the model the best fit?

Therapists within the team are constantly asking themselves how this is useful for the families and to try to respond to the feedback received. It is important to connect with families and not set them up to fail therapy models which do not fit for how they see the world or want to work within. Here the feedback suggests that 100% of respondents felt that the therapist's approach was a good fit for them. The client's words below speak in to the method used, the personal traits of the therapist and the relationship between therapist and client.

Method approach

7. *The therapist's approach was a good fit for me.*

70% Strongly Agree 30% Agree



- *"She (the therapist) was very receptive, she respected people's space."*

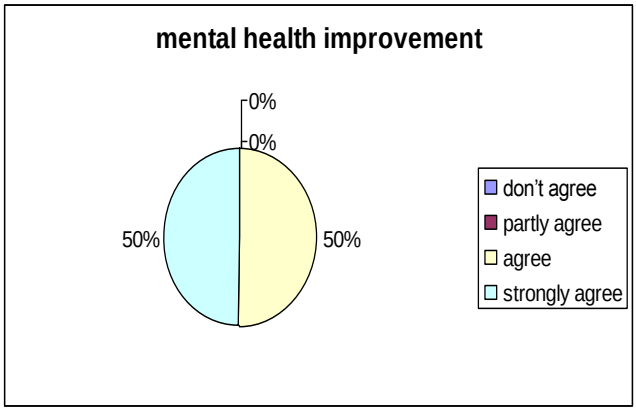
- *"She got me straight away."*
- *"(The therapist) was very calm and understanding and the relationship and rapport made it possible for me to accept some of the things I felt threatened by."*
- *"There was nothing judging about (parent therapist/ project worker)"*
- *"Before the family therapy I have been worried about accessing services – It has been the best thing that has ever happened."*
- *"I would definitely recommend it, even if you have had a bad experience with mental health services."*

The question of well being

Asking a question about mental health is consistent with the team's focus on six key service pathways *link up and link in, think family, promote the positive, encourage action, factor in fun, recognise the child's wider world (NEF report 2009).* This approach is also consistent with the ethos of the ideas surrounding training and interventions offered within the wider of context of mental health.
It is also important to draw the distinction that we are talking about mental health, not about mental ill health or mental illness. This team operates with a mental health promotion frame, not within the frame of psychiatry and diagnosis.
Below is represented feedback from service users about their perceptions of their own mental health. 100% of respondents felt there was an improvement in mental health, with 50% strongly agreeing. The comments below speak in to perceptions of "coping" and the impact on everyday life.

Mental Health

8. My Mental health has improved.
50% **Strongly Agreed** 50%**Agreed**



- *"I took the children to school on my own (sic: for the first time). I breathed and went through what I talked through with (therapist)."*

- *"I have coped better with everything and I have been medication free since October..."*

Conclusions

We wish to be cautious about drawing too many conclusions from this small scale audit. In a context were 54 families used the service, 20 were contacted and 10 agreed to participate there needs to be a recognition that this is a *representation* of feedback. However the feedback does indicate that further enquiry on a larger scale involving more service users would be useful to establish a more comprehensive evaluation. Taking this position though there could be a danger that this rich feedback is minimised or undervalued which is not the intention of the authors. The suggestion here is that the themes that have emerged from this audit will be very useful to the development of the service.

The overall themes generated from the clients have touched on the bigger questions about how therapy is useful and effective. In this service family therapy is offered as a primary intervention, and it is possible to draw some conclusions thus far that the clients of this service have found it useful in helping solve problems and that the therapist and team are beginning to find a good fit for their clients with the model and method practiced. It has also shown the potential for client's mental health and wellbeing to be enhanced and that this can, in turn, can have a positive impact on family relationships. It also touches on the edges of the SROI (social return on investment) approach where wider, sometimes unintended outcomes can be highlighted and appreciated to inform providers and commissioners about what matters. This approach also importantly supports family wellbeing which is a primary goal of this service, and one that is less widely researched.

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Parent therapy to family therapy- Setting up a third sector family therapy provision.

Leah Salter

Leah is a systemic psychotherapist employed by Action For Children as a parent therapist. Based in The Family Intervention Team, in Caerphilly, Leah works with an established team who work systemically with children and their families offering brief, early interventions.

Introduction

This paper highlights some important phases in the setting up of a family therapy team within a third sector setting. It pays attention to the practical steps from designing the space, through to creating the right setting within the room; and pays due attention to the crucial elements of gathering and becoming a team. With references to the Milan model of therapy and the wider systemic field the author also shares her own influences and specific contexts for practice.

Background

From the beginning...

Leah took up the post of parent therapist in June 2009, a post funded by The Big Lottery Fund to support the mental health needs of parents. Initially this one post represented an entire service for parents and was focused on individual therapy with the understanding that this could broaden as the service developed, and in line with the therapist's skills/ experience.

As with most developments within the ever changing voluntary sector this was rapid and responsive. The opportunity arose for such development in March 2010 when organisations within Caerphilly were invited to apply for small amounts of funding with the caveat that it should be spent by the end of March.

This brought with it an ideal opportunity to buy a screen, and all the technical equipment that would enable the service to set up a family therapy team.
With an immovable deadline for the work to be done this pushed forward a development that had already been on the agenda since the parent therapist service came to fruition, the setting up of a team, to support the work that was already underway with the "lone" parent therapist.

The practicalities

There were a few "technical" obstacles to overcome such as making a room fit for purpose, buying the appropriate equipment (all to be purchased with lightening speed to fit with the funding) and gathering a team together, but this was (relatively) easily overcome. A local builder was hired, turning 1 room in to 2, using a partition wall and 1 way mirror, and a technician was found. He gave us the capacity to hear and see what was going on in the new room by placing microphones on the ceiling, fitting a rotating camera, a phone system and all the paraphernalia that enabled us to use such equipment.

We opted for discreet button microphones located in the ceiling of the newly divided room which pick up optimal sound without being intrusive for families. Also a moving camera in one corner of the room that is able to capture most of the space (and hence any movement) within the room. In addition we opted to have the capacity to record the sessions by having a DVD player/ recorder in the viewing room. This is not used routinely, but is useful to have for training/ development/ evaluation purposes (with the consent of families) and also can be used to record sessions and give back to families as a record of their sessions. This is mostly how we use it. We also had a intercom installed to allow the therapist either side of the screen to communicate with each other through the sessions.
We also purchased comfortable chairs, cushions and rugs to provide a therapeutic environment for people to feel relaxed and comfortable in. As we work with individuals as well as large families (the largest family to date has been 2 parents and 8 children) the room needs to be adaptable to seat enough people but not feel like an empty space if you are meeting on a one-to-one basis.
By the beginning of April 2010 this was all in situ and the room was officially fit for purpose.

Now we were ready to consider what a family therapy team would look like within this context.
As earlier papers would suggest there was already a culture within our project (hugely supported by a project manager who is also a systemic psychotherapist) that would support a team approach to therapy. This was one hurdle that we did not need to overcome, and cannot be under-estimated as a grounding for beginning the important work of establishing a team within a team.
However, this still had to be negotiated with sensitivity towards existing, very skilled staff and with sensitivity towards other services within the borough that may get shaken by this development, and the questions it may highlight.

The context

It may be useful then to consider the context in which this development took place.
On a wider level, the Family Intervention Team sits within a national organisation that is a children's charity- Action for Children. Therefore although the team was set up to respond to the local needs of families within the Caerphilly Borough, the system that the team is part of, in a wider sense, is an organisation that has developed over hundreds of years to respond to the needs of children in the United Kingdom.

However there is also a need for national organisations to respond at a local level and to diversify to meet the needs of communities.
The Family Intervention Team (FIT) grew in this way, from local discussions between Child and Family psychology, psychiatry (CAMHS) and Action For Children, in a way to meet emerging need and also to prevent some children and families waiting for higher tier services such as CAMHS (now Child and Family Psychological Health). The remit has been clear since the beginning that the service offers early intervention over a fixed term period (12 weeks) and is part of a wider preventative agenda that we are merely a part of.

Parent therapy to family therapy

As a development post, the role of parent therapist has evolved since 2009, and has come to encompass a number of different strands. It's primary aim was/ is to offer a therapy service for parents with mental health needs and there was an awareness from the beginning that this needed to be broader than any diagnostic definition of mental health. We were also clear that this is about mental health and not mental illness.
This fits with ideas set out in the World Health Organisation's "Promoting mental Health" paper (2004), The National Service Framework (NSF) for Wales(Raising the Standard, 2005) and in research in the field such as Social Care Institute for Excellence (2009).
The service was set up to promote the strengths and resources within families and not to be organised by medical definitions of ill health. (White, M. 1990) (De Shazer, 1991)
The "need" for such as service was identified by the team over their years of practice and in 2007 an external service evaluation of FIT confirmed that up to 80% of the families involved with the service had "adult mental health needs" (based on self report) in addition to (or alongside) the issues that they were hoping to address for their children (usually emotional/ behavioural difficulties).
It also fits with other research in the field for example, Buchanan (1999). This was indeed "backed up" by the New Economics Foundation's evaluation of FIT in 2009 that focused on social return theory.
The parent therapist service then was set up, with funding from the Big Lottery, to attempt to meet this need, and offer a responsive provision without the need of a waiting list or referral to another agency, so that in effect the 2 strands of the overall service could sit together, with an aim to be more effective for the whole family.
This is crucial when we consider the particular context of parental mental health, which we consider to be a family matter that challenges practitioners to step across the traditional divide between adult and child/ adolescent mental health services. (Falkov, 1998)

We also argue that positioning the service within the voluntary sector context places the needs of parents in both a family and a primary health context as recommended by the WHO (1986) treaty. It both sits outside and alongside other primary health services (such as GP counselling) and higher tier services (such as a community mental health team).

Process

Gathering a team

The gathering of a team branched out neatly from the now established wellbeing arm of the parent therapist service. In situ within the project were 2 systemic practitioners (Julia and Sarah) trained at intermediate level who had been facilitating wellbeing groups since early 2010. These 2 skilled and enthusiastic individuals were also in the process of embarking on the last phase of their systemic training and were keen to develop their therapy practice. As such they were invited to be part of the challenge of becoming the first family therapy team at FIT, and one of the few voluntary sector family therapy teams in Wales.

Team formation

This then required considerable action and thinking time, which we blocked out for the new team to come together and talk, to generate ideas and begin the process of forming team relationships and rapport. This was facilitated by an external consultant, and this is something that the team found very helpful.
We began thinking about what we would want the service to look like, how the team would operate, what clients we would be seeing, how the rest of the team would utilise the service and many more questions that we had yet to find answers for.
The first question we asked ourselves was "what does it mean to be a team?" A team, we decided, could be many things and take many shapes. We were aware, for example, that we were a team within a team, and a service within an organisation, within a community, with all of its cultural nuances, and as such within a particular context that needs attention paid to it.
We were particularly keen to pay attention to the wider team, and the existing relationships and to be sensitive to the change that the new team may bring to the overall service.
It was important to recognise our individual and collective positions within each sphere, and to pay attention to the interplay between the three domains.
So for us as a whole team, there were multiple relationships and different positions to negotiate. Our therapy team needed to full-fill a number of objectives. First and foremost the clinic needed to respond to the changing needs of families who use the service. We were and remain clear that this is our primary concern; but we also need to consider the other functions of a therapy team, such as the context of learning for therapists in training.

We began by creating a structure for the clinic, to give clarity and create boundaries around our new venture.
This, we consider was important to set out from the beginning so that the team and the clinical context it provided could grow within the limits of the team's experience and the available resources, so that we didn't stretch ourselves too thinly, or too quickly.

