CYPSP Think Family Workshop

9.00am-9.30am	Registration, Tea and Coffee
9.30am-9.40am	Opening Address- Fionnuala McAndrew, Director of Social Care and Children, HSCB
9.40am-9.50am	Background and Context- Mary Donaghy, Chair of CYPSP Think Family Sub Group
9.50am-10.00am	Young Carers Experience
10.00am-10.10am	Carers Experience
10.10am-10.30am	SCIE Best Practice- Hannah Roscoe
10.30am-11.30am	The Family Model- Dr Adrian Falkov
11.30am-11.40am	Break
11.40am- 12.00pm	Q & A Session
12.00pm-12.15pm	Conclusion

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Children & Young People's Strategic Partnership

HSC Health and Social Care Board

Fionnuala McAndrew

Director of Social Care and Children, Health and Social Care Board

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Mary Donaghy

Social Care Commissioning Mental Health & Learning Disability

Health and Social Care Board

Chair of CYPSP Regional Think Family Sub Group

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Theme

We will improve communication and information sharing between professionals and families

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Theme

We will improve access to early intervention, family support for children, young people and their families

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Theme

We will improve the extent to which assessment, planning and treatment is inclusive of a ‘whole’ family approach

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Performance Measurements

- Use recognised methodology to measure actions
- Themes- safety, effectiveness, experience
- Partnership working with SBNI

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Young Carer's Experience

Action for Children

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Carer's Experience

Mindwise and Joan Stangland

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Think child, think parent, think family: SCIE guide and implementation

Hannah Roscoe, Research Analyst and Interim Head of Learning Together, SCIE

20 December 2013

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Overview

- *Think child, think parent, think family* guide
- Implementation project
- A project example
- Learning from implementation

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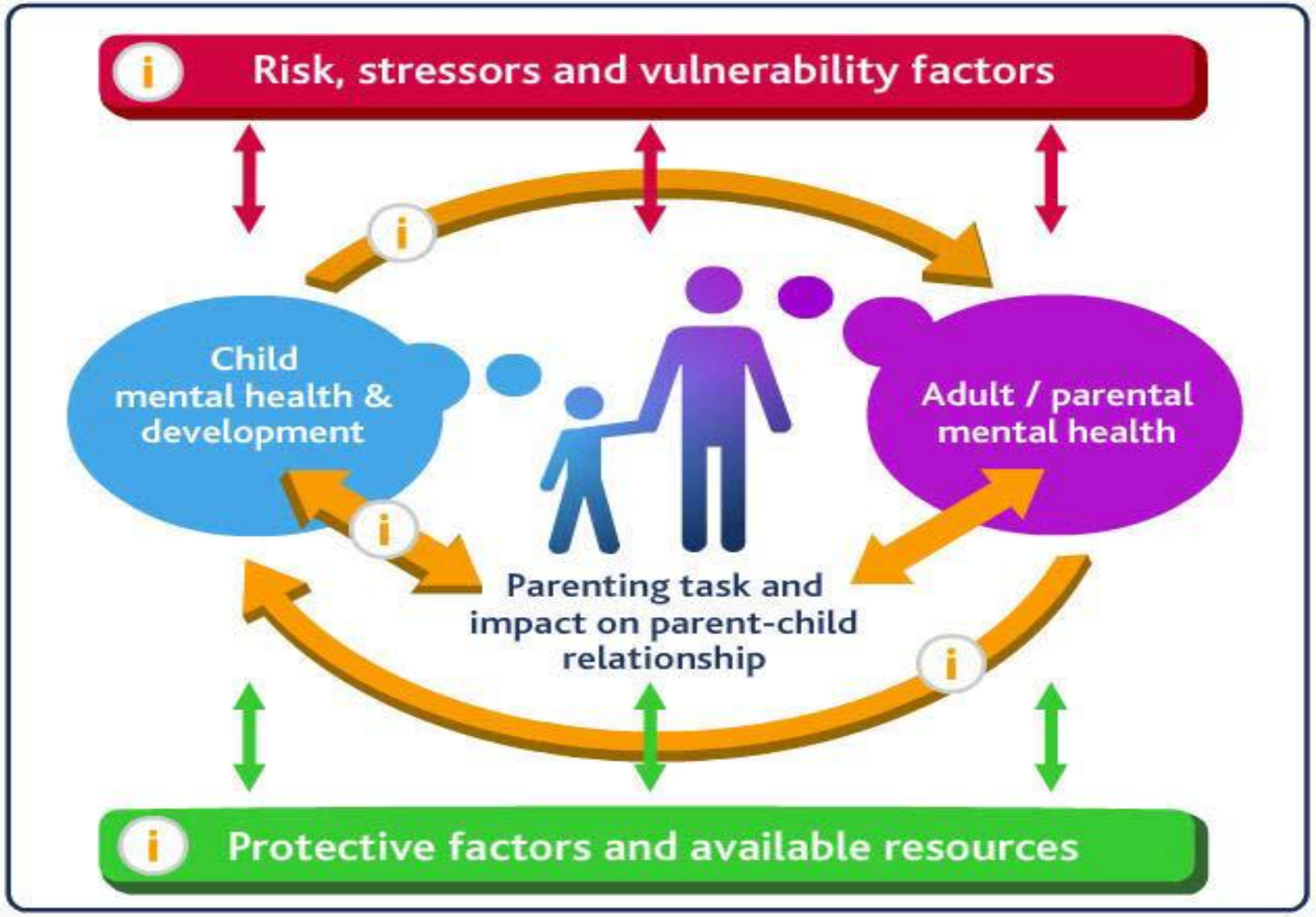
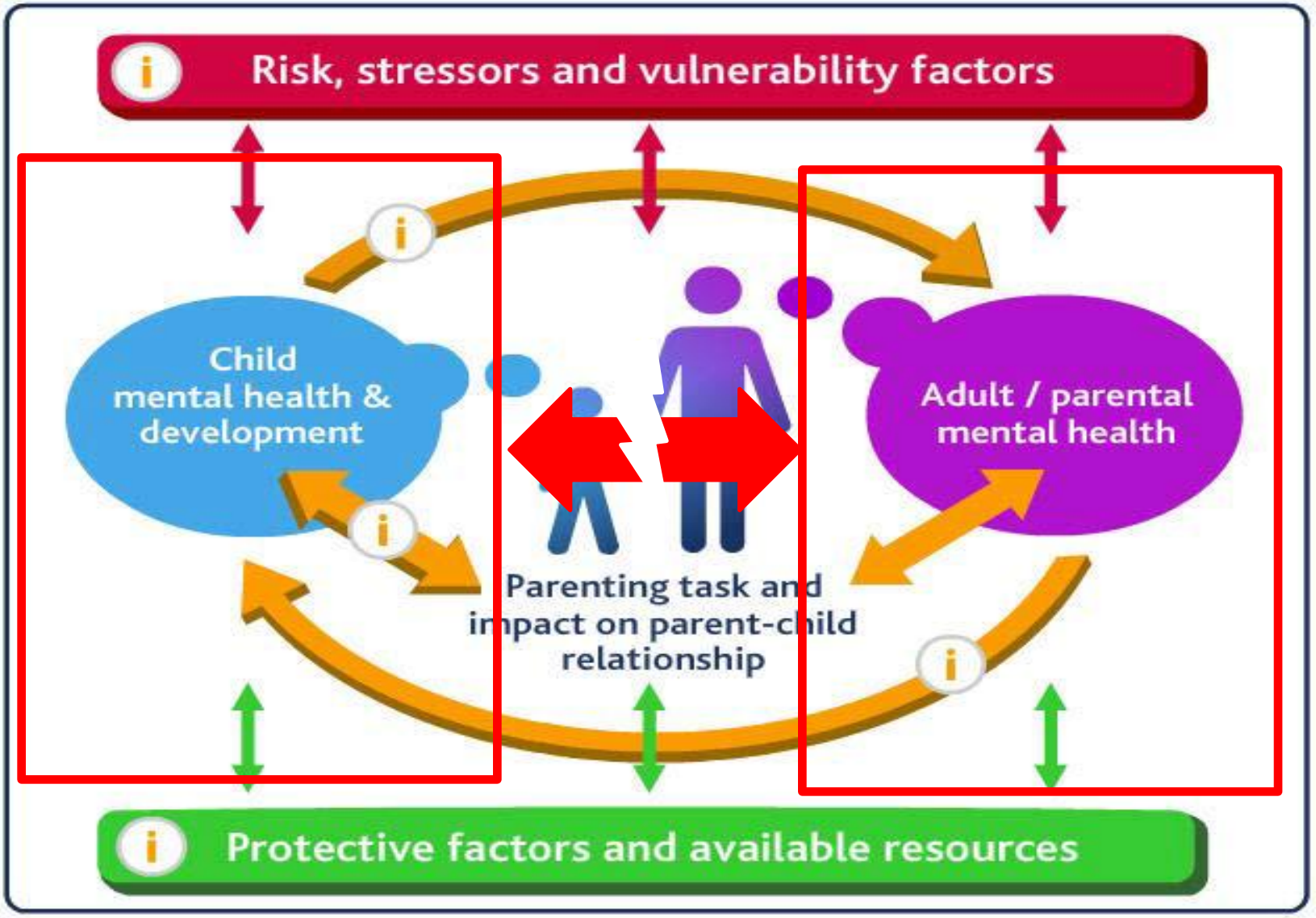
The Family model (Falkov et al., 1998)



