



CONNECTING WITH CARERS IS EVERYBODY'S BUSINESS

A TRAINING RESOURCE FOR FAMILY FRIENDLY
MENTAL HEALTH SERVICES



SOUTH EASTERN SYDNEY
ILLAWARRA
NSW HEALTH

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FOREWORD

This DVD and Handbook have been developed for EVERYBODY working in public mental health services, because connecting with carers is everybody's business.

The importance of adult mental health services engaging and working with the families and carers of consumers with mental illness is well demonstrated in the international literature. Reduced distress and burden for carers, recognising and enhancing the extremely valuable contribution that carers can make to the treatment plans of the consumer and improved clinical outcomes have all been reported. By involving carers from first contact through to discharge, all clinicians in mental health can make an enormous difference to the carer's journey and the consumer's outcome.

The Working With Families (WWF) program was established in 1996 at Sutherland Mental Health Service to provide better outcomes for people with mental illness by increasing the capacity of the Mental Health Service to work with families through systemic change and individual clinician practice that enables clinicians to work in a family/carer framework.

In 2003, the NSW Family and Carer Mental Health Program was developed by the Centre for Mental Health to provide education, support and partnerships with families and carers and to promote family friendly culture in Adult Mental Health Services across NSW. As a part of this program, the WWF program conducted training across NSW during 2004-2006.

The Connecting With Carers Is Everybody's Business DVD and Handbook were developed to meet the need identified by Area Health Services during the Statewide training for a training resource which focused on the skills essential to everyday practice in working with carers of adult mental health clients. There is a dual focus on individual clinician practice and systemic change that encourages the development of key values and a shared philosophy within mental health services.

I would like to thank the Working With Families team for producing this resource and the Statewide Family and Carer Interest Group which provided valuable input during the consultation process.



Dr Beth Kotze

Area Director Mental Health Services

(South Eastern Sydney Illawarra Area Health Service)

ABOUT THE DVD AND HANDBOOK

The DVD and this companion handbook are divided into two parts.

Part 1: Developing Family Friendly Mental Health Services and The Pyramid of Family Care

Part 2: The Pyramid in Action – a scenario of a family partnership with mental health services

This part of the Handbook and DVD introduces a fictional story of a family connecting with a family friendly mental health service. The DVD follows the family through the 18 months following the first admission of their son.

In the Handbook, the **Meet The State Family, How Mental Illness Pushed Our Family Around** and **Working In Partnership** sections tell the story of the family, the mental illness and the involvement with the mental health service over a three year period.

In **Behind the Scenes: Clinicians at Work** family and clinicians reflect on their experiences.

The **Over to You** section contains questions and tasks  and tips  designed to guide individual, team or group learning.

The NSW Family & Carer Mental Health Program has been developed to assist consumers, families and carers in understanding and coping with mental illness. The program is founded on a mandated partnership with Non Government Organisations. This means that every Area Mental Health Service is working together with a partner NGO.

The aims of the Program are to improve:

- *family friendly mental health services* where families and carers are recognised supported and included in treatment, planning and service provision
- *mental health family and carer support* whereby partner NGOs provide education and training to build coping skills and resilience. They also provide individual support, information, advocacy and peer support
- *awareness of, and access to, generic support services* such as counselling, respite and financial support

The Program is supported by the Mental Health and Drug and Alcohol Office (formerly Centre for Mental Health). To find out how to contact your partner NGO refer to page 14.

PART 1

Developing Family Friendly Mental Health Services and the Pyramid of Family Care

What Is A Family Friendly Mental Health Service?

A family friendly mental health service is one where families and carers experience a sense of welcome and partnership in every service contact. This requires commitment at all staffing levels. Managers, clinicians and carer organisations have found that a capacity building approach may be helpful in the development of cost effective and sustainable family friendly mental health services.¹

What Is Capacity Building?

Capacity building has 5 key components. All of these are important and success relies on ensuring none are overlooked.

- 1. Leadership** – support for family friendly initiatives at all levels of management
- 2. Organisational Structures** – family and carer issues are incorporated into policy and procedures; steering committees to implement family friendly practice and service development; family friendly practice skills included in job descriptions
- 3. Workforce Development** – including a range of training opportunities promoting skill development in working with families and carers; supervision and consultation focussing on developing family friendly practices
- 4. Strategic Resource Allocation** – including development of fact sheets and carer information packages; staff positions given a mandate to coordinate family carer initiatives, supported training and supervision of other staff; provision of family rooms where children can safely visit
- 5. Partnerships** – working with services such as Non Government Organisation (NGO) partners in the Family Carer Mental Health Program

OVER TO YOU

-  Rate your service with regard to connecting with carers (out of ten). What parts of your service may get a higher or lower rating?
-  Using the 5 capacity building areas, list some strengths and challenges in your service.
-  Within your role and team what new initiatives could be put in place for families and carers? (Remember little things add up!)
-  Who could you speak to in your service to help move towards a more family friendly culture?

¹ Mottaghypour, Y., Woodland, L., Bickerton, A. & Sara, G. (2006)

THE PYRAMID OF FAMILY CARE

When adult mental health clinicians first start working with families they often comment that they feel uncertain about what to do. The purpose of the Pyramid of Family Care is to provide a guide for involving families and carers in everyday clinical practice.