Design

The Milan Model

To begin with then, the clinic was established for a Wednesday afternoon, with the parent therapist (Leah) supervising the clinic. This required supervising both the team, (Julia and Sarah behind the screen) and also being the therapist "in the room" with the families/ clients.
We would see 2 families/ clients per week, with a one and a half hour slot per family, allowing for pre and post session discussion (as per the Milan model that we were all familiar with). (Selvini Palazzoli *et al*, 1978)
This is a 5 stage model of therapy
Stage 1- Pre therapy discussion between therapist and therapy team
Stage 2- Joining with the family
Stage 3- Talking with the therapy team behind the screen
Stage 4- Offering feedback to the family (from the discussion behind the screen)

Stage 5- Post session discussion between therapist and therapy team

The team are able to talk openly behind the screen sharing ideas, and are able to ring the therapist in the room to offer those ideas or ask any questions to be relayed to the family. This enables open communication between the 2 systems, as per the model design. (a model of "interactive circularity") (Palazzoli, Cirillo, Selvini & Sorrentino 1989& Sorrentino 1989. In the early stages of our development this happened infrequently as people were familiarising themselves with working as a team, and there is plenty to be aware of without introducing technology in to the equation. However this quickly moved with the development of skill, technique and experience within the team.

Moving to present day the session format is still the same, but there is more use of the phone and a further difference has been introduced. Firstly we now see families all day on a Wednesday and also have capacity on a Thursday. This means that we are now able to see up to 6 families per week. In addition, the therapist "in the room" is not always the parent therapist which allows the supervisor to move position to be both sides of the screen dependent on how we can be most useful for the family/ client. This has brought considerable difference to the team, and is an important development in terms of learning, which though not the primary focus of our team, is non-the-less a development that assists the team, and therefore the families who meet with us.

Mental HEALTH model

The family therapy team has its roots in a mental health model and we are informed by systemic thinking and a position of non-pathology. We are positioned in a primary health arena, and though the complexity of work we are engaged with might otherwise fit in to a tier 3 service in a health model, we work hard to maintain our position in a community context. We work to remain outside of the health service, and outside of the local authority.
In particular we are influenced by the narrative approach to therapy, whose influence reminds us to collaborate with families to find space for new stories and different possibilities to emerge, and to be watchful for the potential for dominant stories to be privileged. (White & Epston, 1990; Epston & White, 1992).
This is particularly relevant for families whose dominant story maybe one of mental illness or ill health, and where their experience of others, including services may be one of oppression or subjugation.
Women's mental health has particular relevance here, and is an area where the team have much experience and have much to say about. This may be for another paper but we will touch base with it here.

Themes

Women's mental health

The World Health Organisation has this to say about the role of gender on mental health-

"Gender is a critical determinant of mental health and mental illness... (It) determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks.

Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others."

Our experience of working with women in the context of family therapy confirms this observation. More than 9 in 10 of our clients are women, and the responsibility of seeking help and making changes within their family seems to be felt most closely by women in the family, whether this by a one-parent or two-parent family context.

Having conversations with women in this context we work to reframe ideas of responsibility, blame and shame which are often dominant themes embedded within conversations about the legacy of intimate partner violence, family violence, diagnosis and difficulties associated with child-birth, parenting and childhood transitions.

This fits with ideas within narrative therapy and within a social constructionist/ post-modern frame, that sets the team up as witnesses to multiple stories (White, 1990) and as "helping a voice to be heard", in this case the voice of the mother within a potential dominant discourse for mother-blaming. (Weingarten, 1997)

A third sector provision

There have been many changes in the team over the last year or so, which as usual in the voluntary sector is due to funding (or lack of funding), and this is also something that requires some attention. Services in our sector are often fixed term, which can often mean short term.
We have been fortunate with the Big Lottery Funding that fixed term has been 5 years, which is quite a long stretch in this climate. However through all the developments the time has moved swiftly and we find ourselves now within the last 2 years of that funding. This, of course, requires the team to think about longevity, and can mean that team members move on to find more permanent, or for some, paid positions. This has not affected our team (at the time of writing) but is something to be aware of when planning service design and delivery.

However the existing team continue to deliver a quality service for families from a robust multi-systemic frame and indeed we have just won an award for good practice in mental health that recognises such a wild claim.
In addition the service offers excellent "value for money" for those who fund us (thanks to Big Lottery in particular!) and we have been able to quantify that through research undertaken with NEF (New Economics Foundation) who undertook a social return on investment analysis. (NEF, 2009)
The families we work with do not pay for any service we offer, and we have had the privilege of talking with many people (women in particular) whose story may otherwise never have been heard, as they would otherwise not have come to the attention of services that respond to mental illness or conversely may have had their illness treated without due attention to their wholeness. (De Shazer, 1991) (Epston & White, 1992)

Conclusions

This paper has traced some of the important steps in the setting up of a family therapy team and service. Whilst attention needs to be paid to the practicalities of such a venture, I propose that the most critical phase in this development is the formation and development of a team, and a team identity. This was important to pay attention to, and put time aside for, and we have benefitted from that initial stage.
Setting boundaries around what we could do and offer at this stage has also meant that we have developed within our own limitations and our own sense of ourselves as a team. This may go some way to making sense of the somewhat "mystical" notion of "team mind" Selvini (1991). As a development paper this is not the subject for us here, but I consider that this will be an important area for us to reflect on, and is likely to be the subject of future writing.
The areas that are covered in this offering could also each be developed for further exploration and writing, and of particular relevance is the importance of gender given that we are an all-female team working predominantly with women. Both of these areas for development speak to ideas of sameness and difference, and require considerable attention.
We are, at this stage still, we consider, a relatively new team in terms of the life of the service, and this is an important stage in marking out the initial phase of development. There is much to learn in the early phases and we are in a position now to reflect on that process, and begin to look to the next phase. We have touched on where that might take us, but we remain open and curious about the potential for difference.

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Women's wellbeing following childbirth: voices from Caerphilly.

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Abstract

This paper offers a review of the processes involved in the setting up of a pilot group for mothers and babies around the theme of Postnatal Wellbeing.
The group was designed and run by the Caerphilly Family Intervention Team to meet, what was considered to be, a currently unmet need in provision in this area. The design and facilitation of the programme was framed relationally, with a focus on providing a context in which women could share their experiences and allow them to think about the transition to motherhood and their relationship with their baby. The report commences by describing the background, context and intended purpose of the pilot and then continues to give detail of the content, evaluation process and results.
The authors work together in the project and were the facilitators of the group. Leah is a systemic psychotherapist and Julia is a systemic psychotherapist in training.

Introduction

For many years it has been widely accepted by researchers and clinicians from diverse areas such as; paediatrics, psychiatry, primary care and public health that the well being and mental health status of women following childbirth is an important area for consideration and support of services.
Psychiatry as an example has focused its lens on Peri-natal psychiatry a relatively new branch of psychiatric speciality but pioneered by Kumar (1996), Brockington et al (1996).
Tomm (1990) offers a critique of the DSMIV which he calls "The Bible of Psychiatry", and the dominant discourse of the diagnostic agenda, which we would refer readers to for more information.
The field of Midwifery took a more PTSD approach such as explored with again a potential for pathologising women at this transitional time in their lives. However, health visiting had a more social/community development approach. It could be argued though that health visiting has moved away from this in recent years and this position is now quickly being filled by the 3rd sector organisations who are providing innovative, acceptable and socially specific approaches to the need that has never gone away, but has been forgotten in service planning and provision.
This paper will focus on a small pilot study by a 3rd sector organisation relatively new to the vast playing field of postnatal mental health and wellbeing.

The locally focused agenda.

The Welsh Assembly Government [2002] published the Adult Mental Health National Service Framework (NSF) setting out service standards with the core aim of improving mental health for communities and reducing inequalities highlighted by the variation in service provision across Wales. This revised National Service Framework and Action Plan, entitled "Raising the Standard" (2005) built on this initial plan with an aim to continue improvement within Wales.

The county of Caerphilly responded to these key objectives with a focus on service entitlement that provides early intervention, aids recovery, supports self-management and can be accessed within the community. Families living in this area face significant adversity related to deprivation and poverty and are more likely (than the national average) to suffer with mental health difficulties.

The Welsh Health Survey (1998) suggests that the prevalence of depression and/or anxiety is strongly associated with levels of deprivation finding that mental "ill-health" was substantially greater than average in the most deprived areas. A recent report by Caerphilly County Borough Council (2008) also recognises this and defines Caerphilly Borough as the 4th highest (of 22) in receipt of mental health services within Wales. Within The Family Intervention Team (Action for Children) we have been able to "pull out" from internal and external monitoring that up to 80% of families using the service to address their child's emotional or behavioural difficulties, are also managing with adult mental health problems. (2007 figures)

A Public health position

Five key themes were highlighted through the extensive 2003 wellbeing consultation in Caerphilly, and formed the basis of the action plan that followed for the period of 2008-11, the themes being-

- To improve public health by promoting factors that contribute to healthy lifestyles and well-being
- To reduce health inequalities by tackling deprivation and the wider determinants of health
- To expand and develop community based health and social care services
- To enable independent living in local communities, through appropriate support mechanisms, for individuals, families and carers
- To develop and strengthen preventative work and service provision for vulnerable children and adults.

The mental health of women.

Given the context for people living in Caerphilly and the prevalence of mental "ill health", attention needs to be paid to the correspondence with the socio-economic factors listed above and the role of gender in the diagnosis, treatment and service use by women.

Women's health and mental health needs to be seen in this context and places the needs of women as a high priority for services that are set up to support children and families.

Women are at much greater risk of developing mental health problems particularly common mental "disorders" such as depression, anxiety and somatic complaints. These disorders affect approximately 1 in 3 people in the community with unipolar depression being twice as common in women. (WHO, 2012)

This same World Heath Report also points to serious gender inequalities in relation to power and rank, social mobility, financial and employment inequality, and crucially, the role of violence against women. These are commonly felt and experienced by the population in the context we practice within.

Parental mental health-

'Rare is the family that will be free from an encounter with mental disorder' (World Health Organization 2001).

Its of no surprise that , depression is the most commonly occurring mental health problem in the UK, and is between 1.5 and three times more common in women than in men with nearly 10% of women experiencing a (diagnosable) depressive episode (in comparison to 6% of men) in any 12-month period. (WHO, 2001)
Significant research in this area (Rutter, 1984; Duncan and Reder, 2000; Oates, 1997) has highlighted the prevalence of diagnosable mental ill health in the population of adults who have responsibility for caring for children, and much has been said about the causal relationship between parental mental ill health and psychopathology in children. (Falkov, 1998).
Oates (1997) specifies from his research, a quarter of female patients newly referred to mental health services were caring for a child under the age of five.
This points to a very obvious need for services that respond to adult mental health to be working with services that respond to the needs of children and vice versa as discussed by (Jacobsen et al, 1997, Falkov, 1998).
These discussion further highlight that that there is very little information held within adult mental health services about the child dependents of adults patients, which suggests that there is likely to be a sharing of information (Jacobsen *et al* 1997).
This relationship between mental health and parenting needs further exploration. Much of the literature points to a relationship between child abuse and neglect and parental mental ill health (with a focus on parenting deficit) with insufficient research in the area of "good enough" parenting and mental health (with a focus on parental competence). (Salter & Hardy 2009)

Post natal mental health

The term Postnatal depression is often used as an all encompassing term (excluding the more complex and severe puerperal Psychosis) [DSM1V 1994] and has been a consistent area of concern and by professionals and groups as well as political spheres [DoH 1995][Nice 2007].
Post natal depression itself is not attended to in DSMIV, and as such is not a diagnosable disorder, but it is often discussed in such short hand terms. Most, but not all of the depressions that are referred to as post-natal depression start in the first 3 months (Cooper & Murray, 1998), and many people now refer to depression within the first year of childbirth as a post-partum disorder (Shared Care in Mental Health 2006).