Mental health and family relationships

- Between 33% and 66% of children with a parent suffering from mental ill health will go on to have a mental health problem (Meltzer et al., 2000)
- 29% of young carers support an adult with a mental health problem (Dearden and Becker, 2004)
- In England, parental mental ill health was a factor in a third of Serious Case Reviews in children's services (Falkov, 1996)

The Family model (Falkov et al., 1998)



Barriers to thinking family

- Culture and professional identities
- Statutory thresholds
- Information sharing
  - Regulations
  - Practicalities
- Confidence and willingness to work outside professional boundaries
- Knowledge of services
- Workload
- Fear and stigma

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Key messages from the guidance

- Develop services that:
  - Take a ‘no wrong door’ approach
  - Look at the whole family throughout the care pathway
  - Co-ordinate and tailor support effectively
  - Build on family strengths

- In addition:
  - Improving access via communications strategy
  - Workforce development
  - Strategic approach – ‘Think Family Strategy’

- Screening
- Assessment
- Planning care
- Providing care
- Reviewing care plans

Screening

- Routinely and reliably identify *and record* information about which adults with mental health problems are parents, and which children have parents with mental health problems.

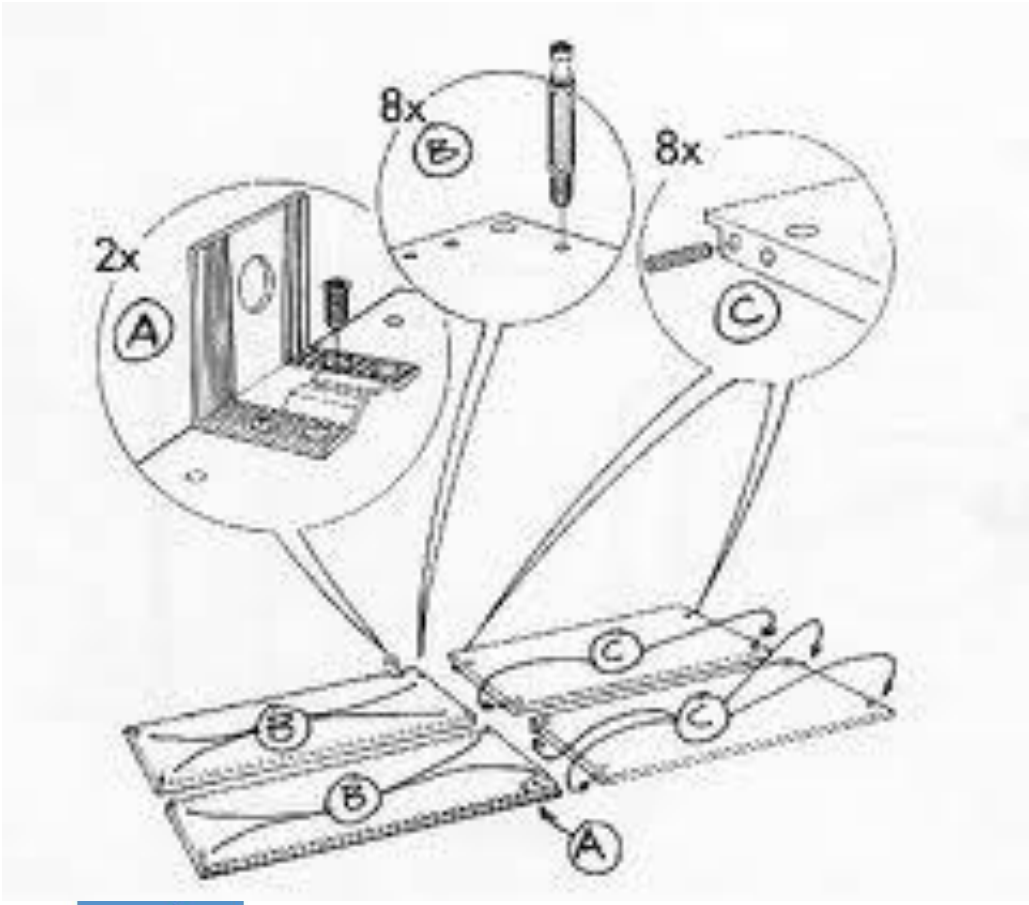
Assessment

Planning care

Providing care

Reviewing care plans

Putting it in to practice



- What **processes and practices** are effective in implementing the guide?
- What are the **barriers and enablers** for implementing the guide?

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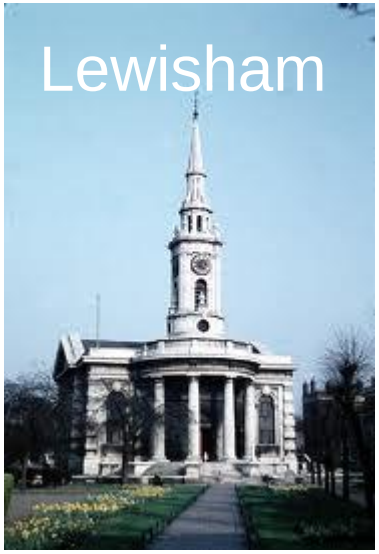
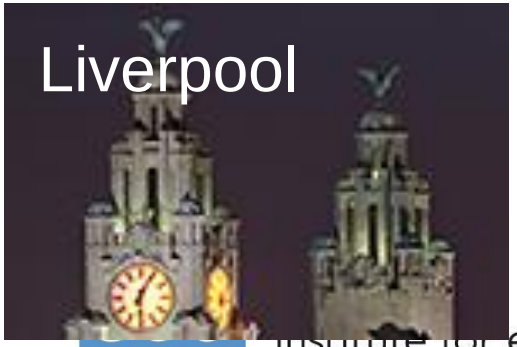
The Implementation Sites





What did the sites do?