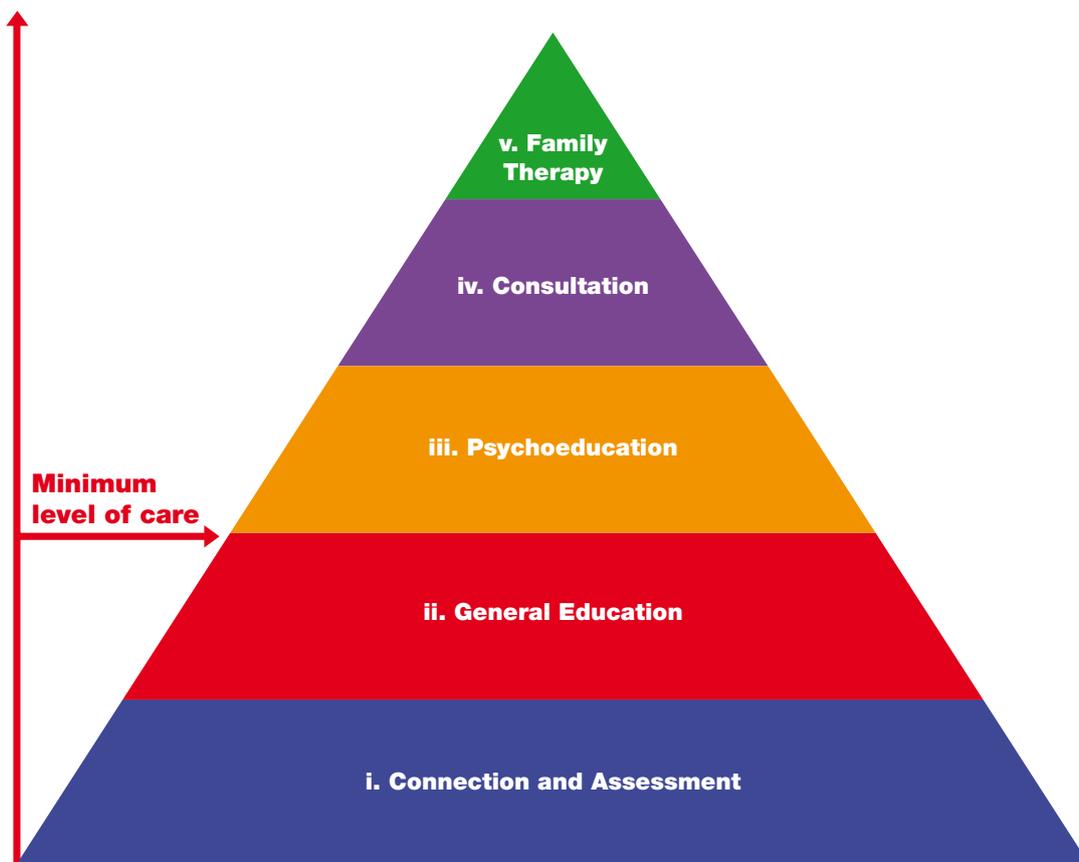


Figure 1a. The Pyramid of Family Care: A guide for involving families and carers in everyday clinical practice²

The pyramid is divided into 5 levels with levels 1 & 2 comprising the minimum level of care. ALL clinicians offer levels 1 & 2 to ALL families and carers. Levels 1 & 2 require skills in communicating (in ways that respect everyone's safety and privacy), and knowledge about mental illness, treatment, and services available to consumers and carers. All mental health clinicians should have these skills and knowledge.

The minimal level of care is NOT about specialist interventions.

A small number of families and carers, but certainly not all, do benefit by moving up the pyramid to higher level interventions. Clinicians may have the specialist skills to provide some or all of these levels, or may consult with experienced clinicians in their service, or partner agencies, to provide the higher level interventions.

A model of care, like the Pyramid, facilitates an integrated and coordinated clinical approach to families and carers across the mental health service.

² Mottaghypour, Y. & Bickerton, A. (2005)

THE TASK PYRAMID

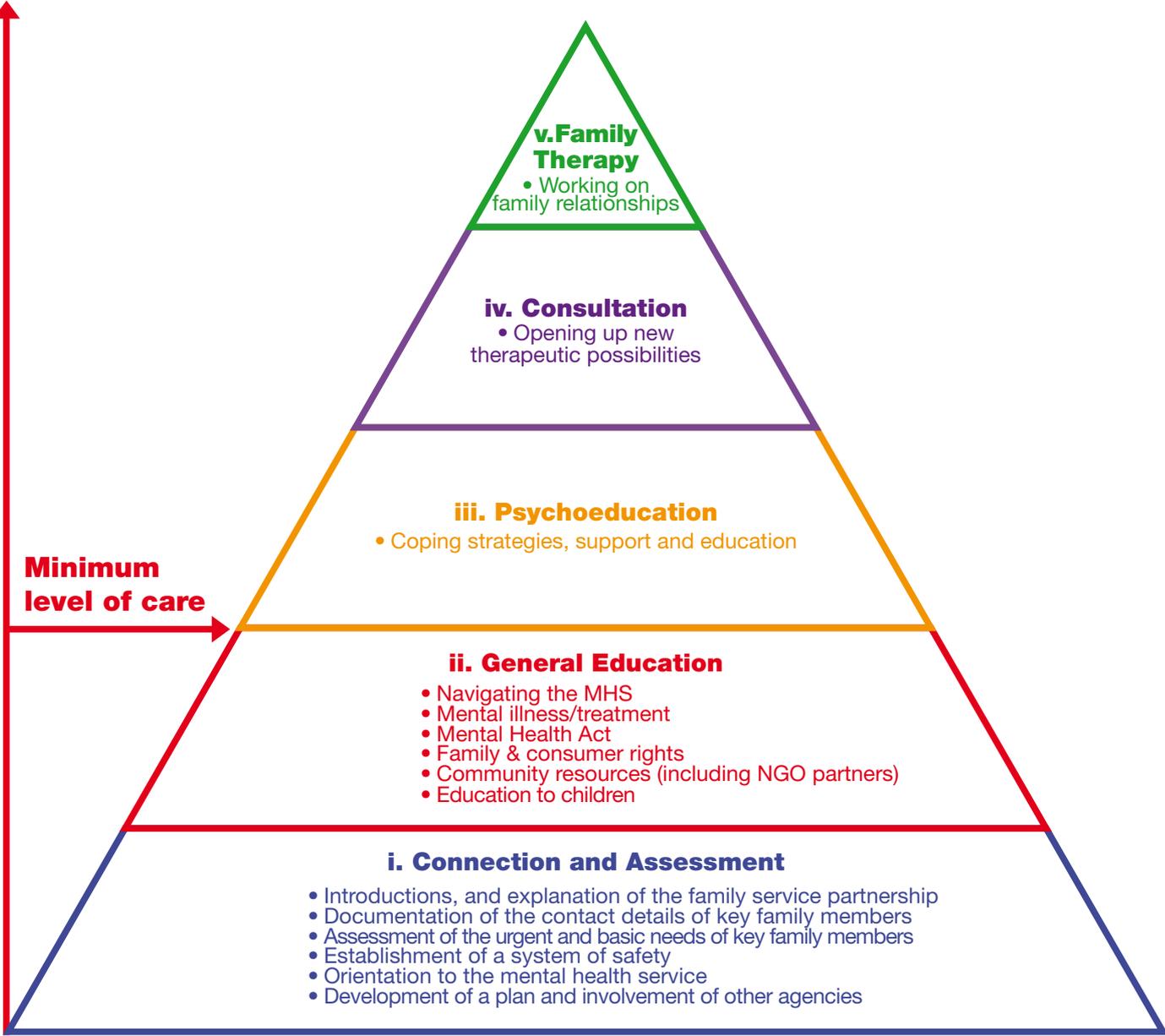


Figure 1b. Task Pyramid: A quick reference to the key tasks in each level of the Pyramid of Family Care