In the UK 25% of all maternal deaths are linked to potential mental health Problems (MIND, 2006). There is also an increased risk of new mothers being admitted to a psychiatric hospital or of seeing a psychiatrist (Mind, 2006) (Kendell et al, 1987). Oates, (1996) suggests that after the birth of a child, a woman could be five times more likely (in comparison to other women) to develop severe depression or to be referred to psychiatric services following childbirth . It is also seen as a major factor in the well being of children and child development as discussed by

many including [Field et al 1988, Cogill et al 1986, Meyer 1994, Dennis 2005].

However, we take the position that the interplay between parenting, child wellbeing and parental mental health is complex and relational, and cannot be easily deconstructed and neatly placed into a convenient box. For many years the debates have eschewed over the language and definitions of diagnoses versus quasi diagnosis.

Postnatal depressions

The experience of Post natal depression is characterised by a set of "symptoms" or presentations which include sleeplessness, tiredness, low mood, tearfulness, loss of confidence, loss of interest/pleasure/ enjoyment, loss of concentration, guilt, self-blame, and potentially suicidal thoughts.

For people reading this who have had children, this is also likely to read as a list of common feelings that could easily relate to becoming a parent. What parent has not experienced sleepless nights, tiredness or feelings of guilt? We imagine, very few! Therefore when we are talking about mental health in this period it is more useful, we propose, to think about this in terms of common thoughts/ feelings that are likely to be around, rather than to think in terms of symptoms. It is also useful, we suggest, considering this time as a period of adjustment and loss (Nicholson, 1998) rather than using the language of psychiatry and mental illness.

Providing Early Interventions

Early intervention is a term that gets widely used and often means different things to different people. One definition of early intervention in terms of supporting families may be working with families with young children (babies). Another definition may be working with families (of any age) where the defined problems are newly emerging. At The Family Intervention Team (traditionally supporting families with children aged 5-14) we have tended to think in terms of the latter definition. However the wellbeing group can be seen in both ways. The idea is that the intervention comes both at a time when the child is very young and before significant problems have developed.

Early intervention (as supporting families before problems become entrenched) has significant cost benefit for the individual and at a wider level, the community and the state. This has been evidenced effectively through the New Economics Foundation and their evaluation report (2009) on the social return on investment of the Family Intervention Team. This report measured both short term and long term return and the outcomes were found to be significant.

In addition there is significant research to suggest that early intervention in respect on mental health can be highly beneficial again for the individual and in terms of economic resource. Research such as McCrone et al (2010) highlights this well. There is much evidence to suggest that early intervention in serious mental illness (especially psychosis) has life saving as well as resource saving benefits. (E.g. Melle et al, 2006).

In terms of more common mental health problems such as depression and anxiety the research also points to early intervention. (Newton, 1988; Mrazec & Haggerty 1994 etc)

"Early intervention offers possibilities both of interrupting distress before it reaches the level of clinical depression (at the border of primary/ secondary prevention) and of markedly shortening clinical depressive episodes." (Scott, 1995)

In addition early intervention in mental health can have significant impact on family life and parenting.

"Parenting supports aimed at minimizing disruptions to parenting should be initiated preventatively, when the mental health problems become apparent in the parent, and before they become apparent in the child." (Smith, 2004)

Process

Setting up the group

The primary motivation for piloting a group focusing on post natal well being arose from feedback from mothers who had previously accessed the Parent Therapist Service as discussed in Salter and Hardy [2009]. A number of mothers accessing therapeutic services had described that, following the birth of their children, they had experienced many of the symptoms associated with post natal depression but didn't find that they were eligible for services or that there were services available for them.
Consequently, they had suggested that the challenges that they, and their children, were experiencing were greater than they may have been had they been able to access support earlier.

The Pilot group was funded by a Families First grant provided to complement and enhance existing Family First Projects. The group provided 5 sessions which ran from 2nd – 30th March 2012. This represents 7.5 hours of service input- a short term, non-intensive, early intervention service.

The pilot was designed to complement the Family Intervention Team existing group work programme, which is provided through the Families First Inclusion and Support Project and the Big Lottery Funded Parent Therapy Service. This enabled the pilot to run within the community, and crucially provide child care facilities for parents with older children as well as babies. The group was promoted as a "Post Natal Wellbeing Group for Women", with the intent of keeping it within a mental health promotion frame, and paying attention to the descriptors of health and ill health.
Within the frame of wellbeing, (as opposed to Post Natal Depression or post-natal mental health), this description places the service in a non stigmatising frame providing the context for the group in a primary mental health setting not within the context of perinatal mental health, which has its place in psychiatry.

It is recognised, that the women attending the group may not have any mental health diagnosis but may be keen to access a context providing early support. This links with the early intervention principles of the project, and link with the idea that "prevention is better than cure".

The group was targeted at mothers with babies up to the age of 18 months, based on research describing the postnatal period up to 18 months of age. The Royal College of Psychiatry advises that most women will get better without any treatment within 3 to 6 months but 1 in 4 mothers with PND are still depressed when their child is one-year-old. (RCPysch 2012) In our experience of talking with families many women are "diagnosed" beyond this stage and are still under the understanding that they are post-natally depressed often when their child has started school because they are not "un-diagnosed".

We debated criteria for the age of children, but felt that enough literature (e.g. Monti et al, 2008) suggesting that the propensity of symptoms being experienced in the first 18 months was enough to support our view that we attend to this group as the "target group". The group was open to both "first time mothers" and mothers who already have children.

Policy and political Rationale for group-

NICE (National Institute for Clinical Excellence) recommend that women who have experienced mental ill health previously should have access to psychological therapies such as cognitive behavioural therapy or interpersonal psychotherapy. For women without previous significant mental ill health group support or informal individual support is recommended.

Group support and early (informal) intervention has found to have had a significant impact (e.g. Craig et al, 2005) on the health and wellbeing of women at this time, and of course is cost effective in comparison to medication, formal therapy and in-patient care. This highlights the key role that health visitors and midwives can play in early detection AND prevention of mental ill health for women in this period. For this reason we liaised with health visitors, GP's and the GP counselling service who were able to refer to our group.

Furthermore, Nice (2007) have stated that: "Psychosocial interventions (for example, group psycho education) designed specifically to reduce the likelihood of developing a mental disorder during pregnancy or the postnatal period should not be part of routine antenatal and postnatal care."

Setting up

We utilised a local Community Centre as the venue provided a welcoming context with separate rooms for the crèche and group. It was also centrally located within Caerphilly which proved beneficial for the purpose of setting up a pilot group. In order to improve accessibility, transport was provided where required.

The groups were "advertised" by posters and fliers which were distributed to appropriate agencies within Caerphilly. Information was sent out to the Caerphilly health visitors & mid wives, parenting programmes, Home start, Communities First, Flying Start, Right From the Start, The GP Counselling Service, The Parent Network, GOFAL, Sure Start, GAVO, Young Mum's and to the Caerphilly Sexual Health Outreach Worker.

The Pilot group was funded by a Families First grant provided to complement and enhance existing Family First Projects. Requirements of the grant stated that it needed to be spent by the end of the financial year. Therefore, the setting up process of the group and contacting of the referrers was condensed to a period of approximately 2weeks. This may have impacted on the referral process but with persistent communication with our networks we achieved a referral source sufficient for the success of the group.

Design

The pilot provided 5 sessions with each session lasting for 1 ½ hours. The sessions were based around giving mothers a notional space to think about their own needs and the needs of their children. Each of the sessions involved the provision of a context for talking, reflection and mindfulness meditation. Within this it was considered important to provide a contextual space for mothers to share their experiences of parenting and to also be able to have a context where they could reflect on their experiences of motherhood (with specific gender reference).

Content

The group consisted of 5 sessions that focused on key themes. Session 1 focused on parental expectations, hopes and fears and making time for you as a parent. Session 2 focused on mother and baby interaction using mindfulness, and art (baby foot and hand prints were done on canvasses for parents to keep). Session 3 focused on baby massage, with a qualified practitioner running the session. This was accessible for small babies and for toddlers. Session 4 focused on parental mental health and wellbeing with discussion on what it means to be a parent/ a woman, and with each participant having a massage or reflexology therapy. The last session focused more specifically on mindfulness and mindful parenting, with a mindful appreciation of ourselves and others (including baby).

Evidential interventions -

Baby massage

The sensitivity of early interactions conveyed through eye contact, voice tone, facial expression and gentle touch plays a crucial role in healthy infant development. Infant massage has been adopted as an early intervention because touch offers a unique opportunity to support early interaction. (Underdown & Barlow, 2011)
This significant research explores the effects of baby massage on baby and on mother/ baby interaction. Her findings suggest that there is evidence suggestive of improved mother-infant interaction, improved sleep and relaxation, reduced crying and a beneficial impact on a number of physiological processes. Her research indicates also that there is a correlation between massage and stress hormone levels which also has important links in terms of attachment processes and brain development.
It is suggestive that massage could affect the release of the hormone melatonin, "which is important in aiding infants' sleeping patterns," Underdown, (2006)

Mindfulness

Mindfulness is often defined as 'paying attention on purpose moment by moment without judging, (Jon Kabat-Zinn, 2001) and involves learning to pay attention to what is going on in the mind and body in the present moment without judgement.
Mindfulness has been shown to be effective for the prevention of depression (NICE, 2004) and may be a useful approach for helping vulnerable groups or as a universal public health measure. (Hughes, 2009)

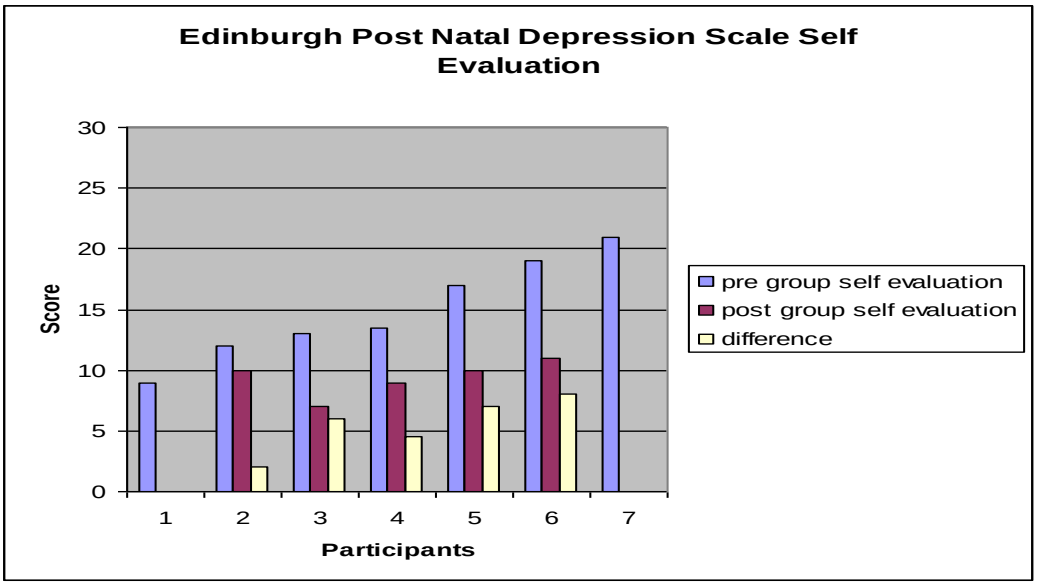
Evaluation

Edinburgh post natal depression scale

The Edinburgh Post Natal Depression Scale (EPDS) is a validated method of screening for post natal depression. As post natal depression is not an official diagnosis (not in DSMIV), this is not intended to be a diagnostic assessment but a screening to identify mothers who may be at risk of developing mental health concerns and mothers who would benefit from support at this stage.
The scale is scored based on the answers given by the mothers. The team who developed the tool (Cox et al, 1987) designed it to work on a scoring system, with people rating 9 or over being indicative of those at risk of developing post natal depression (therefore seeing it as a preventative tool). Simply put, the score of 9 is seen as a critical number in indicating possible post natal depression. A score lower than 9 would suggest the mother is not at risk; a score of 9 or more would suggest a risk, with the higher score representing higher risk. However it can also be used to screen for "definite major depression" (Davies et al, 2003) for which the cut-off is suggested to be 13. The total possible score is 30.