- Whole-system approach involving many services
- Looking across the care pathway
- Numerous innovations and changes
- Some ‘quick wins’ and some longer term projects

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Achievements and solutions

Strategic

- Think family strategies
- Joint working protocols agreed at a senior level

Service design

- Embedding support within other services
- Services aimed specifically at parents with mental health problems

Procedures

- Changes to screening and assessment procedures
- Establishing ways to cross-reference electronic databases

Practitioner knowledge and skills

- Training ranging from awareness-raising to specialist training courses
- Groups designed to support better relationships and understanding of roles

Practice example – CMHT and Children's Centres project, Liverpool

Aim:

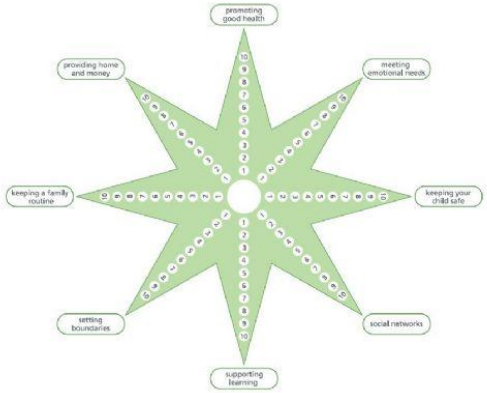
- To improve support to parents receiving services from Community Mental Health Teams

Approach:

- Recruitment of Family Support Workers to sit within each of the CMHTs in the city

Family Support Worker role

- Work alongside Care Co-ordinators
- Provide outreach and home-based support to families
- Liaise with statutory and voluntary sectors
- Encourage take-up of universally available resources, e.g. Children's Centres
- Using family 'outcomes star' to set goals and monitor progress



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Outcomes

- In the first two years of the project:
  - 187 families with complex needs supported by FSWs
  - 119 families with a parent with a mental health problem registered with a Children's Centre
- Improvement in wellbeing as measured by Global Assessment of Relational Functioning scores

Barriers and enablers

- Competing pressures
- Senior support
- Organisational and professional attitudes to change
- Time to build relationships

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Where to learn more

- www.scie.org.uk
- Guide with practice examples
- Evaluation report
- E-learning- 8 modules
- Social Care TV- 3 short films
- hannah.roscoe@scie.org.uk

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The Family Model

A collaborative approach to integrated care for mentally ill parents & their children

Dr Adrian Falkov

Child and Adolescent Psychiatrist

Director Redbank House, Westmead Hospital

adrianfalkov@bigpond.com

www.thefamilymodel.com

September 2013

Redbank House

Todays options

- Prato
- We Know… breadth, burden, barriers, benefits
- Conceptual approaches
- TFM outline
- Thinking to doing; policy to practice
- Family Focused MH services in W Sydney
- Reflections – ‘non science of implementation’
- Conclusions

Overview – What we know... (Ch 2)

- **Breadth** - Increasing evidence from many countries…
  - Epidemiological surveys, census (every family in the land?)
  - major public health issue
- **Burden**
  - Personal, lived experience (individual, family), social & economic
  - Comorbidity & complexity
  - Risk AND Protective factors (nature VIA nurture)
- **Barriers**
  - Stigma
  - Historical
  - individual, team, service, agency, community, society
- **Benefits** of a 2 generation investment in prevention & early intervention
  - Parenting is a MH issue (good relationships protect)
  - Family MH (early and quickly)
  - Building the evidence base
  - Better use of existing resources
  - Collaborative practice & service integration

Burden

Heide Lloyd, mother of Hannah & Georgina

‘I did not realise how depressed I was at the time & now looking back I feel quite shocked to think that I coped with a new baby & a toddler, having just given birth, & believing that I could be living in a world where I thought I could hear & even see people who were not there. This eventually subsided over about 5 months, though I had felt unable to share the experience with anyone, sensing disbelief & feeling really afraid that I would be locked up & my children taken away’

Burden

Young Carers

"When I was younger, mum had a problem. She had difficulty with us 4 kids - sorting us out for school - she wasn't getting a lot of help and she was shouting a lot. Her words were all jumbled up - didn't come out properly. She was having too many cups of tea... Always asking me for cups of tea so i was late for school. I told the teachers an excuse that mum overslept and I had to make breakfast for the younger ones - mum didn't want them to know she was sick because she thought they were watching her and coming round".

This child went on to state that she thought it very unlikely anyone was watching because "if there were watchers I'd have seen them - but I didn't tell mum this because she would have said how do you know it's unlikely?"

Burden
Parenting

"It took me 6 months to come to terms with my diagnosis and during that time I lost most of my self-confidence, which does not make a good parent. I felt they (the children) knew better than I did what was right for them. Slowly I returned to 'normal' feeling older and wiser but let down by the system."

Burden

AMH Perspectives

'You know, the thing is, the kids are important but there's always so much going on, so much to do … that you, well, you go in with good intentions but they're so ill (pts), or chaotic or needy or doing worrying things that you, well, you kind of … I guess just forget. I know I shouldn't but that's what happens'

Barriers

Tackling Stigma & Discrimination

"The subject first caught my attention twenty years ago when I came across a table of charitable giving showing cancer close to the top and mental health near the bottom. I wondered why care of the mind should rank so much lower than care of the body. The position is the same today. The cancer charities are followed closely by the animal charities. We give more to dogs than to those with mental problems."

Jeremy Laurance

'How fear drives the mental health system.'

Benefits

Building the evidence base – aggregated data

- **Fraser *et al* (2006)**: data *'provides very limited evidence of program effectiveness as determined by well-being or illness outcomes for the child'*
- **Siegenthaler *et al* (2012)**:13 trials meeting inclusion criteria (1,490 children). 161 new diagnoses of mental illness were recorded, with interventions reducing the risk by 40%. Interventions included cognitive, behavioural, or psycho- education components delivered to individuals, groups and families, with predominant focus on depression in mothers

  '*… interventions to prevent mental disorders and psychological symptoms in the offspring of parents with mental disorders appear to be effective'*

Benefits

Earlier intervention & prevention

“Preventive psychiatry will be well served if schools and community mental health agencies single out for special concern the children of mentally ill and/or alcoholic parents.”

George Vaillant, 1977

Prevention
why invest?

- Half of all lifetime cases of diagnosable mental illness have begun by the age of 14 (Kessler et al 2007; Shiers & Kendall 2012)
- Stigma & the treatment gap - Common mental disorders 24% Rx prevalence, diabetes 94% Rx prevalence:
  - Nearly 23% of the Dx burden (Dalys) & 11.1% of 2010/11 NHS budget vs. diabetes (1.8% Dx burden & 1.5% of 2010/11 NHS budget (Bailey et al)
  - 2004/05 health research investment (largest UK resch funders) mental health 6.5% of total funding; 25% cancer; 15% neurological; 9% cardiovascular
- YET - Improved availability of early intervention services for children and for young people can prevent up to 50% of mental illness (Kim-Cohen et al 2003)
- Prevention paradigm shift – Investment in children, youth & families…

What about the MH of parents whose children are known to services?