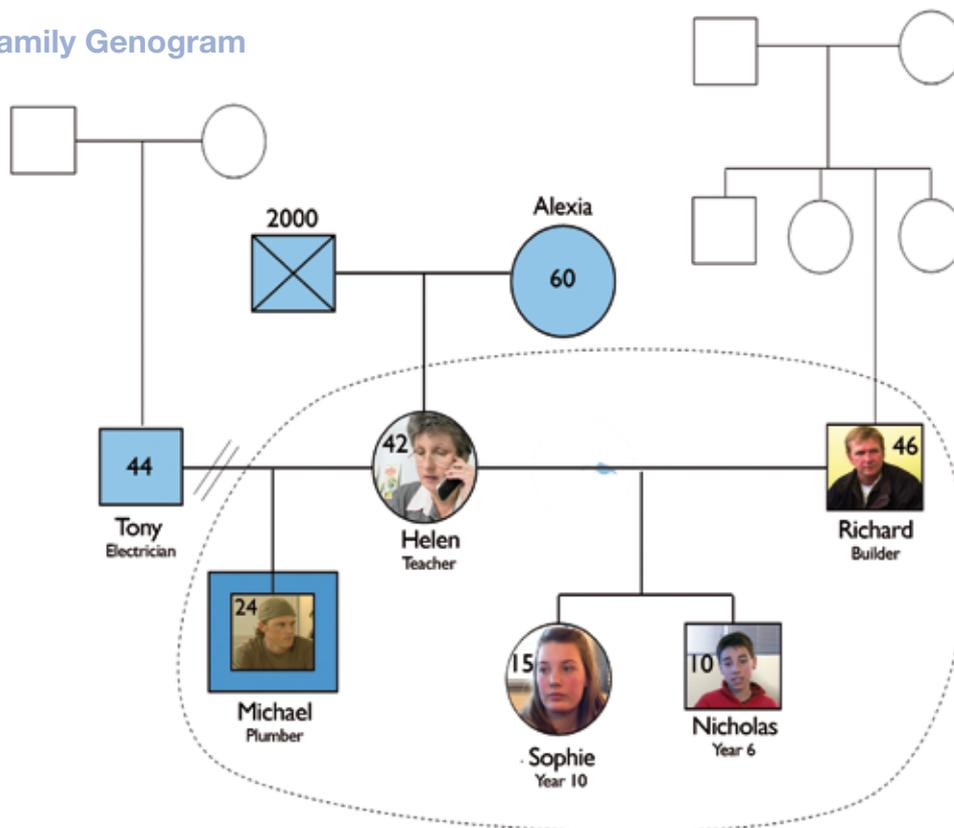
As you progress to each level reassess the individual and family needs and connect with other services as needed.

PART 2

The Pyramid in Action - a scenario of a family partnership with mental health services

MEET THE STATE FAMILY

The State Family Genogram



Key to genogram



Helen (mother): “I was a naïve 18 year old when Michael was born. I thought that things would get better between my first husband Tony and me. But Michael was a grizzly baby and every time he cried it seemed to infuriate Tony. He never hit Michael. But there was a lot of violence towards the end. Michael did see Tony kicking and punching me. I left Tony when Michael was quite small.”

“The best thing that ever happened to me was meeting Richard. He’s a true blue Aussie bloke. He was completely different to Tony. He treated Michael like his own son. We had Sophie and Nick and I was the happiest I have ever been. Richard helped my mother, Alexia, and I get through my dad’s death and we found a house for Mum in the neighbouring street.”

“It’s three years now since Michael first came to hospital. Mostly our life is back on an even keel. Working closely with the mental health service definitely helped Michael and our family achieve this.”

OVER TO YOU

Genograms are a simple way of presenting a lot of family information.

-  How often do clinicians in your service use genograms as part of standard documentation? In case reviews? In family sessions?
-  Practice on your own genogram or have fun with celebrity or cartoon family genograms.

HOW MENTAL ILLNESS PUSHED OUR FAMILY AROUND

Helen (mother): “It’s three years now since Michael first went to hospital. He was always my pride and joy. He was a great sportsman and he had a good job. His behaviour changed when he got into drugs. He would get quite scared for no reason. We suspected something was wrong for a long time, but we didn’t know where to turn. The people from the hospital gave me some information about mental illness when they visited Michael at home once. But back then I couldn’t bear to read it.”



“Michael’s first admission, just after his 24th birthday, was an enormous shock. I don’t think we will ever get over it. But the mental health team involved us which was great. It has been valuable having Frances, the community mental health worker to call on as well.”

“At one stage when Michael relapsed and went back to drugs in a big way, I really went downhill. You know what they say about teenagers who take drugs having an unhappy home life! I started to worry that I was to blame for Michael getting sick. Was it because of Tony’s violence? Was it genetic? Was it because I was depressed when Michael was little?”



“With Michael’s relapses my life became a mess again and I was back in a space where I never wanted to be. I felt I had to make it up to Michael somehow – give him everything he wanted. Richard seemed to forget how sick he was. We were at loggerheads with Michael stuck in the middle. I nearly lost my marriage. Thank goodness we had some help.”