We asked the parents who attended the group to self-score in the first week. We followed this up after the group, so that we could have 2 sets of scores to compare and which will serve to illustrate in some way the process of change for those who attended the group.

Feedback and Results



As evidenced from this 100% of participants' scored 9 or above in the first questionnaire "suggesting" (and this is important to reiterate that this is just an indicator) that all participants could be at risk of developing mental health concerns.
The post group questionnaire indicates that scores moved from above 13 to below 13 in 4 cases (57%), with 100% of participants (who filled in both a pre and post form) having scored lower after the group. The average change in score was 5.5.

It is important to recognise that these results are self-reported and as such illustrate the felt/ lived experience of the individual. It is also relevant that 3 mothers chose not to fill in their forms. 1 hypothesis about this is that these parents felt too vulnerable in the first week to share this information with us when they may have been feeling quite fragile at that stage in the group process.

Evaluation Questionnaire

Additionally we also used a satisfaction questionnaire which asked three initial questions to ascertain a) Whether the women felt listened to and respected, b) satisfaction with the venue and the facilities c) satisfaction with the crèche facility. These questions were considered relevant considering the group was focussed on acknowledging and appreciating both experiences of mother and child. The questions were asked using a 5 point (Likert) scale from strongly disagree to strongly agree. Each of the questions received a response of 100% "Strongly Agree" from each of the respondents.

Themes

The evaluation then questioned what difference the group had made to the mother's mood, to their child, to the parent child relationship, and to the Parents wellbeing. Below are some quotes from the evaluations:

Difference to Mood

"Provided opportunity to discuss concerns with other mums and realise that you aren't the only one that feels that way."
"The group is great at mood lifting due to the chance of chatting and positive conversation."
"It has made a massive difference to me as it's time to think about me.
Made my mood change as it was nice to sit and talk to others."
"It's made me a much calmer person."
"Feel relaxed when I leave the group and much more at ease with my mind."

Difference to Child

"This is the first group where my daughter has been separated from me, apart from family members; she is moving to be confident.
"Loves playing in the crèche."
"She enjoys the crèche facilities and its good as she is learning to socialise with other children."

Difference to relationship (with child)

"My relationship *(with new baby)* is better than with my daughter. This group has helped remind me about ways of bonding."
"Made us closer."
"Think it has made us closer."
"It has been lovely to bring my child to a group knowing that she is in safe hands while I am relaxing."
"Its been a fantastic change by putting all the practices into action."

Difference to Wellbeing

"It has given me the chance to experience some relaxation time and learn techniques."
"Only having been to 2 sessions, I feel better in myself but would love for more groups to happen."
"Helped me to get going in the morning I had a purpose to be somewhere."
"Feels better."

Conclusions

This papers main aim was to offer an exemplar of the work of the 3rd sector in a field which has largely been forgotten by statutory services despite a wealth of evidence over the past 30 years. We have discussed the main threads of some of current research in the fields of parental, maternal and post natal mental health and we positioned ourselves and the group intervention firmly in the context of health and wellbeing. We attempted to illustrate "what works" as an intervention on a community level in a small but significant borough in South Wales. It has also highlighted that funding for interventions are inextricably linked with a funding formula which is the Social Return on Investment .This economic model - NEF [2009]- is socially focused and its outcomes are predictive and as such provides demonstrable early intervention outcomes that are key to many 3rd Sector funding and service provision.

The key findings from this pilot group suggest it is very simple to set up .The key ingredients appear to be offering and creating a context with other mothers, offering a warm and friendly environment and facilitative style, being open and non-judgemental, offering a space for parents to feel relaxed outside of the busy schedule of their lives, offering time to talk to others.
We also suggest the careful positioning of such a group in a community health promotion frame also added to the success. Additionally, we suggest that this was aided by the systemic knowledge and understanding that the facilitators brought with them one is a registered psychotherapist and the other a final year trainee in systemic and family therapy.
The use of the EPDS provides a robust screening for such a client group and we suggest it is more rigorous than the NICE 3 question approach. Equally we were interested in satisfaction of the service we provided and our simple but user friendly questionnaire highlighted for us the importance of relationships and context.

In many ways then though the interventions were simple in design, the thought and preparation for the group was sophisticated and complex, and paid attention to the many subtleties of relationship and context that form part of the rich tapestries of women's' lives.
We attempted to pay attention to the role of gender, culture, societal pressures and expectations, the role of diagnoses and psychiatric definitions of health and ill health and the interplay between all of these factors. In particular the authors have strived to pay attention to the negative connotations of mental ill health on women and the family; and the usefulness of such a definition when considering the normative transition of parenthood, which can be anticipated and planned for and for which early intervention and a preventative, community focused service can play a key role.

This pilot project and its small but significant outcomes will hopefully provide a platform for future developments. In a context where cost and benefit is a financial as well social reality this 3rd Sector provider needs to focus its resources in a way which promotes health and well being for mothers, fathers and children.

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Referrer perceptions of the Family Intervention Team

Jessica Williams

Jessica is currently an Assistant Psychologist at the Skills for Living Project, Action for Children. Previously Jessica worked for the Family Intervention Team as a Project Worker.

Introduction

The family intervention Team, providing early home-based intervention for children and young people with emerging emotional and behavioural difficulties, was established in 2004. Annual routine evaluations of the project have been positive. An external evaluation by NEF has also shown encouraging results. (NEF, 2009)

In light of the positive outcomes achieved by the service to date, a greater understanding of how FIT delivers successful interventions with families was desired and it seemed appropriate to seek feedback from the professionals who refer families to the service. The aim of this paper is to present data from a service audit into the perceived success and effectiveness of the service by referrers and to reflect on the service's role within the provision of services for children and families in the Caerphilly County Borough.

Design

Questionnaires were designed to gain data on referrer's perception, understanding and satisfaction as well as to gain a greater understanding of how the team reduces the burden on other services in the borough. This was with the recognition that satisfaction surveying has been viewed, in some circles, to be controversial. Lasek, (1997) Williams (2009) and Gribble, R K. Haupt, C (2005).

Questionnaires were sent out to all partner agencies and 20 completed questionnaires were received. Questionnaires were sent out to the following partner agencies:

- Schools
- GPs
- School health nurse and health visiting service
- Paediatricians
- Child and Family Psychological Health
- Social services
- Education Welfare
- Educational Psychology
- Behaviour support
- Voluntary sector agencies operating in the borough

The data from the questionnaires includes both quantitative and qualitative feedback which will be analysed separately. A mixed method approach was chosen as researchers have described the benefits of combining quantitative and qualitative methods (Sprenkle & Bischoff, 1995; Sprenkle & Moon, 1996) and this approach can provide rich, descriptive data that illustrates numerical data. (Ward, 2000) The data has also been divided into feedback relating to the effectiveness and role of the service in the borough and feedback relating to the satisfaction with and understanding of the internal processes of the service.

Quantitative data

Figure 1 shows that the feedback received from referrers and partners was very positive with a mean score of over seven received for all questions relating to the aims and effectiveness of the service. It is particularly significant that the average rating for how easy it would be to find an alternative service to the Family Intervention Team in the borough was just 3.53 out of 10 and the average rating for the perception of how much of a difference the service has made to the provision of services in the borough was 8.6. This feedback suggests that the Family Intervention Team has an important role in meeting the needs of children and families in the area and this combined with the high score for the effectiveness of the focus on early intervention suggests that it is providing a service that would otherwise not be available. The perceived benefit, by referrers, of early intervention is also reinforced by research. Early intervention: The Next Steps states that:

> *"One great merit of Early Intervention is that it can help so many families under stress to fulfil their mission of giving children a secure and loving space in which to grow up. It can keep families together and save many children from the trauma of break-up and removal." (Allen, 2011)*