Conceptual Approaches

(Ch 3)

- Continuum of need – everyone's responsibility

- The Family Model
  - Helping children helps parents help children
  - Helping parents helps children help parents
  - Template for organising the evidence
  - Informs thinking, supports a shared understanding for joint working

- Family Focussed Assessment (FFA)

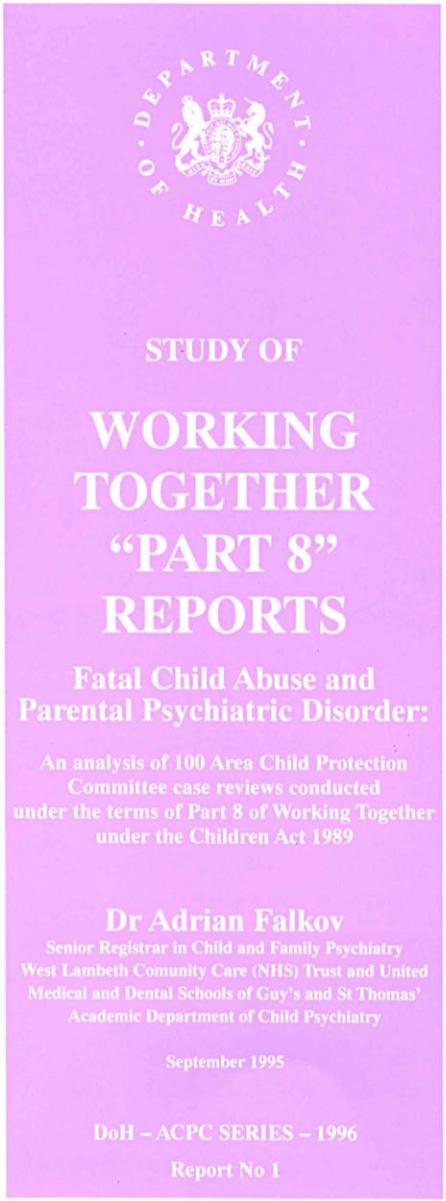
The Continuum of Need

A spectrum of P-Ch-Prof Interactions

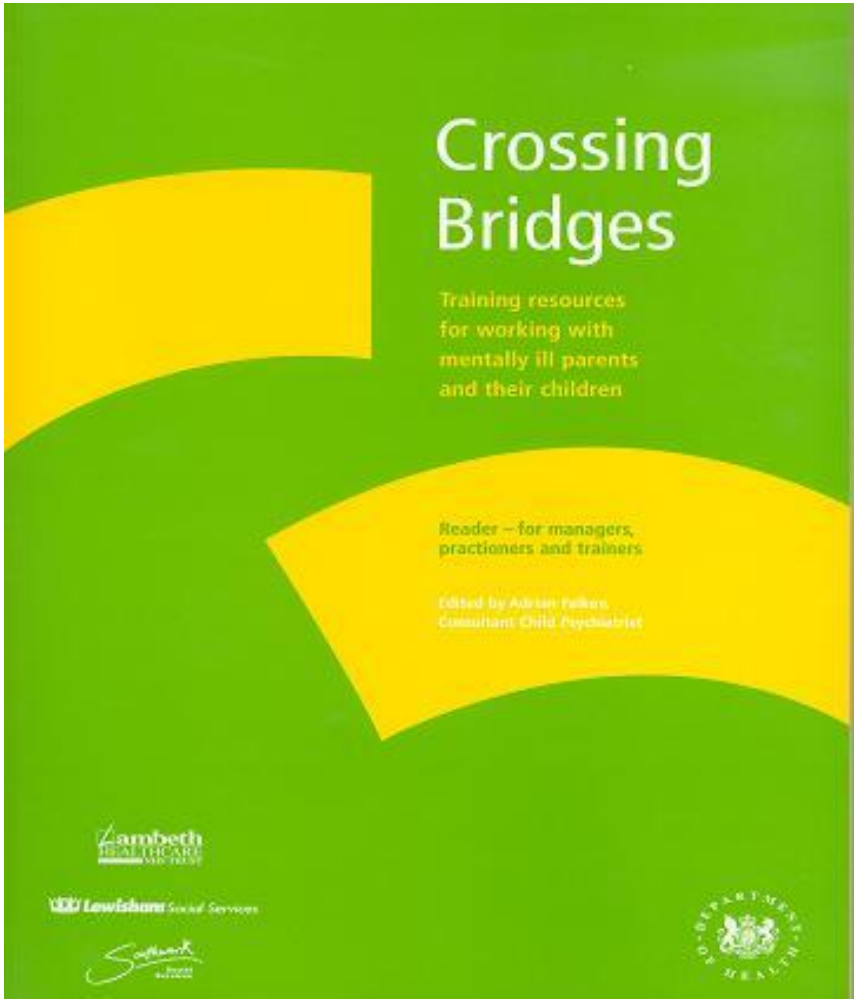
- Many parents cope well despite their symptoms
- Experiencing a MI / SA does not automatically imply inability to meet children's needs
- Substantial numbers of parents could enhance their parenting through recognition of parental status & provision of appropriately timed & targeted support
- A proportion of parents will not be able to meet their children's needs, despite best efforts & provision of additional supports
- NB minority do not have their children's safety & best interests uppermost - calculating, deceitful, dangerous & capable of difficult to imagine cruelty, including homicide

Links between parental psychiatric disorder & child fatalities (1996)

- Key finding not the absence of MH service input but rather an absence of effective intra- & inter-agency coordination, collaboration & communicatn
- A parental MH perspective amongst child agencies was lacking & there was little emphasis on CP and the nature of children's experiences prior to their premature deaths amongst adult services