Richard (stepfather): “Michael used to be such a nice kid! I thought of him as my own son. But it got really hard when he started to get psychotic. I didn’t know whether I should come down really hard on him or not. Talking to him made no difference and the other kids

were upset. Helen always made excuses for him and the tension between us was hard to deal with. I never really understood how bad she felt about the past until it all came out with Michael’s illness. It was rocky for our marriage for a while but we’re back on track now.”

OVER TO YOU

-  What were the main ways that mental illness impacted on Helen and Richard as individuals, on their marriage and on the parenting relationship?
-  Think about parents you have connected with. In what ways did mental illness impact on them? Notice similarities and differences.



Sophie (sister): “Michael really changed when he got sick. I missed him goofing around and watching TV with me. I even missed him borrowing my music without asking. At first Mum was always crying and then the fights with Mum and Dad started. For a year or two everything was Michael, Michael, Michael. I was lucky I could escape and spend most afternoons at my girlfriend’s house. You don’t want to tell people about mental illness but my friend’s mum had an uncle who had schizophrenia so she sort of understood. It was always good to talk.”

“At one stage I was scared that mum was getting sick too. That was the worst time. Mum crying and Mum and Dad fighting. That was a year or more ago. Things are better now.”



Nick (brother): “I was sad when Michael got sick. I missed him and had nobody to play soccer with. I missed Sophie – she was always out at her friend’s. There was a lot of yelling – Michael, Mum and Dad. I didn’t want to upset them and I tried to be really good. I went round to Yaya’s a lot. That was good, but I couldn’t talk about Michael. It’s better now. We can have fun again.”

OVER TO YOU

Kids are resourceful.

-  In what ways did mental illness push Sophie and Nick around? What strategies did they use to cope?
-  How might a child’s age and developmental stage change their coping strategies (infant and toddler; pre-school; primary school; high school)?
-  What strategies do kids use to cope in the families you work with?



Michael (consumer): “For a long time I didn’t believe the doctors and Mum and Richard when they said I had a mental illness. I thought they ganged up on me. I just wanted them to leave me alone and give me freedom. All my mates used drugs and had a drink on the weekend - why did they want me to be a freak? I hated the hospital and just wanted to get out. I think it wasn’t until I got to hospital the third time that it started to sink in – the magistrate agreed with them all.”

“For a while I hated everyone, especially Mum and Richard. I know I gave the kids a hard time too. I wanted to move out but they wouldn’t let me. They made me a flat downstairs. When I got angry Mum went to pieces and would give me anything. It was easy to get money out of her.”

“It was when Mum and Richard stuck together and wouldn’t give me money any more that I guess things started to change. I suppose I started to take responsibility for my life again. I started to get into recovery. Frances, at the centre, helped me a lot. I take my medication and have learnt how to beat the voices some of the time. I try to lay off the drugs. I’m back at work three days a week. Things are better with my family again.”

OVER TO YOU

-  How did Michael’s illness impact on his relationships with his family?
-  What helped Michael move towards recovery?
-  What is the role of the family in recovery and how can a clinician assist with this?

Other Family Members

Alexia (grandmother -Yaya): “My grandson will be all right, I know he will. I don’t think he is sick. He was just going through a stage. Helen worries too much! I don’t like him taking medicines and I tell Helen that all the time. I tell them to let him stay with me. I’ll look after him, make him his favourite sweets. That paper about sickness Helen gave me is here somewhere. I know it’s in Greek. I’ll read it later.”

OVER TO YOU

Alexia migrated to Australia as a young woman from Greece.

- ❓ What reactions is Alexia showing to mental illness? In what ways would her response be helpful and/or challenging for other family members?
- ❓ What techniques and resources do you have in your service for connecting with Culturally And Linguistically Diverse (CALD) carers?

Tony (father): “Helen rang me a while back. They reckon Michael’s sick. Probably just needs a good kick up the backside! Besides I’ve got problems of my own at present. I never caused it! Got to stop thinking about the past...”

OVER TO YOU

Many consumers have minimal contact with a family member or carer.

- ❓ How do you work with the consumer to think about the potential benefits or disadvantages of reconnecting? What forms may reconnection take?
- ❓ What safety issues would you consider if Michael wanted to reconnect with Tony given the past history of violence?

WORKING IN PARTNERSHIP

Frances, psychologist and key community mental health clinician (MHC) reflects on her mental health service's three year involvement with the State family



Frances (MHC): *"A whole of service family approach makes a difference. Our service is probably pretty typical of suburban mental health services in big cities. We have a locked mental health unit, a number of community mental health teams and an acute care team that provides urgent and after hours support. Probably one of the differences in our service is that for nearly ten years the whole service has been trying to work more effectively with carers and families."*

"It's three years ago since I met Michael when he first came to hospital. He had been intermittently psychotic, in the context of cannabis use, for a few years before this. But back then he responded within 24 hours to small doses of antipsychotics prescribed by his GP. Our acute care service visited the home on a few occasions, but as things settled there was no ongoing contact."

"About two weeks prior to his first admission, the family started to notice Michael wasn't well. He was irritable, withdrawn and started to talk of people being out to get him. He refused to see his GP. It was a huge shock to the family when he went missing for two days and was found talking to himself and dishevelled in a park about 10 kilometres away."

"The hospital staff sowed the seeds of partnership between Michael, his family and our mental health service. This helped our community team develop a good connection with the family. In the next year things settled down and Michael got back to work. But as so often happens, with a combination of cannabis, alcohol and not taking medication, Michael again relapsed and had a few re-admissions to hospital. A Community Treatment Order helped get things back on track for Michael, but the illness had taken a toll on the family and the couple were in crisis. Our specialist family clinician's assistance was invaluable then."

“It’s twelve months further down the track now and Michael seems to be doing well. He has some residual symptoms but he’s working and is actively focussing on his recovery. Helen and Richard popped in the other day. They looked great and had just got back from a beachside holiday (their first in many years as a couple). They asked me about staff they met that very first time they came to the hospital. *Everyone in the service played an important role.*”

OVER TO YOU

On the DVD you see our clinicians from various teams using the Pyramid to guide their work with the State family over the 18 month period following Michael’s first admission.