Figure 1: Referrer responses- view of effectiveness and role of service

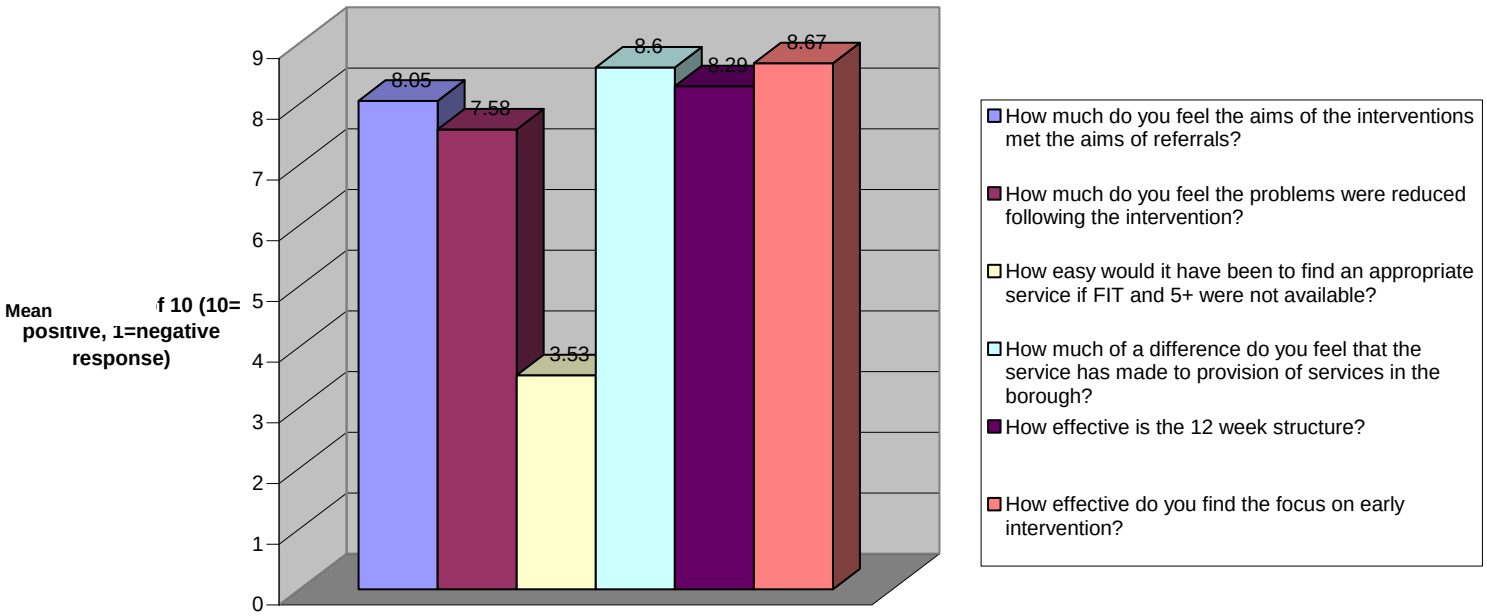


Figure 2: Referrer responses- satisfaction/ understanding of process

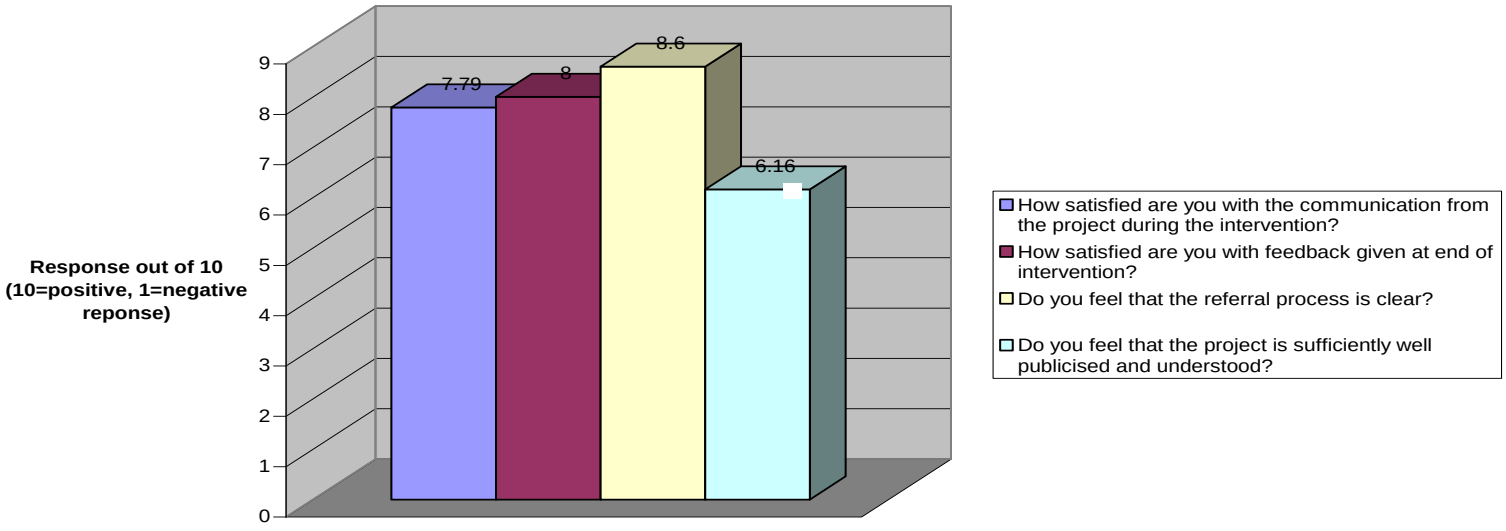
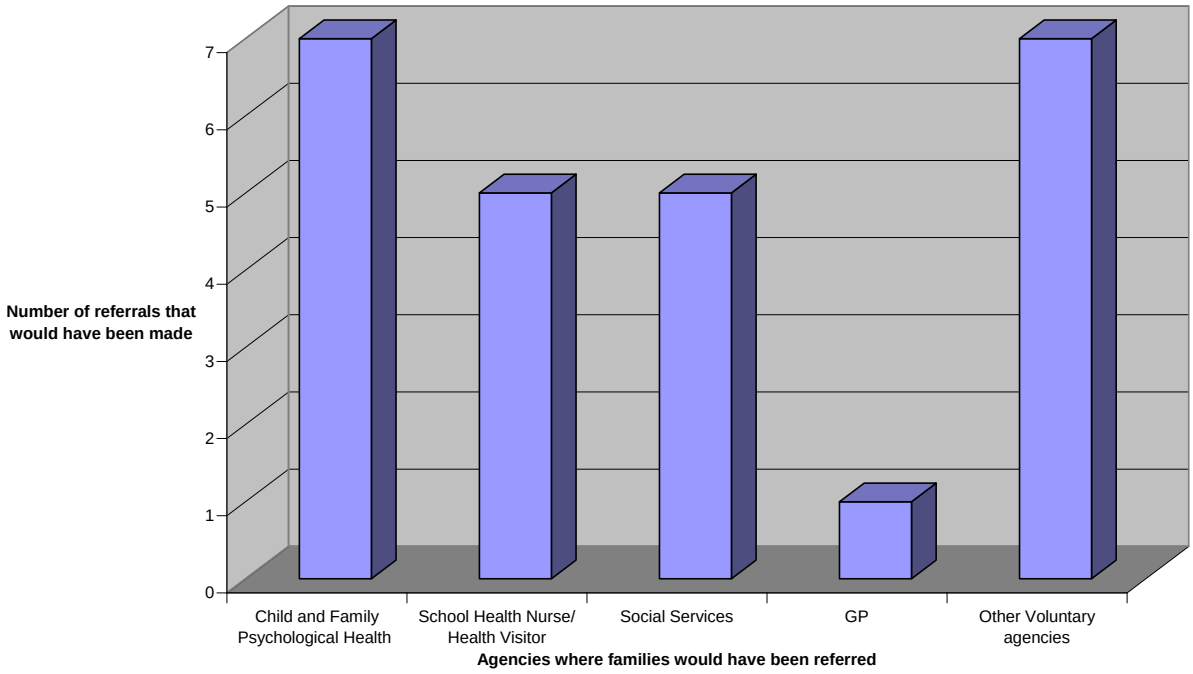


Figure 2 illustrates that satisfaction levels with communication and feedback are high and that, in particular referrers are clear about how to go about referring into the service. These results demonstrate that the project has a well functioning role within the borough and that the service works well alongside other agencies. The results do highlight however that more could be done to publicise the service in the borough.

Qualitative data - Alternative referral routes

The questionnaires asked referrers to state where they would have referred families should the Family Intervention Team not be available. Several referrers commented that it would be very difficult to find an appropriate alternative service. Those who responded to the question often suggested two places they may have referred on to and Figure 3 below shows which services would have received these referrals.

Figure 3. Alternative referral routes



Comments:

Referrers were asked to comment on what they felt contributed to the service's success. Four broad themes emerged from the comments given.

Model and approach

Many of the positive comments about the service centred on the approach of the work, and the models used by the service.

> *"The service works incredibly hard to engage families and provides a flexible and appropriate intervention. I think the work the team does with schools as well and parents and the child leads to important change."*

> *"It is made clear to agencies and families that work is time limited and this is always viewed as a positive"*

> *"Parents appreciate somebody to help them both at home and in school"*

> *"Variety of models (family, individual, liaison)"*

Engagement

Many of the comments focused on the ability of the service to engage and build relationships with families in their own homes.

> *"Relate well to parents and give lots of feedback and link well with the school"*
>
> *"Families are not threatened by your intervention, possibly would be if social services were involved"*
>
> *"The worker was very down to earth and interacted well with the family"*
>
> *"Families report being heard with respect"*
>
> *"Visiting homes- dealing with parents in a different way to schools"*
>
> *"I have had very positive feedback from families I have referred about their experience of the service and their relationship with the project workers."*

Communication

Many comments were given regarding the effective communication and feedback to referrers from the team.

> *"I have really appreciated the discussions I have had with members of the team at the point of referral to clarify what the hopes for the work are."*
>
> *"Very positive telephone communication from FIT staff, helpful and polite always."*
>
> *"Information received from fit on formulation, intervention and response to intervention is helpful and supplied now."*

Impact on partner agencies

Comments were made about the impact of the service on the referrers workload their and ability to work effectively. In some cases participants felt that they received reduced referrals into their service due to the FIT team.

> *"I really value your service and input with families. It really makes a tremendous difference to my workload and ability to support families in crisis, Thank You!"*
>
> *"FIT are incredibly useful and valid projects and have had a huge impact on the number of behavioural referrals received by specialist CAMHS"*

Conclusions and thoughts for the future

The results of this audit highlight that the service is valued in the county borough and that many of the referrers feel that the model the project uses and the structure of the intervention is effective in meeting the needs of families. It appears notable that the referrers consulted have commented on the impact the service has on other agencies operating in the area and that other services have identified that an emphasis on early intervention work has prevented many families from accessing tier two services.
A high percentage of participants felt that the project had been successful in meeting the aims of the referral and it was also evident that referrers would have found it difficult to referrer families to an appropriate service if they were not able to refer to FIT. A reduced burden on statutory services such as CAMHS, social services and school health nursing can be inferred as referrers frequently identified that they would have referred to these services in the absence of FIT.
This audit has considered the referrers' perspective to add to the understanding of what makes the FIT model successful. The emergent themes from the interview suggest that along with the focus on early intervention, success comes from the ability of the service to engage with families. FIT appears to hold a unique position amongst services in the borough as referrers perceive there to be less stigma related to referring a family to FIT than to other statutory agencies and the time-limited approach seems to be helpful in achieving this.
It also seems that FIT's ability to work in partnership with other agencies is important for success. This contributes to a sense that the focus that the FIT team offers in terms of setting goals and sharing aims is helpful.

This paper highlights that referrers to the FIT service perceive it to be an important and unique service within the borough and that they have confidence in the effectiveness of the model. It would be interesting to investigate the mechanisms by which referrers believe FIT achieves success in greater detail and to consider this feedback alongside feedback from other key stakeholders in the service.

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Three year post intervention follow up study of families referred to the Family Intervention Team- What are the outcomes and what makes the difference?

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Jessica is currently an Assistant Psychologist with the Skills For Living Project (Action For Children). Previously Jessica worked with the Family Intervention Team as a project worker.

Introduction

The family intervention Team, providing early home-based intervention for children and young people with emerging emotional and behavioural difficulties, was established in 2004. Annual routine evaluations of the project have been positive. An external evaluation by NEF (2009) and an evaluation of referrer perceptions of the service (Mantle, J. 2012) have also shown encouraging results.

The study discussed in this paper investigates perceived outcomes three years post-intervention. Semi- structured telephone interviews were conducted with a parent of a random sample of 15 children and young people referred to the service between three and four years prior to the point of interview. Outcome data is routinely collected at the end of the 12 week intervention which has provided evidence that the project is efficacious in achieving its aims. It was felt that a greater understanding of the long-term outcomes for families who had received a service from FIT was necessary.

The aim of this investigation was to examine the outcomes for these young people on a range of indicators including school success, involvement with other agencies and the perceived effectiveness of the intervention and maintenance of outcomes by the parents. In addition to gathering this data relating to outcomes we also sought to establish what care givers felt was the mechanism leading to successful outcomes from the intervention: What made the difference?

Design

Longitudinal research is generally agreed to be the most appropriate methodological approach for studying developmental change over time and long-term effects of significant events on development (Holmbeck, G et al; 2004). Supported by significant research in the field (Loeber et al, 2003; Wierson & Forehand, 1994).

The interviews were designed to elicit both quantitative and qualitative data. One aim was to collect data on the social trajectories of children and young people who have used the service, looking at factors such as involvement with the youth justice system, number of school exclusions and number of referrals to social services and CAMHS. In addition to this, care-givers were asked whether any changes seen at the end of the 12 week intervention continued to be maintained at the point of interview.

Care-givers were also asked to rate the young person's behavioural and emotional situation both at home and at school using a 10 point Likert scale. The interview was designed to elicit information regarding what the parents of the children and young people believed had been helpful about the service.

A thematic analysis was conducted on the qualitative data. This paper will first present the quantitative data and then the thematic analysis will be discussed. Supervision was accessed by the author with the clinical psychologist within the team at each stage of the

evaluation process, in line with recommendations for good quality research (Elliott *et al.,* 1999).

Maintenance of outcomes and social trajectories

Figure 1 illustrates that 87% of care-givers interviewed rated the service they had received as helpful. 7% did not feel the service was helpful and 6% felt that although the service was helpful during the 12 weeks of intervention, there were no changes seen in the young person's difficulties. *Figure 2* illustrates that of those caregivers who reported change post intervention, 85% reported these changes to be maintained at the 3 year follow up. The remaining 15% reported partial maintenance of change which included reports of maintenance of improved confidence and changes with friendships. In the 15% of cases that reported partial maintenance, it was reported that changes had been maintained for some length of time but there had been a recent deterioration.