Origins of TFM



The Family Model Handbook

An integrated approach to supporting mentally ill parents and their children

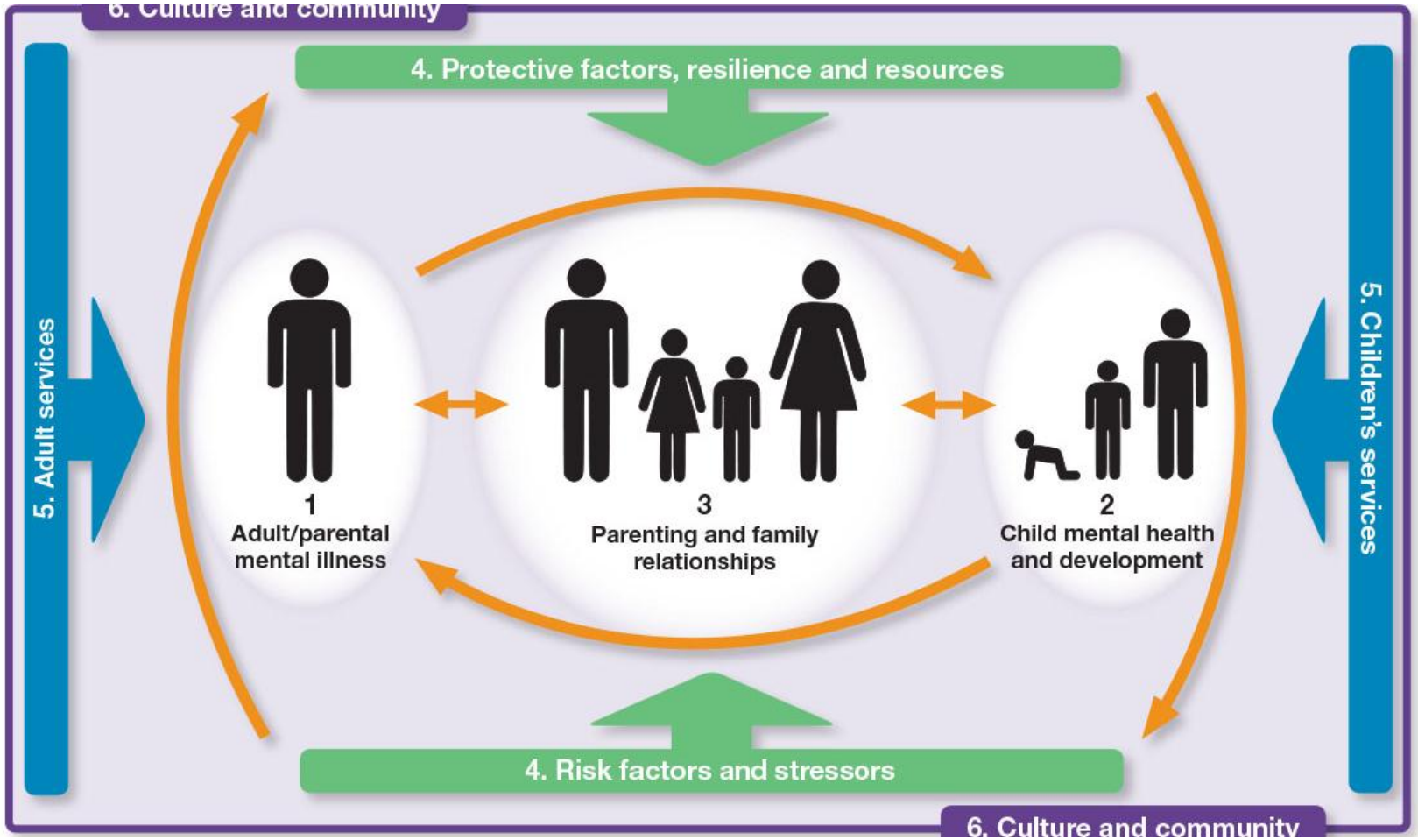
Dr Adrian Falkov

The Family Model
Overarching Principles

The MH & wellbeing of children & adults within families in which an adult carer is mentally ill, are intimately linked in at least 6 ways:

1. PMI can adversely affect the development and in some cases the safety of children
2. Growing up with a MIP can have a negative influence on the quality of that person's adjustment in adulthood, including their transition to parenthood
3. Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers
4. Adverse circumstances (poverty, lone parenthood, social isolation, stigma) can negatively influence both child & parental MH
5. The quality of contact / engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members.
6. The above family domains and their interactive relationships all occur within a broader social network encompassing cultural and community influences

TFM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4. Risk factors and stressors
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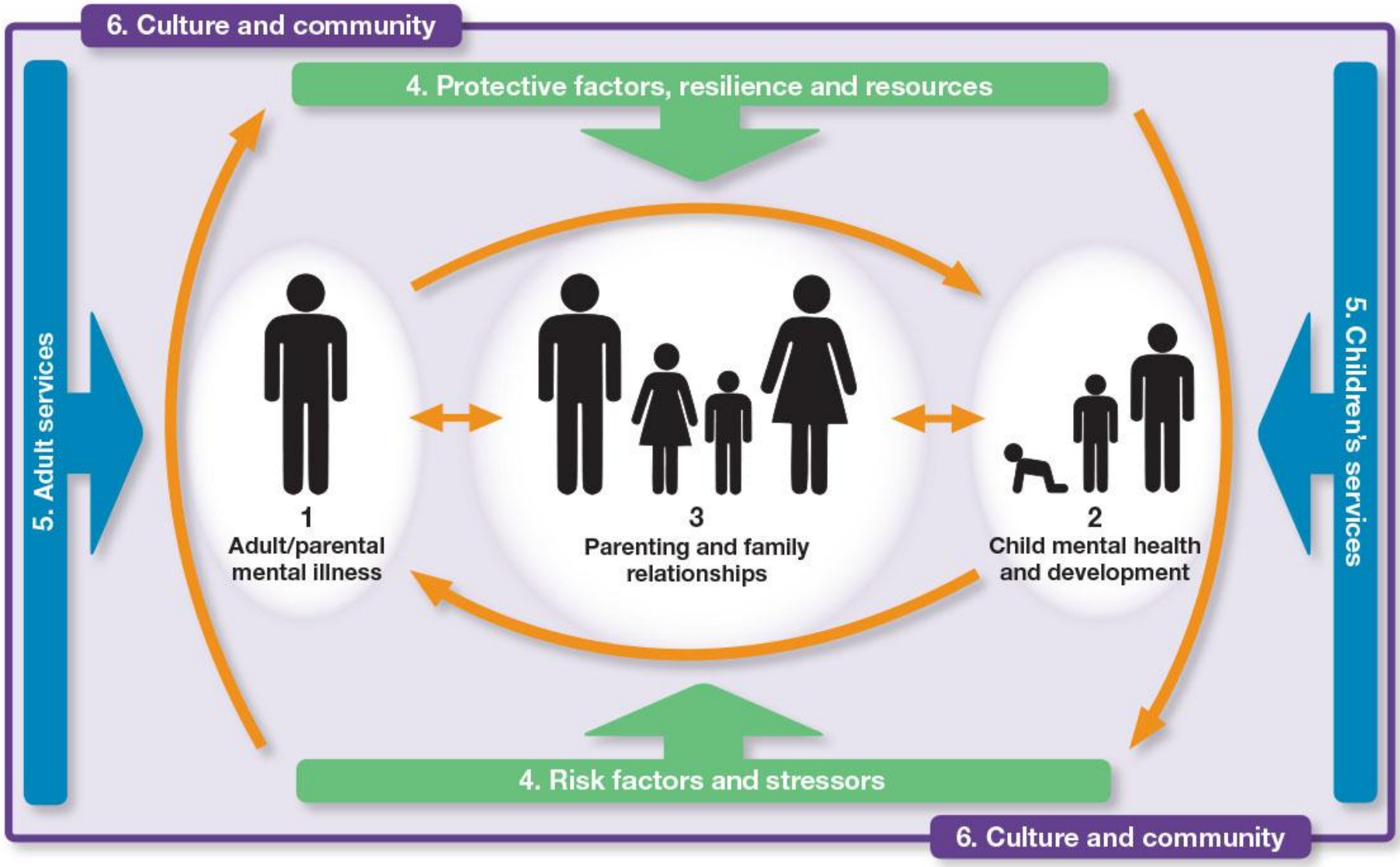
The Family Model