 What pyramid tasks do each of the clinicians perform? (Hint: see pyramid in top right corner)

WORKING IN PARTNERSHIP WITH YOUR CARER NGO

Partnerships between Area Mental Health Services and NGOs have been developed across NSW to meet the aims of the Family and Carer Mental Health Program.

See below for your NGO partner.

Area Health Service	NGO	Contact Details
Sydney South West	Carers Assist	9816 5652
Hunter New England	Carers Assist	9816 5652
Greater Southern	Carers Assist	9816 5652
Sydney West	Uniting Care	8842 8289
Northern Sydney Central Coast	ARAFMI	9332 0700
South Eastern Sydney Illawarra	Carers NSW	9280 4744
North Coast	Carers NSW	9280 4744
Greater West	Carers NSW	9280 4744

BEHIND THE SCENES: CLINICIANS AT WORK

SCENE I: EMERGENCY DEPARTMENT

Acute care clinician Leo, clinical nurse consultant (CNC) meets parents in crisis

Leo (CNC): “Simple things can make a difference! It’s always busy in acute care. That’s probably what I like about it. But I always try to find a few minutes to seek out and talk to the family. They can sometimes get overlooked in the rush of the crisis. Michael was extremely unwell when he was brought in floridly psychotic and very dishevelled. The emergency staff mentioned the parents were in the waiting room. I didn’t have much time, but given Michael had been missing for two days I guessed they must have been very worried. They needed to know he was safe. They looked so scared and bewildered. *It was Michael’s first admission to a mental health unit, so I got their phone numbers and gave them some fact sheets.*”



Helen (mother): “When Michael went missing of course I feared the worst. I didn’t sleep for two nights and Richard drove me round and round our suburb. We made a hundred phone calls to all Michael’s work and soccer mates – anyone we could think of who may have known where he was. We were all beside ourselves. Mum came over to mind the younger kids. When they rang to say Michael was at the hospital I broke down with relief. We got to the hospital as quickly as we could. *I will always remember the mental health clinician coming to talk to us and telling us Michael was safe.*”

OVER TO YOU

Acute care services are often the first point of contact with families and carers.

- 🔍 How did Helen and Richard show their distress?
- 🔍 What key pyramid tasks did Leo complete?

Families and carers in crisis may connect by phone or in person.

- 🔍 In what ways can a carer in crisis show their distress?
- 🔍 How would a family in crisis rate (out of ten) their first contact with your service? In what ways could things be improved?
- 🔍 What verbal and written information do you give to these families?
- ⚠️ First impressions count. Posters and fact sheets in your reception areas, offices and your emergency department make carers feel welcome. Carer information packages can be a useful way to connect.

SCENE II: INPATIENT UNIT – 2 days after admission

Family meet social worker Jane, inpatient unit social worker (SW) and Dr Philip Kuzo, registrar

Jane (SW): *“I attempt to make a connection with families and carers within 24 hours of admission. That’s the practice I have developed in the 10 years I have worked on the mental health unit. I always try to seek the consumer’s consent to contact their family. Even when consumers are very ill, like Michael, I work to get their trust. I was able to help him understand that by meeting with his family we were likely to understand how best to help him.”*

“Developing a trusting relationship with the family or carers is definitely the most important aim of my first session. Sometimes connecting is easy, but sometimes trust takes time especially when carers have experienced the system as letting them down. Validating this experience seems to help them move on. This was the case for Helen and Richard.”



“When setting up the first family session, Michael was very unwell. I still was keen to have Michael attend the beginning of the session as I think it promotes trust. I think we really connected with the parents in our first session. This helped to lay the foundations for a strong partnership with our team. I usually allow at least an hour for the first family meeting or assessment. I always invite all family members, but respect it is the family’s decision who they bring along the first time. Like with Helen and Richard, adults often come in first and then feel safe to bring the kids in later.”

“It’s not helpful to judge or take sides unless safety is an issue. I work hard to stay neutral. I aim to help the family members try to listen to each other. It is often surprising how, by taking time to listen, they realise they have been jumping to conclusions about the other person’s thoughts or actions.”

Philip (registrar): *“I was really anxious about meeting with families when I first started working as a registrar earlier this year. I thought I had to “fix” them. But now I know that was my issue. Helen and Richard just wanted to tell their story and to get some information. It has been helpful seeing families with Jane. She has taught me a lot and it was good to share the tasks and responsibilities with another clinician. The Pyramid is a good prompt. *Each time I see a family I grow more confident.*”*

Helen (mother): *“I was pleased when Jane invited Richard and me to the session. We had so many questions. But I was a bit apprehensive. From the start Jane and the young doctor made it clear we were there to work together. That was important right up front, to know I wasn’t going to be blamed. *I trusted them with the care of my son.*”*

OVER TO YOU

Communicating in ways that respect everyone's safety and privacy is essential when working with consumers and their families.

- ② How did Jane and Philip achieve this?
- ② How do you achieve a balance between confidentiality and connectedness in your work with families and carers?

There are many ways to undertake a successful family session.

- ② What would be your agenda for a first family session?
- ② In what ways would you have conducted a first session the same or differently to Jane and Philip?
- ② If you are an experienced clinician like Jane, how do you use your skills to promote family work with others?
- ② If you are a newcomer to family work, like Philip, who in your setting could help you further develop your confidence and skills?

Connecting with carers is not about doing it all yourself.

- ② What services exist in your area (health, NGOs or private) to support families and individuals' needs.
- ① Organise a meeting with the family and providers to ensure a coordinated approach.

SCENE III: INPATIENT UNIT – 4 weeks after admission

Family attend discharge planning ward round

Elizabeth (administrative assistant): “Carers look really anxious when they arrive at reception, especially for the first time. I try to put them at ease. When Helen and Richard first visited I pointed out the fact sheets and carers’ information packages in the waiting area. Helen visited nearly every day. We’d have a chat and sometimes a joke. She’d tell me how her son was doing. *Connecting with carers seems to make a difference.*”



Chris (primary nurse): “Our mental health unit is locked now and nursing staff have to open the door for all visitors. This gives us an informal chance to connect with carers. Helen wanted to know the names of the treating team members and our fact sheet explaining staff roles was helpful. Helen was worried about her younger children visiting Michael on the unit. *I showed her our family room and she bought the kids in the next day.*”



Dr Philip Kuzo (registrar): “*I have found that connecting with carers has really changed the way I view patient’s problems - like going from seeing in black and white to colour!* Meeting with Helen and Richard really helped me understand Michael’s problems – of course his parents knew him best of all.”