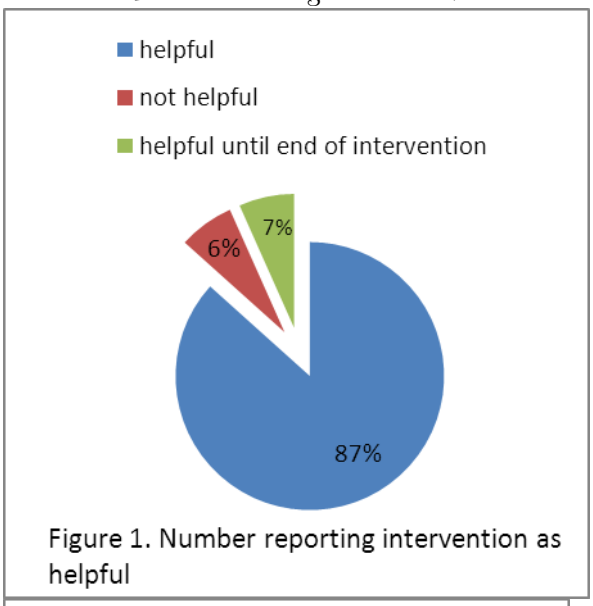


Figure 1. Number reporting intervention as helpful

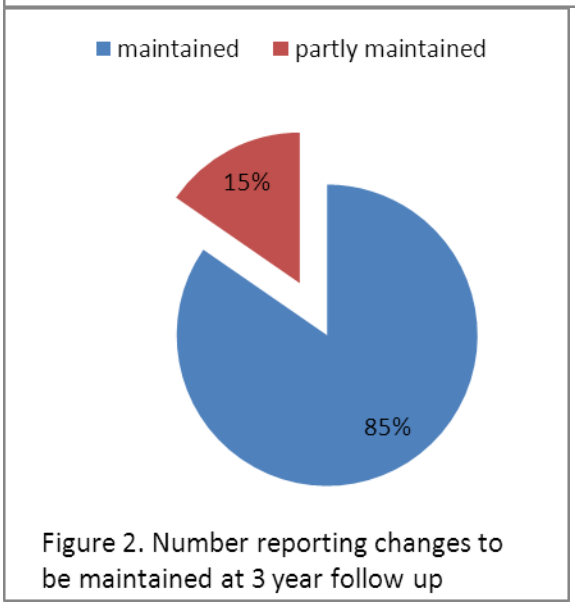


Figure 2. Number reporting changes to be maintained at 3 year follow up

Care givers were asked to rate how positive they felt things were with regard to the young person both at home and at school with 10 being the most positive. The mean of the reported rating is shown in table 1.

	Home	school
Mean score out of	6.43	7.71

10		

Table 1. Mean score of carer perception of young person at home and at school.

This data is also illustrated in figure 3 to show the split between those rating 5 or below and those rating 6 or above. This shows that a greater number of care givers rated the current situation within the higher half of the scale with only 29% responses in the 1-5 bracket for home and 14% in the 1-5 bracket for school.

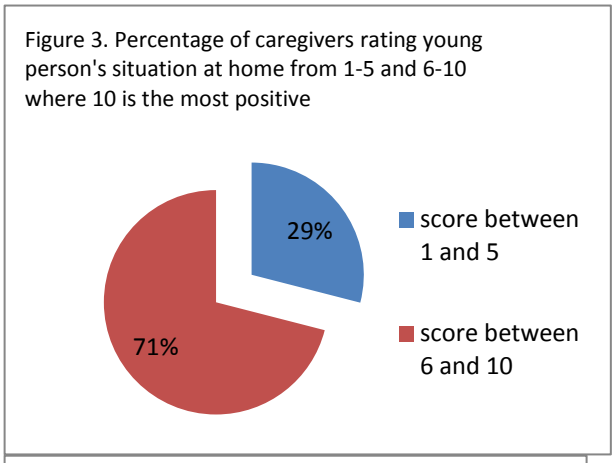


Figure 3. Percentage of caregivers rating young person's situation at home from 1-5 and 6-10 where 10 is the most positive

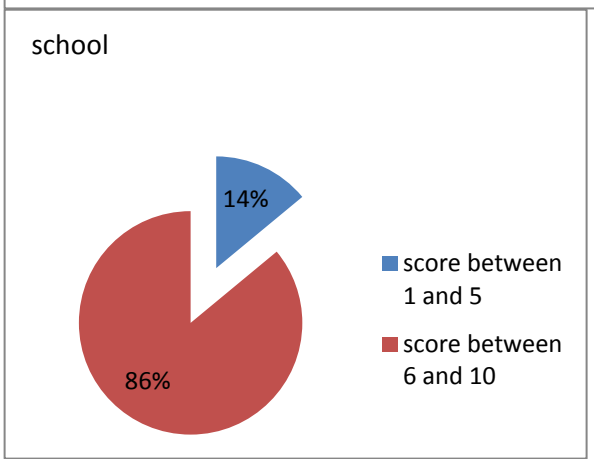
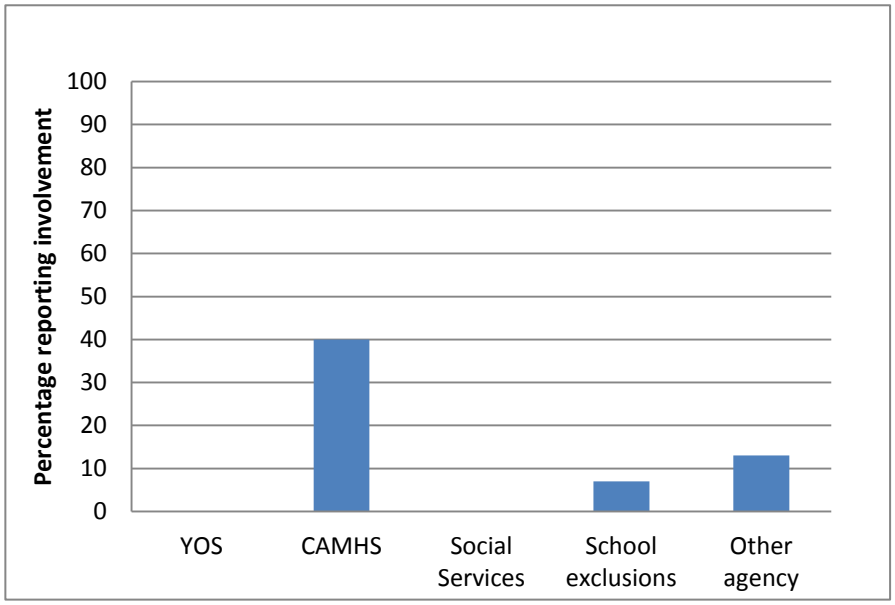


Figure 4. Percentage of caregivers rating young person's situation at school from 1-5 and 6-10 where 10 is the most positive

Figure 5 below shows that the sample of families has had little involvement with other services and school exclusion in the 3 years post intervention was reported in only 7% of cases. It is of note that none of the families interviewed had had any involvement with either Youth Offending or Social Services. The largest number of involvement with other agencies was with CAMHS with 40% of the 15 families interviewed reporting some future involvement with the service. In two cases it was reported that a referral was made by the project worker at the end of intervention and in another case CAMHS were accessed for a diagnosis of Asperger's Syndrome. The services reported in the 'other' section were a young carers' service to which the family were referred by the project worker at the end of intervention and the Paediatric Service.

Figure 5. Percentage of referrals to other agencies and school exclusions reported by



Thematic analysis

Care givers were asked to comment on whether they had found the service helpful and if so what they felt had made the difference for their family. After examining the responses seven dominant themes emerged. These are:

- Relationship with project worker
- Strategies recommended/ implemented
- Positive focus
- Parent support and reassurance
- Independent perspective
- Family focus
- Service model

Relationship

Participants frequently identified both the relationship between the project worker and themselves and the relationship between the project worker and the child as significant to the effectiveness of the intervention. The idea of genuine relationships with someone who was seen to understand and listen was identified and using creative and age appropriate ways of engaging with children was also discussed.

This is consistent with ideas of the therapeutic relationship and alliance which is much discussed throughout psychotherapy research (Luborsky et al, 1975; Luborsky, 1976; Bordin, 1976) and suggests that the therapeutic relationship, rather than the model is key to success in therapy.

- *'Good relationship was important'*
- *'Listened when we needed someone'*
- *'They talked and communicated, using things like arts and crafts was good.'*
- *'They were professional but friendly and allowed the children to open up'*

Strategies

Caregivers commented that the strategies used had been helpful in making a difference. This involved comments about the strategies for managing behaviour and implementing boundaries and rules that the project worker had shared such as using reward charts. Participants also spoke about the strategies that the project worker had used directly with the young person and the work they had done together.
This is in line with feedback indicated by the highly researched positive parenting programmes such as Solihull Approach, (1996); Webster Stratton, (2005); Triple P programme (2008).

- *'Reminded us of rules and boundaries'*
- *'Different techniques were helpful- strategies for managing him'*
- *'Working on social skills helped'*

Positive focus

Care givers felt that the positive focus of the work was helpful. The project worker looking for positives and building on strengths was seen as important and is consistent with a solution focused approach to therapeutic work. It was also identified that information about positive parenting was useful and had contributed to success.
Again the links with positive parenting models are significant but also here the connection the team has with solution focused brief therapy as a model for bringing about change that the service user has identified themselves. This model is collaborative and resilience based and enables project workers to focus on families' resources rather than the potential for focusing on deficits. (De Shazer, 1998, 2001; George et al, 2000)

- *'Information about positive parenting was useful'*
- *'They didn't give any negative answers- always looking at positives'*

Parent support and reassurance

Care givers made comments relating to the feeling of reassurance and support from the team during the work. They spoke about the impact of the work on their own well-being, particularly in terms of parental anxiety and the implications this had had for outcomes for the young person. There was also a sense that the availability of the team was important for achieving success. This speaks to the responsiveness of the team that keeps its' focus on early intervention and prevention.
This flexibility and an early intervention agenda allows the project workers to hold in mind the impact of "problems" that could be located in the adult domain, such as parental mental health, whilst working in a way that brings about change within the wider system. This positioning can be seen to be useful in balancing the needs of the family with the views of the referrer (and wider systems) thus moving away from what Anderson & Goolishian (1988) would call the 'problem-saturated' ways of talking.

- *'They were on the end of the phone'*
- *'It helped us to know where to go'*
- *'I think I was holding him back- It helped me to be less anxious'*
- *'It helped us to see we were worrying too much. It helped us to let him be'*

Independent perspective

Those interviewed identified ideas relating to perspective and that it is useful to have someone from outside of the family to offer an alternative view. There was a sense that someone independent or neutral who was able to be inquisitive was useful. This fits with ideas within systemic psychotherapy/ family therapy of the use of meta-positioning and use of team to enable new and useful ideas to emerge. (Andersen, T, 1987)

- *'They were able to take a step back and speak to us and ask us why we were worrying so much'*
- *'Having someone from outside the family'*
- *'We are a close knit family and having someone to poke their nose in helped'*
- *'It was someone from outside the family to help with him and understand*

Family focus

Caregivers commented on the family approach the project has to working with young people. This way of working was seen as helpful and there was a sense of the whole family participating in the intervention rather than just the referred child. The comments suggested that this approach offered the opportunity for family cohesion and improved family relationships. Again this sits well with the team's own ideas about what they do, and how they do it (Salter et al, 2012) and also fits with an overall systemic ethos that has developed significantly over the time of the project. Systems theory would understand events and occurrences not in isolation but as interrelated, relational and interconnected with the context within which it occurs, namely the family (Bateson, 1976).