www.thefamilymodel.com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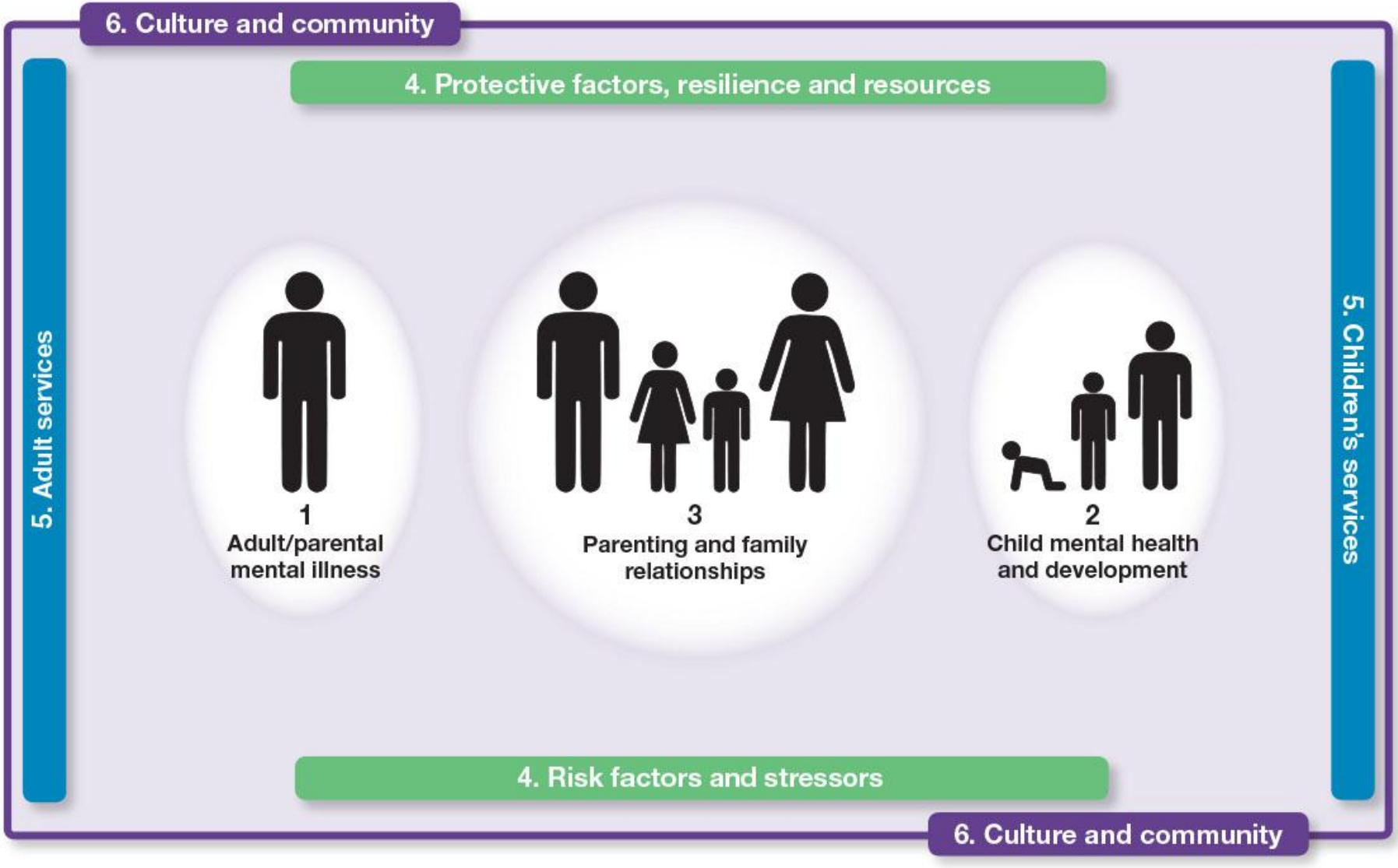
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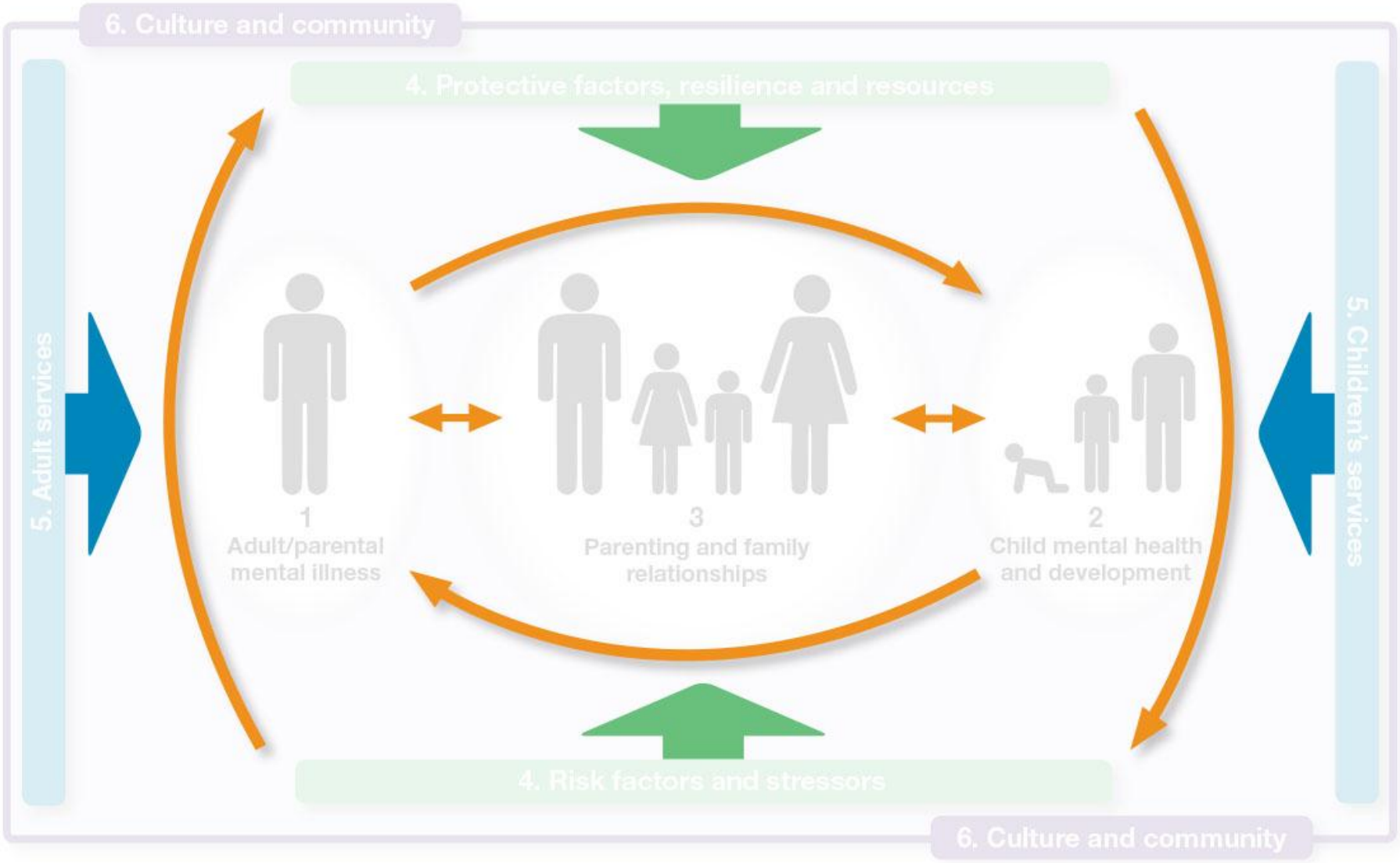