Elise (occupational therapist): “*Carers have a major role in supporting a consumer’s recovery.* I try to involve them in the process. Richard was very keen on how I could help Michael get back to work.”

Dr Leanne Betts (psychiatrist): “*I trained in mental health units where there were strong multi-disciplinary teams. Our skills complement each other.* I’ve continued to work in this way since coming to this unit four years ago. Some people see ward rounds as old-fashioned, or taking too much time. But for me, they are essential for communicating and working in partnership. Involving carers and consumers in discharge planning meetings has become routine for our team. We work to put everyone at ease. It was good to meet with Richard and Helen to check on safety and hear their ideas for Michael’s discharge.”

Richard (stepfather): “*We appreciated being invited to meet the team about Michael’s discharge.* We wanted him home, but to be honest I was worried how it would go. The team seemed to really want to hear what we had to say. It was good to meet Frances from the community team and to know we wouldn’t be on our own.”

Helen (mother): “I had tried a few times to tell the kids what was wrong with Michael, but I started crying so they stopped asking. They didn’t want to upset me. I felt comfortable saying this at the team meeting and *I was so relieved when Jane offered to meet the kids with us.*”

OVER TO YOU

Coming to team meetings or ward rounds is an important opportunity for collaborative planning but some families have described this as daunting.

-  What strategies and resources did Dr Betts and the team use to put the family at ease and demonstrate partnership? Did you notice the posters for families in the DVD?
-  Does your service invite families and carers to ward rounds?
-  How do you think families in your service would rate their experience?
-  Encourage families to prepare lists of their concerns, or to bring along a support person.

Good teams complement each other and understand each other's roles.

-  List the roles and responsibilities of each of the various professionals who helped the State family during the admission. In what ways is this similar or different to your setting?
-  Consider developing a fact sheet for families to explain who is who on the unit.
-  Connecting with carers on the inpatient unit is everybody's business.

SCENE IV: INPATIENT UNIT - 4 weeks after admission

Family attend children's education session with Jane, (SW) and Frances, (MHC)



Jane (SW): *"We all have the skills to talk with the children of consumers. Little children usually just want reassurance and some basic information. Older children may want to talk about their experiences, worries and fears about mental illness. We have all been children and most of us have some close contact with children in our daily lives. Our professional training gives us skills in connecting with people. Talking with kids often feels daunting to adult mental health clinicians. Just trust yourself and give it a go."*

"Safety is an issue for some of our consumers' children. I know we have an important role in helping the kids get safe. I talk openly about child protection concerns with my clients where possible. I help them work in partnership with the Department of Community Services (DoCS) and other agencies to get safety back into the family."

"Keeping family connections strong in hard times is important. By the time we met Nick and Sophie we had a trusting relationship with their parents. This made a difference. I think the session helped the family talk about the illness and their sadness about what they felt they had lost."

Frances (MHC): *"I was anxious about talking with kids at first. It was helpful to sit in with a colleague the first few times so I could build my confidence. Recently I have been involved with Camp Kookaburra, a camp for 8 – 12 year old children of our families. What amazes me is the resilience of these kids. Some of them have experienced many hardships and yet it's their strengths not problems that are striking. I hope Nick will go along next year. Talking to kids is now one of the more satisfying parts of my work."*

Sophie (sister): *"It was good to talk, although I was anxious when mum said we had to go to a meeting at the hospital. Part of me just wanted it to all go away. It had been hard at home and Mum, Dad and Yaya (my grandmother) were all so upset. I was upset too, but I tried to look after everyone. I cried in bed at night. In the session it seemed OK to say how I felt."*

Nick (brother): *"I felt better when the ladies at the hospital said no one caused Mike's sickness and that we couldn't catch it. Mike and I always played soccer and he used to coach my team. He screamed at me the day he went missing. I didn't mean to make him run away. Mum and Yaya were crying. I thought it was my fault. I could tell my Mum and Dad liked the ladies at the hospital. It was okay to talk."*

OVER TO YOU

Remember the kids. Gaining the trust of parents and their children is the key to helping kids.

- ② How did Jane and Frances achieve this?
 - ② What issues would you plan to address in a session with children?
 - ② If serious safety or other complex issues emerge for the children, who can you turn to for help?
 - ② How would the children of consumers rate (out of ten) your service? List the strengths and challenges.
 - ⓪ Family friendly visiting rooms and offices with children's toys, pencils and crayons, DVDs and fact sheets for children are all helpful.
- NGO partner services provide a number of initiatives for children including kids clubs, newsletters and camps.
- ② What resources do your NGO partners provide?

SCENE V: COMMUNITY MENTAL HEALTH – 8 weeks later

Family meet Frances (MHC)

Frances (MHC): *“Connecting with carers in the community serves to bring us all together as a strong support team for the consumer’s recovery. Most consumers agree to some sort of contact with their family when I explain it that way. Michael was fine with his family keeping in contact with me and coming to meetings from time to time.”*

“Meeting all family members helps to get everyone’s perspectives. I try to give each member some separate time. When the State family came in together, I knew Helen and Richard were worried about Michael’s drug use and going back to work. The kids were still feeling sad about not doing the things they used to with Michael. Using humour and looking for strengths really helped to lighten things up and help the family feel less stressed.”

“We worked out a plan to reduce stress at home. Michael and the family looked relieved at the end of it. I was pleased that the good partnership we had developed meant that we could have a productive meeting.”



Michael (consumer): *“I wasn’t looking forward to the meeting really but it was better than I expected. I trusted Frances. It hasn’t all been bad at home. We have had some good times like on Nick’s birthday. I thought everyone was going to gang up on me about the drinking and smoking but it wasn’t like that. Things got a bit better at home after that and Mum and Richard got off my back most of the time.”*

Frances (MHC): *“I always notice a difference when the families start attending the psychoeducation groups. The groups focus on teaching coping strategies, providing education and a forum for families to meet each other. Stress*

levels are reduced and there are fewer phone calls to me. That’s good for everyone in the family and for me too.”