- *'It helped me and her at the same time. She learned she could talk to me'*
- *'It helped us to make sense of the family'*
- *'Reminded us that we were a family'*
- *'The family approach was helpful'*

Service model

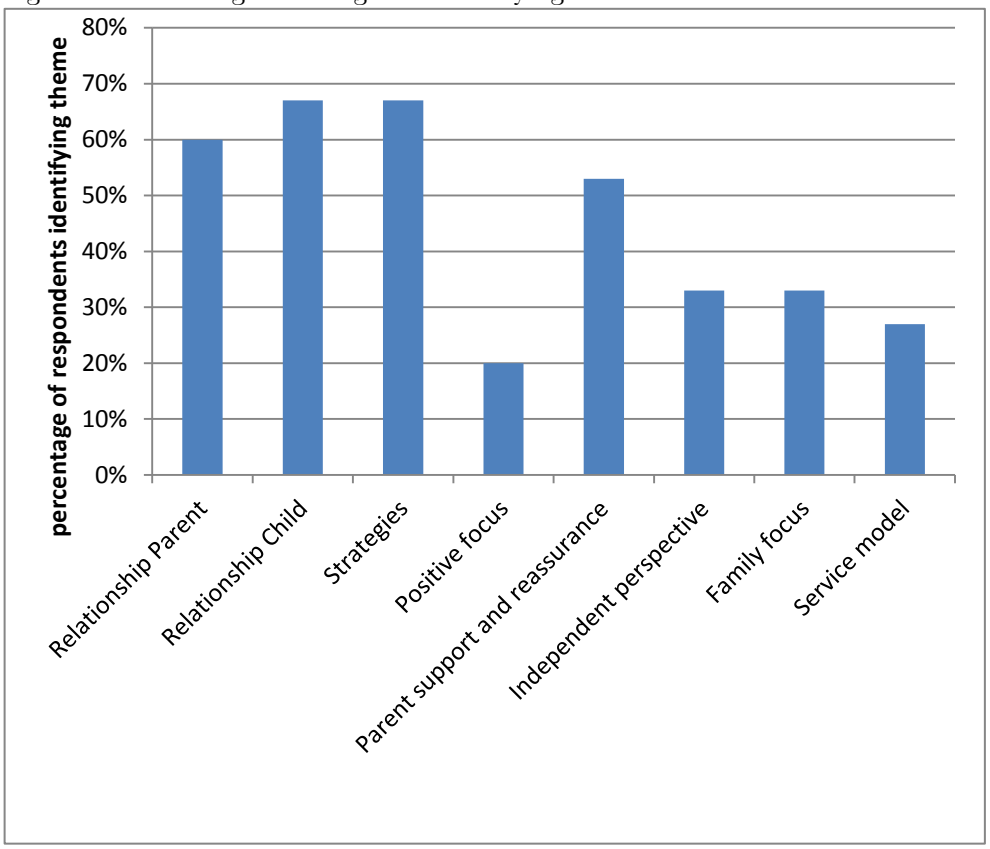
The service model and delivery method were identified as helpful for the success of the work. These comments related to the early intervention model of the project and the 'timely' nature of the work as well to the home visiting model of service delivery. This connects with the very beginnings of the team development, which came about following key messages from a review of CAMHS services in Wales- Everybody's Business (2001), which held key messages about the importance of early intervention, prevention, and community engagement.

- *"Mental health promotion and prevention of problems and disorders are key to this approach because good mental health in children is a positive indicator of the future wellbeing of the adults they become."* (Everybody's Business 2001)
- *'It was helpful to get in there early'*
- *Home visiting'*
- *'Someone coming out to you was helpful- home visiting was helpful'*
- *'Came at the right time'*

Figure 6 shows the proportion of caregivers interviewed who made reference to each of the themes that emerged from the interviews. A high percentage of those interviewed

spoke about the importance of the relationship with the project worker and a high percentage also spoke about the strategies used.

Figure 6. Percentage of caregivers identifying themes



Criticisms and suggestions for improvement

Only four of the caregivers interviewed had any criticisms or suggestions for service improvement. Some of these comments related to feeling the service was not long enough and wanting a process for getting back in touch with the service if it was needed. Some examples are:

- *'No changes to make to the service we received but it ended too quickly. 12 weeks is not enough. I wished it could have continued. Now and again having someone to talk to would help with this'*
- *'I would have liked longer. Perhaps a break for a couple of months and then come back.'*
- *'There was nothing that wasn't helpful. It did feel difficult to re-contact them if we had needed to. Perhaps a process for if families need help again would be helpful but we haven't needed to.'*

Conclusions

This evaluation provides promising evidence that, three years post intervention, families who have received a service from the Family Intervention Team continue to display positive outcomes. It is particularly positive that none of the families interviewed reported involvement with Youth Offending or Social Services post intervention.
Greater numbers of young people did go on to access child and adolescent mental health services however and it may prove useful to investigate this further to identify how often young people are directly referred to this service by the Family Intervention Team as part of an exit strategy at the end of the intervention.
The therapeutic relationship has, as in previous evaluations of service, been identified as an important factor in the process of change and even three years post intervention the strength of this relationship is perceived by families as significant. It is also interesting that parents identified the strategies that were either suggested or implemented by the project worker as important in the process of change. This suggests that a practical approach to the work carried out by the service is seen as particularly helpful by parents.
Criticisms of the service centred on the time limited nature of the work and pointed towards the need for an option to become involved with the project at a later date if it was deemed necessary. Since the point that the parents interviewed finished working with the project, this issue has been addressed by introducing an optional 'top-up' session for families, which can be used at any point following the end of the intervention. The feedback from this review highlights the importance of the perceived availability of this option, even if families may not decide to utilise it.

Recommendations

Further to this evaluation it may be useful to consider implementing a routine follow-up with families several months after the end of the intervention as this would help to capture a more accurate picture of the evidence of long term change.
In addition building in even longer term follow-ups every 1-3 years may also add weight to these early findings that go some way to suggest the long term nature of change following an early (short term) intervention.

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Drama as a means to engage with children whose parents experience mental ill health.

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Sarah is a practitioner/ therapist at The Family Intervention Team, and also shares a passion for the theatre and the use of drama to engage young people. Prior to working with the FIT team Sarah worked with "The Amber Project" a theatre project working with young people who self-harm.

Abstract

This paper follows the important phases in the development of practice of 2 therapists/ drama facilitators and the development of the young people taking part in a 10 week drama group. We follow the phases of the group, and of the group's shared learning, from the early joining phases, though the stages of engagement -taking part in drama games and exercises- through to the final performance. We also follow the practitioners' ideas in preparation for the group (background), and their thoughts following the group (reflections).A significant aspect is that the group was filmed, and the director and film crew became part of the group, as did the drama facilitators.
The paper is written by the 2 therapists/ drama facilitators.

Introduction

Parental mental health

> *"'Rare is the family that will be free from an encounter with mental disorder"*
> (World Health Organization 2001).

According to recent (2012) statistics published by The Royal College of Psychiatry 68% of women and 57% of men with a diagnosed mental illness are parents.
There is also compelling evidence that parents who maltreat their children are frequently struggling with problems such as poor mental health, substance and alcohol misuse, and domestic violence, which of course makes this a matter of public interest. Brandon et al. (2009); Daniel et al.(2009); and Stein et al. (2009)
Significant research in this area (Rutter and Quinton, 1984; Duncan and Reder, 2000; Oates, 1997) has highlighted the prevalence of diagnosable mental ill health in the population of adults who have responsibility for caring for children, and much has been said about the causal relationship between parental mental ill health and psychopathology in children. (e.g. Falkov, 1998).
Oates (1997) specifies from her research, a quarter of female patients newly referred to mental health services were caring for a child under the age of five. This points to a very obvious need for services that respond to adult mental health to be working with services that respond to the needs of children (and vice versa).

Research also highlights that there is very little information held within adult mental health services about the child dependents of adult patients, which suggests that there is likely to be a lack of sharing of information. (Jacobsen *et al* 1997).
Slack and Webber [2007]shows the reluctance of some adult mental health professionals to take a whole-family approach feeling in particular, that child care issues are not their responsibility. In addition there may be a reluctance from families to engage in services or ask for support for fear of being judged, victimised or discriminated against because of their mental health status. (Ruerpert and Mayberry, 2007)

Though this is not the primary focus of this paper, this relationship between mental health and parenting needs further exploration. Much of the literature points to a relationship between child abuse and neglect and parental mental ill health (with a focus on parenting deficit) with insufficient research in the area of "good enough" parenting and mental health (with a focus on parental competence). (Salter & Hardy, 2009)
As a team working within the wider field of mental health, with a specific remit to consider the impact of parental mental ill health on children and the wider family, we consider it essential to position ourselves in the realms of mental health promotion with an ear out for stories of competence and resourcefulness. In so doing, we have developed many creative ideas and interventions that respond flexibly to the needs of families experiencing these difficulties. This paper speaks to one such intervention- that of a group work programme for children, using the medium of drama.

Why then a drama project?

In the process of reflecting on this experience, this became a key question to ask ourselves. Why did we do it the way we did it? We imagine this would be useful for anyone else who might want to replicate what we did also.
The answer is both simple and complex. The short answer would be "because we felt it would work", the longer answer would talk to experience, skill, knowledge and research. We will attempt to speak in to that space throughout the course of the paper.

Method

The method also speaks to different positions. On a practical level the group took the format of 10 weeks of meeting together for 1.5 hours. We met at the project where both authors work, so was a familiar venue which was suitable for the purpose of meeting with young people and having enough space to "perform" (on a small scale). We met after school from 4.00 until 5.30.
The young people were referred from within our own project and from a young carers' project in Caerphilly, run by Barnardo's. The young people and their parents were contacted before the group started, and we discussed issues of confidentiality, consent, transport, support needs etc.
It was also important to engage with the children's parents so that the young people felt supported in accessing the group, and so that we had a contact point to follow up any areas of concern. We also wanted to invite the parents to attend the performance at the end, so that they felt involved and part of the group in some way.
In addition to offering the children a space on the group, we also offered parents a space at adult wellbeing groups that ran concurrently (day time), so that they felt that they were offered a similar support structure. Some parents took this up (6/11).

Transport was arranged for both groups, (for those parents who did not have transport) and we utilised staff vehicles and a volunteer driver to minimise the financial impact of offering transport.

Approach

We took a collaborative approach to facilitation by guiding the young people through games, improvisation, and acting. The adults in the group took part in the activities in order to create a safe and collaborative place in which expression and creativity were able to flourish. Having an age range 6 to 14 years was also positively regarded, with older young people often taking a respectful yet guiding role, and the younger children feeling listened to by all. The mixed age range also helped the older ones to enjoy taking a less responsible position than they might have to take in their caring capacity.

The drama facilitators were also joined in the group by 2 other adults, a young carers' project worker who already knew 5 members of the group, and a film maker who also took part in all group exercises so as to be "part of" the group. This we felt was essential for establishing a group culture that included everyone. On 4 occasions we were joined by the cameraman who filmed the group from an "outside the group" or "meta" (Bateson, 1972) position, as an observer of the production that was emerging.

Joining and transition

In the same way that every day transitions can be eased by ritual, such as the transitions we make between work and home, and the routines that mark and support them, in the same way we believe that having a consistent structure and format each week, that the young people could look forward to, created a helpful transition from the school environment to drama group. The group became familiar with the routine and this then created safety. This is in line with ideas within systemic therapy of ritual and transition (Imber-Black et al., 1988), and that of "joining" (Minuchin, 1974).