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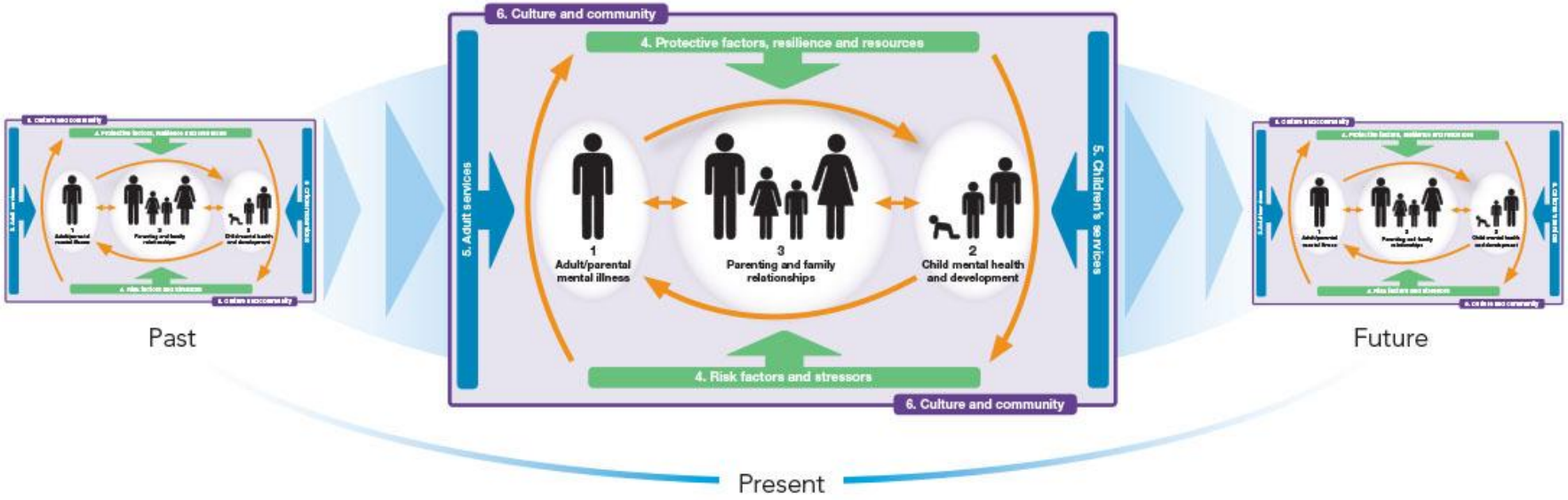
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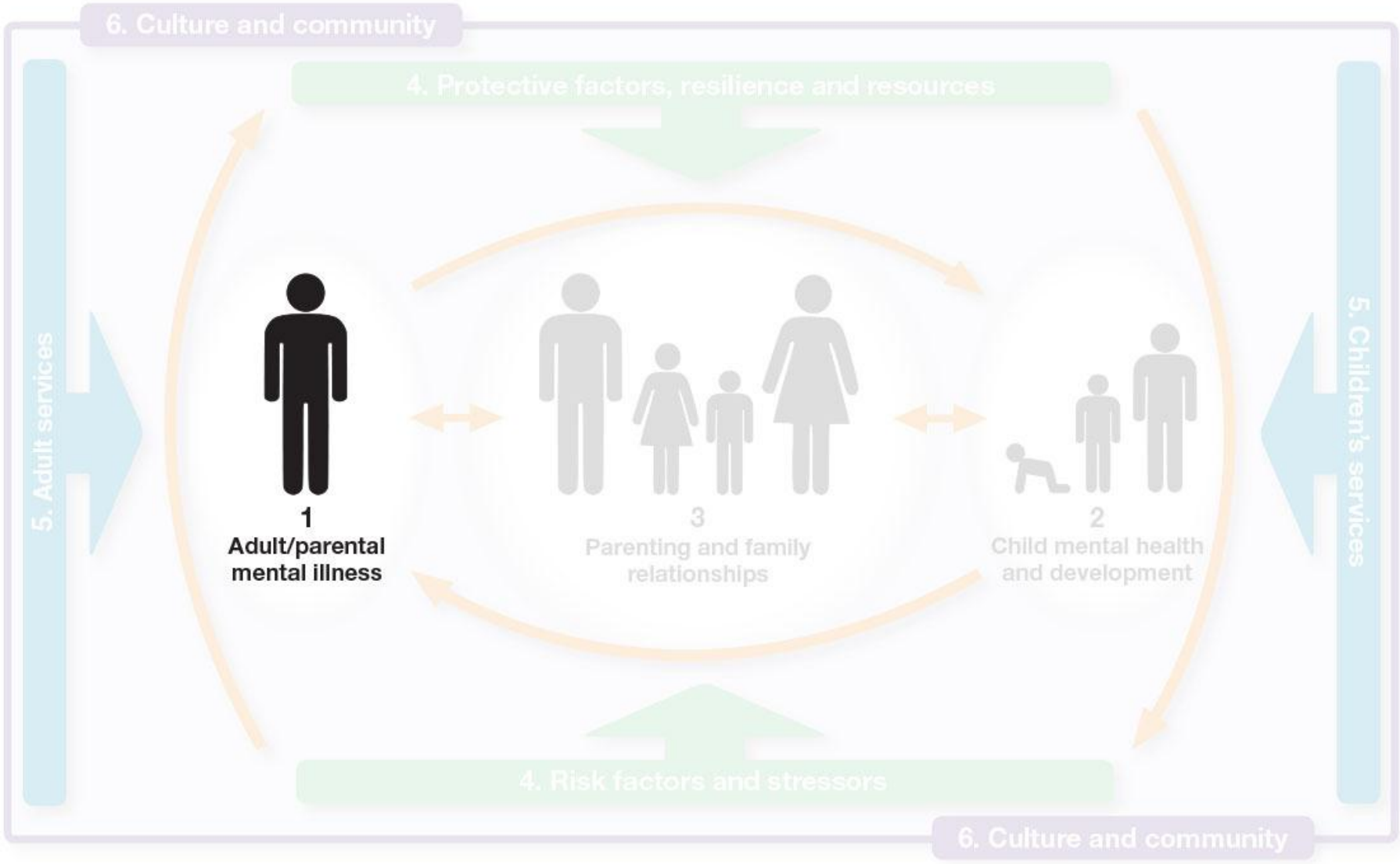
Past
Future
Present