Richard (stepfather): *“By the time I got to one of the education groups I was a bit over it. But to look around and realise the other families there had the same problems, even worse than us, really helped. You think you’re the only ones but you’re not. It’s just that mental illness still doesn’t get talked about much.”*

Helen (mother): *“We got a lot of education and this time I was ready to hear it. I had been scared about the medication, especially in the hospital when Michael was a bit of a zombie, but the doctor’s session explaining how it worked really helped me understand.”*

OVER TO YOU

Staying connected after discharge is essential.

🔍 What strategies and processes did Frances use to negotiate a respectful partnership with Michael and his family?

🔍 What ideas and strategies might have been in the plan to turn the stress levels down at home?

Psychoeducation can be undertaken with single families or in groups.

🔍 In what ways may Helen and Richard have benefited from attending the group? How might Michael, Sophie and Nick have indirectly benefited by their parent's group involvement?

🔍 Do psychoeducation groups run in your service or community? How might clinicians benefit from being involved in a group?

⚠️ Knowing about the group's timing, content and number of sessions can help you successfully refer families and carers.

A sustainable psychoeducation group program requires partnership between managers and clinicians.

🔍 How might this happen in your mental health service?

⚠️ Capacity building is the key.

SCENE VI: COMMUNITY MENTAL HEALTH – 18 months later

Frances, (MHC) consults with Adrienne, specialist family clinician (SFC)

Frances (MHC): *“Using team meetings to get ideas and support is the way I keep my hope alive for families, especially when the going gets tough.”* That’s essential when you work in the community, often staying connected with consumers and their families for the longer haul. It’s probably what I like about my job – really getting to know people. But without support, you can feel as down as the family are when things get tough.



*“When Helen phoned and said that Richard was threatening to leave, it came as a surprise as things were just looking up for Michael. I felt like I hadn’t been doing enough to support the family. It was great to have access to a specialist family clinician like Adrienne. I knew I could talk to her informally or as part of our clinical meeting. *With Adrienne’s involvement I could concentrate on supporting Michael.*”*

Helen (mother): *“Things really fell apart between Richard and me when Michael relapsed and was readmitted a few times. You could cut the tension with a knife and we couldn’t agree on anything. I know I was heading downhill myself, always*

crying and not sleeping. Frances was the only one I could think of to turn to when Richard said he was going to leave.”

Adrienne (SFC): *“My role is to offer consultation around complex family issues to clinicians from all parts of our service. It took some advocating for our executive to support the development of my position, but it has been really well utilised. I attend team meetings and ward rounds and the staff know how to connect with me. Sometimes it turns out that the clinicians are doing a fine job and just need encouragement. But sometimes a face to face consultation with the family is the best way to proceed.”*



“I encourage staff to use genograms when they are consulting with me – it helps me understand the family structure really quickly. Sometimes family consultation meetings include the consumer and community clinician with the family, but in other cases I meet the family separately. I always keep connected with the referring clinician to ensure a coordinated approach.”

“On hearing from Frances about the State family it seemed the distress was coming mainly through the marital relationship at that point in time. I thought it was important initially to give the couple some space to understand what was happening for them.”

OVER TO YOU

When a family goes into crisis or feels hopeless it is important for the clinician to have access to support and consultation.

- ② What reactions did Frances have when Helen called in crisis? How did Frances manage her own reaction?

Consultation keeps hope alive.

- ② Worrying about the family on weekends? Dreading another phone call from the family? These are all signs of your care and commitment but also that you need support. Make a list of the tell-tale signs that your hope is getting depleted.
- ② What options for discussing consumers and their families exist in your service?
- ② Do you have a clinician in your service with specialist family skills with whom you can consult? How might you work together?

SCENE VII: COMMUNITY MENTAL HEALTH

– 18 months later

Helen and Richard meet Adrienne (SFC)

Adrienne (SFC): *“In my role I mostly offer short term (up to 6 sessions) goal-oriented family therapy. This can help carers cope in new ways with the mental illness and aims to keep family relationships helpful. I often describe it as trying out different, more helpful ways of dancing together around the illness. Sometimes as I get to know families and carers, issues from the past emerge. We try to make sense of how the past is impacting on the present. I help them link with appropriate services if they want to work on this. For some couples I suggest ongoing marital therapy with an appropriate private therapist or agency.”*



“In the first session Helen and Richard were very distressed but they were still able to hear each other. They readily agreed to 3 further sessions. Initially I helped them focus on Helen’s past trauma and how this was getting in the way of their current relationship. I encouraged them to prioritise time as a couple. They had such a strong base to their relationship and time together got them back on track. Helen started to prioritise caring for herself again. By the second session they were able to constructively talk about their concerns for Michael and come up with some ideas for a united approach. This really made a difference. Fairly quickly Michael shifted to taking responsibility for his recovery. Michael and Frances joined us for a few sessions till things got back on track.”

Helen (mother): *“I was pretty nervous about going to see Adrienne for the first time. I felt like I had failed Michael in some way and that she would find out that I was a bad mother. I was relieved when she helped me make sense of how much the violence in my first marriage was getting in the way of the present. I thought I had put it all behind me. I felt better because Richard seemed to understand. He could support me again. *Adrienne helped me find hope for the future for Richard and me and for Michael.*”*

Richard (stepfather): *“I was so over it all by then. I didn’t feel like coming to another family meeting. I didn’t see that it would achieve anything. I was surprised that Adrienne didn’t take sides. I understood a lot better why Helen had been soft with Michael. *She just encouraged us to talk and listen. That was the start of us getting back on track.*”*

OVER TO YOU

Family therapy focuses on keeping relationships helpful and safe. When families are in crisis their distress can be contagious and the clinician will be invited to take sides.

-  What strategies might Adrienne have used to keep calm and stay neutral?
-  What individual and relationship issues emerged in the session with Adrienne?
-  What other family therapy providers exist in your area? What services does your NGO partner offer?

Ann's Story (A Carer's Perspective)

Ann's son, Graeme, had a 25 year struggle with schizophrenia. In the interview on the DVD she describes aspects of her journey as a carer, the impact of the illness on her son and his family and relationships that her son had with those around him.