The use of chairs to form a circle at the beginning and at the end of each group became a body-made container for the group and created a physical safe space that was supported by the safety generated from familiarity and repetition. This was, we reflect, an extremely important aspect that supported the young people to then take note of the space that their own bodies inhabited, and begin to explore relationships in respect of themselves as well as others. Such body in space awareness using warm up exercises enabled the progression and flow towards performance.

Embodiment

"Suit the action to the word, the word to the action"
Shakespeare, W. "Hamlet", Act 3, Scene 2, 17

Embodiment in psychotherapy has arguably been neglected as a focus for research; however the move away from Cartesian (Descartes, 1628) ideas of mind or body towards a relational experience of mind/body has been given more weight in recent publications. In particular embodiment seems to have "found its place" in drama

therapy (Milioni, 2008), with significant reference being made to the embodied therapist. This is perhaps because the body in drama is far more than an object for observation; it is the means in which the actor communicates.

Stanislavskian (Stanislavski, 1936) acting, for example, relies heavily on the position of the actor as not just an interpreter of a feeling but the embodiment of that "lived" emotion. His aim, to reach the "believable truth", relied on techniques such as "emotional memory" to encourage the actor to inhabit the emotional space that connected to felt experience. In this way, the "construction of the organic body-mind" was achieved through a process of embodiment where the actor is trained to respond bodily to the impulse of the mind.

When we consider Merleau-Ponty's (1962) proposition that it is through our bodies that we "engage with the world" and also "make sense of our place in the world"; then the positions of bodies in any space (including the therapeutic and the theatrical space) has significance.

Engagement: The body in relation

"Visible and mobile, my body is a thing among things; it's caught in the fabric of the world, and its cohesion is that of a thing. But, because it moves itself and sees, it holds things in a circle around itself."

Maurice Merleau-Ponty (1962)

We introduced warm-up exercises that connected group members to one another, building trust, and encouraging the emergence of self-expression. Some of these exercises were movement based, some were mime based but all were grounded in the principles of spontaneity and creativity (Moreno, 1974). These exercises became pivotal in providing the platform to move towards spontaneous expression, where physical awareness of self was explored through movement at an appropriate level of expectation (Jennings et al, 1994). Acknowledging the importance of the warm-up (recognised in drama therapy and psychodrama), we also found inspiration and guidance in the work of Augusto Boal, (2002).
Such games enriched and enlivened our group work. One example was 'Columbian Hypnosis' where we worked in pairs; one person would be the leader and one person the led. The led person would follow the leader's hand that is vertical and parallel a few inches from his or her face. This game is physical, fun and encourages the use of different muscles in the body. As Boal (2002) says, such an exercise is concerned with 'ways of walking and moving, with externalising emotions.....and helping the actor to find new ways of expressing herself and acting on stage and in life.'

In the group it was noticeable both in the moment and later in observing the video of the group that the children opened up not just in their verbal communication but in the opening of their bodies. From initially taking up little space they began to take up more, inhabiting new and different space. This mirrored again the structure of the weekly group where we would move from being contained within circle at the beginning of each session, to breaking free of the circle, thus the acting was a move out of the familiar.

Embodied words

It is "...not...(that we are) in the world through language or through the body separately, but because language is in itself embodied even as the body is en-worded, we are in the world in a unified manner"

(Sampson, 1998)

Our aim was to "hear" from young people in a way that promotes their own language, their own form of communication and allows their position to be acknowledged. This has significance in this context where the presence of "mental ill health" could easily privilege the voice of doctors, psychiatrists, and the adult patient above the voice of the child or the family. In this way the family story could easily be subjugated by a more dominant medical discourse. (Foucault, 1961;White, 1990; etc)

We also needed to pay attention to the currency of communication and the stories that get voiced within the peer group. This was particularly relevant for 5 of the young people, who, through a "young carers group" had already begun to develop an identity as a "carer". Whilst noticing this particular definition of relationship, we also had to ensure that we made room for different stories to unfold, in line with a narrative approach that allows for new stories to emerge from the relational experience of being with others and having a story witnessed (White, 1990).
We also had to find a balance between the need for us to respect a potentially important and validating role that a young person feels that they have, when looking after a parent, whilst also recognising the negative impact that such high demands might have on young carers' lives at school, at home and in terms of their social lives (Cooklin, A. 2010).

Dominant discourse

The currency of communication began to develop early on in the workshop series, when we explored different descriptors of mental ill health, and placed these into categories based on feedback from the young people. The group came up with as many words as they could that they had heard about in relation to mental health and then decided together which category they should be placed in.
The categories were: words that doctors or other health professionals use (medical words); words used by those who don't understand (derogatory); and words that the young people preferred to use to describe the mental ill health of a family member (our words). This one exercise resonated loudly with the group and began to shape our drama from this point. Five of the preferred words were enacted through sculpted shapes that the young people designed together in two groups and presented to one another. There emerged a movement and flow of communication between and amongst individuals, a relational 'space between' (Hoffman, 2008).

Irreverence

We were clear from the outset that we were providing a therapeutic environment for the young people but that this was not 'therapy'; we were also clear that we were borrowing from the world of drama but that this was not strictly theatre. So, the therapeutic value of spontaneity and creativity that are embedded in Moreno's ideas of Psychodrama and Socio drama (Moreno, 1974), were closely felt because they fit well within the post-modern and narrative approaches to systemic theory (Blatner, 2007), both for the clinical setting, and outside 'therapy'.

In this way we were able to work collaboratively to redefine relationships, not shying away from the subject of mental health but also not to being overly organised by it, so as to blur out the rich detail of children's wider frame of reference. Our systemic background allowed for us to be open to an underpinning concept that those who are in relationship can co-create a space for new stories to emerge (White, 1990). Using the lens of the theatre, can help us become liberated from a position of fixing peoples' minds towards a less directive therapeutic encounter (Mac Cormack 1997).

It is worth adding that we have taken advantage of the manoeuvrability of being positioned as practitioners both within, and outside of mental health services, and in this way we are able to remain open and curious about the client/ family relationships. It was important for us to create a space where strengths and resources could be highlighted above the definition of the "problem" of mental ill health (De Shazer, 1988).

This wider view, we propose, offered us more flexibility and more space for creativity, catching those moments on the periphery of the definitions of group where the "bending" of rules meant that some children created their own space for their story.

We found that the young people were much better at changing the rules than we were. Our favourite "bending" of rules happened at the beginning and ending of each group where we asked the children to score how they were feeling from 1-10. Sometimes the experience fitted within the confines set, but sometimes it didn't, and the younger children in particular, often scored out of 11 or 100, or even 111, therefore creating their own boundaries.

Whilst gentle rule-bending was accepted by adults and children in the group, we consider it was vital to have enough structure to support some movement but not to bend out of shape entirely. On the one hand we would hold on to the systemic idea of encouraging 'difference that makes a difference' (Bateson, 1972, p. 459), and in this case it was to offer a new and creative platform on which young people could explore their experience of a parent's mental ill health.
However for difference to make a difference, it cannot be "too unusual" (Andersen, 1991, p.19) so as to destabilise the group and impact on safety. Here, rising to the challenge to participate creatively might have felt too different and therefore become

impossible had it not been for the collaborative learning, joining, and the sense of safety provided by circle, games and warm-ups, as described earlier.

As we moved towards performance, the group's choice and interpretation of their particular chosen words emerged as a dominant theme, and a starting point for meaningful and embodied performance.

Performance

...in order to see the world and grasp it as paradoxical, we must break with our familiar acceptance of it...."
Merleau Ponty (1962)

The journey towards a final performance for parents and other family members was a journey of creativity where from day one the young people practiced performing to an audience as well as practicing being an audience. Even as they rehearsed ideas from previous weeks, their propensity towards spontaneity kept each performance fresh and fluid.

"....there is no inner man, man is in the world, and only in the world does he know himself."
Merleau-Ponty (1962)

Stories lived and stories shared

The structure of safety and a developing sharing of experience through mime, improvisation and story-telling became the scaffolding) for the group experience; and the agreed use of language gave us the form we needed to enter in to a staged performance. In the world of therapy the idea of scaffolding offers a space for trust to be built and stories to emerge (Pare & Lysack, 2004). The words acted as threads through the exercises, games and drama techniques that were introduced week on week and began to build in to a performance that was to be shared with parents and family members from home.

We were clear, from the beginning that we did not want our group to take any role in a parenting blaming culture that can so often exist in services that work with children who are defined in some way as "in need of services". We were also careful not to place ourselves in a position where we might seem more "expert" than the parents of the young people we were in contact with. Therefore, alongside the work with the children, we were also meeting with parents, offering them group support and also keeping them up to date with the progress of the group. Having a performance for young people to celebrate WITH their parents was therefore fundamental to the collaborative process.

The group then showed the work that they had been doing through the ten weeks, and used the words that they had chosen to perform beautifully crafted tableaux, mimed performance and improvisations that spoke to their experience both inside and outside of their group.

Discussion

The group reached eleven young people from a total of twelve who were referred and one chose not to take up the service. In the end ten young people completed the whole 10 week programme. One young man moved out of area through the course of the group.
Four of the young people went on to make digital stories as a way to share their individual stories, and consequently presented these digital stories and the drama video at a conference that reached over 100 professionals working in the field of mental health and family support.
One young person from this group went on to co-facilitate a workshop for professionals at national conference in Wales.
The filming and resulting DVD remains a marker of the transitional nature of the group and offers the viewer an insight in to the development of the young people and their own ideas.

Conclusions

In this paper we have aimed to pull together some of the major influences and theories informing our work as therapists and in particular in relation to this paper, our work as drama practitioners working with children and young people.

We have covered a lot of territory, passing through the landscape inhabited by drama, psychodrama, drama therapy, and our most familiar terrain, that of systemic psychotherapy.

We consider that our group provided a safe space for young people to explore their experiences of living with mental ill health, to begin to define their own way of communicating their experience and also to formulate a group identity that was not inhibited by one definition such as that of "carer" (a label well utilised for the compliant ones) or "EBD" (emotional behavioural difficulties) (reserved for the ones who have something big to say about this stuff).

We were struck by our own observations of the emerging qualities of confidence, imagination and creativity shown by the young people, and also how they noticed these qualities grow in themselves and others as the weeks went by. Several young people have subsequently co-facilitated two workshops with us, further exploring their own learning abilities but also teaching adults about how we can engage meaningfully with young people.

Parents were able to celebrate with their children the success of their group, and their work, which was a respectful and sensitive representation of their understanding of mental ill health. The privileging of the child's voice through this process we believe did not serve to reduce the voice of the parent or professional but adds another layer to the beginnings of a shared relational understanding of wellbeing.

In our irreverence to rigid positioning and having worked flexibly to adapt an idea to fit our own context, we posit the invitation for others to move in to a relational space and potentially to adapt this way of working to fit their own contexts.

Recommendations

If this pilot group were to be replicated we would consider it possible to identify core outcomes in terms of the impact on the children in the group and the wider impact on the family. If this were to be evaluated some key themes are likely to emerge. We propose these might relate to confidence and self-esteem, developing knowledge and understanding of mental health and ill-health, improving family relationships, and widening definitions of identity.

The filming of the group was a key element and could be used to track developments in any chosen areas for evaluation/ impact assessment. More crucially for us it added to the "fun" component and to the overall experience of performance which gave purpose to the young people and structure to the group.

Though this pilot group was facilitated by therapists with an interest in drama, similar groups have been run by the combination of drama professionals with a psychiatrist (Cooklin, 2010); and could be run by other professionals from within statutory or voluntary sectors, and provide an excellent opportunity to work across those sectors, taking a position of appreciation of "difference".

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