OVER TO YOU

-  What are some of the key issues raised in Ann's interview?
-  How might some of these issues be addressed in a family friendly mental health service?

Tips For Trainers

-  Target all staff for some level of training. Remember administrative staff in reception areas have a role to play in connecting with carers.
-  Find out about existing training forums in your service and use the DVD and Handbook in these.
-  Consider using the Connecting with Carers resource for specially targeted training to teams such as inpatient teams or professional groups such as medical staff. Optimise the service development and team building opportunities in these workshops.
-  Carry your mental health service's resource packs such as fact sheets and carer information packages with you to personalise the workshops to your site.
-  Train in teams with "champions" from your service or your NGO partner. The more staff trained to train, the more the work will spread.
-  For staff working in rural or isolated settings, send them the Connecting with Carers resource. Arrange a phone contact afterwards to discuss implementation and support strategies for carers and clinicians.
-  Have fun, use games, quizzes and icebreakers and give rewards. Have a bag of dress ups with wigs for fun role plays such as a family unfriendly scenario. This will help staff learn and connect with each other.
-  Develop 30, 60 and 90 minute workshops using the DVD and Handbook so you are ready for any training opportunities that arise.
-  Photocopy pages from the Handbook for training purposes and individual learning (with appropriate acknowledgement).

References

- Mottaghipour, Y., Woodland, L., Bickerton, A. & Sara, G. (2006) Working with families of patients within an adult mental health service: development of a programme model. *Australasian Psychiatry* Vol 14. No3 Sept.
- Mottaghipour, Y. & Bickerton, A. (2005). The Pyramid of Family Care: A framework for family involvement with adult mental health services. *Australian e-journal for the Advancement of Mental Health* 4(3)
<http://www.auseinet.com/journal/vol4iss3/mottaghipour.pdf>

FACILITATOR FEEDBACK FORM

Please complete this form after every training session and return a copy to:

Working with Families Program, Statewide Training Coordinator
The Sutherland Hospital & Community Health Service
Locked Bag 21, Taren Point NSW 2229 Tel (02) 9540 7800

Facilitator Information:

Name: _____ Position: _____

Mailing Address: _____

Email: _____ Phone: _____ Fax: _____

Summary of Training:

Area Health Service: _____ Mental Health Service: _____

Training Location: _____ Date held: ___/___/___

Participant Information: # Managers ___ # Social workers ___ # MH nurses ___

Admin ___ # Psychologists ___ # Psychiatrists ___

OTs ___ # Other ___ please describe:

Which components of the training were used? Please circle appropriate response(s)

Entire DVD Sections of DVD (which ones)? _____

Entire Handbook Sections of Handbook (which ones)? _____

Recruitment Process:

How would you rate the ease/difficulty of recruiting participants for the training?

extremely easy easy difficult extremely difficult

Please describe any challenges you faced in recruitment:

Please describe any factors which assisted in recruitment:

Training:

How would you rate the ease/difficulty of delivering the training?

extremely easy easy difficult extremely difficult

What aspects of the training worked particularly well?

Do you think the training was able to achieve its goals? yes no Please explain:

What, if anything, would you do differently next time?

CONNECTING WITH CARERS IS EVERYBODY'S BUSINESS:
 A TRAINING RESOURCE FOR FAMILY FRIENDLY MENTAL HEALTH SERVICES

PARTICIPANT REGISTRATION FORM

Participant details:

Name: _____ Position: _____
 Area Health Service: _____ Mental Health Service: _____
 Mailing Address: _____
 Email: _____ Phone: _____ Fax: _____
 Occupation: MH nurse Social worker OT Administrative Psychologist Psychiatrist
 Manager Other, please describe _____

Current work with families:

How would you describe your current level of involvement with the carers and other family members of clients in your service?

extremely involved somewhat involved not very involved no involvement

Do any of the following barriers to working with families exist in your service?

	No	Yes	If yes, how would you rate the severity of the barrier?		
			mild	serious	severe
a. lack of time			mild	serious	severe
b. lack of knowledge about how to work with families			mild	serious	severe
c. lack of resources to offer families			mild	serious	severe
d. lack of historical practice of working with families			mild	serious	severe
e. reluctance of families to be involved			mild	serious	severe
f. reluctance of clients to have families involved			mild	serious	severe

Training:

What would you like to get out of the *Connecting with Carers is Everybody's Business* training?

Please describe any particular areas related to working with families that you would like more information/skills on: _____

Future evaluation/follow up:

Would you be willing to be contacted in the future regarding a possible follow-up/evaluation of this training program? no yes, please write your name and sign below:

Name: _____

Signature: _____

Date: ___/___/___

CONNECTING WITH CARERS IS EVERYBODY'S BUSINESS:
A TRAINING RESOURCE FOR FAMILY FRIENDLY MENTAL HEALTH SERVICES

PARTICIPANT EVALUATION FORM

Location of training: _____ Date: ___/___/___

Participant details:

Occupation: MH nurse Social worker OT Administrative Psychologist Psychiatrist
 Manager Other, please describe _____

Evaluation of training:

Did the training meet your expectations? yes no, why not? _____

How would you rate the relevance of the material to your practice?

extremely relevant moderately relevant somewhat relevant not at all relevant

To what extent did the training increase your understanding of:

a. the Pyramid of Family Care	a great deal	a little	not at all
b. carers' experiences with the mental health service	a great deal	a little	not at all
c. carers' needs from the mental health service	a great deal	a little	not at all
d. the roles various team members play in working with families	a great deal	a little	not at all
e. the importance of ensuring that the needs of children are addressed	a great deal	a little	not at all
f. the importance of continuity of care from acute to community	a great deal	a little	not at all
g. how to set up and conduct a family session	a great deal	a little	not at all

Which aspect(s) of the training did you find most valuable? _____

Which aspect(s) of the training did you find least valuable? _____

In what ways do you think you will be able to apply what you've learned in the training? _____

Facilitator:

How would you rate the facilitator(s)' ability to:

a. deliver the material clearly: excellent good fair poor
 b. answer any questions: excellent good fair poor

Please add any further comments about any aspect of the training: _____