THE FAMILY MODEL

Domain 1: Adult Mental Health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Impact of positive symptoms

Symptoms

- Delusions
- Hallucinations
- Disorder of thought form
  - Disorganised speech
- Disorganised behaviour
- Incorporation of children in delusions
- Distracted by hallucinations
- Chaotic behaviour
  - Delusions/hallucinations
- Distractibility
  - due to perplexity
- Inattention
- Poor communication

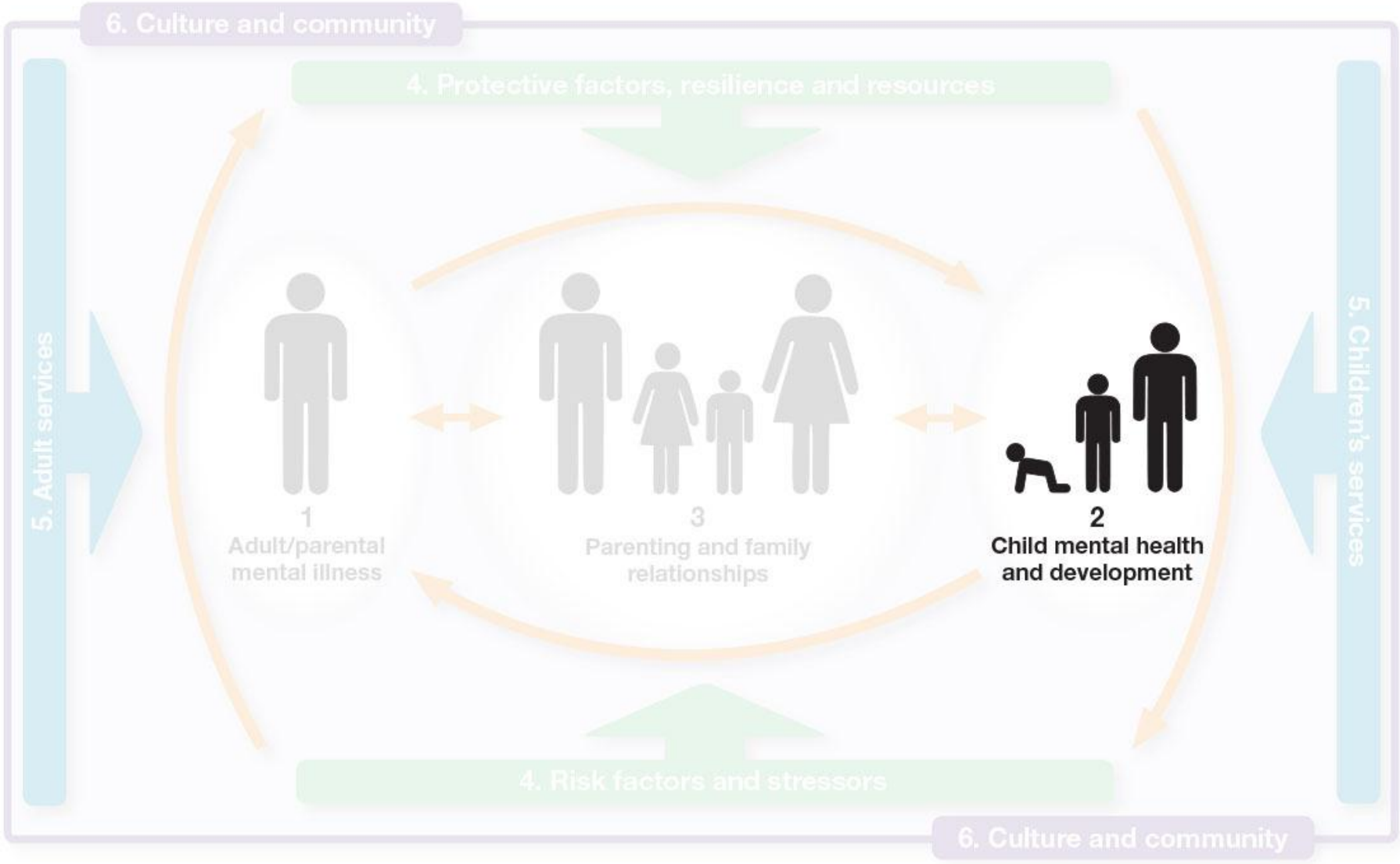
Impact of negative symptoms

Impoverished environment for the infant - poor quality interaction

- Disinterest - poor planning
  - anhedonia
- Lack of responsiveness
  - anhedonia
- Limited play
  - Avolition
  - Amotivation
- Limited talking

THE FAMILY MODEL

Domain 2: Child MH & Development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2. Impacts on Children

Children are at greater risk compared to general population for experiencing a range of problems & disorders including:

- Disruption of early attachments & low self esteem
- Dev delays, cognitive impairments & academic underachievement
- Emotional, behavioural problems & psychiatric disorders
- Consequences of abuse &/or neglect
- Separation, loss & suicide
- Impairments in peer and family relationships
- Fatalities

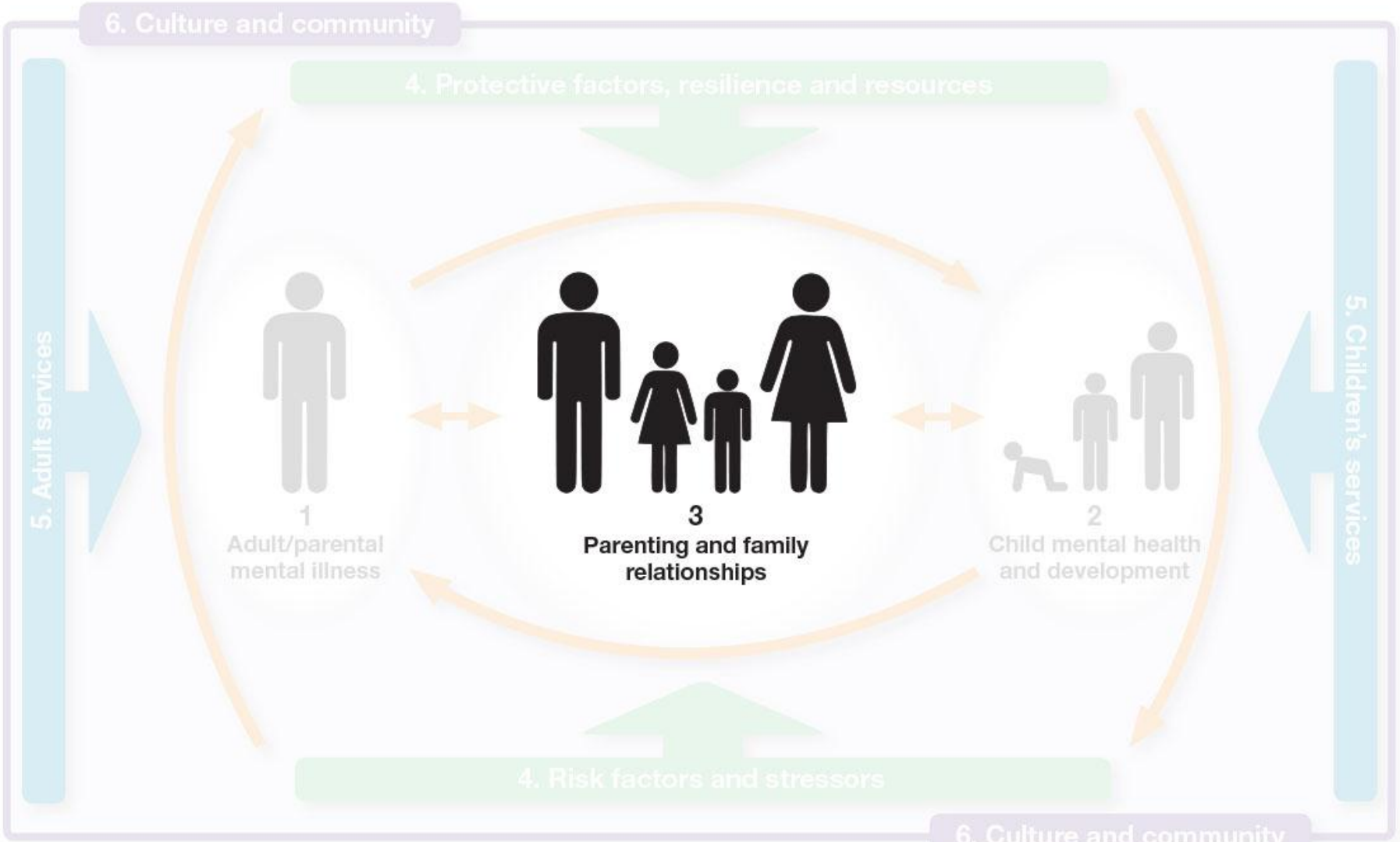
Impact of PMI on Children

Children's experiences of & adaptation to parental mental illness will be determined by:

- Nature, severity and duration of the illness(es)
- Degree of genetic loading for particular disorder
- Extent of involvement and exposure to parental symptoms
- Alterations in parenting
- Alterations in family structure or functioning
- The effects of parental treatment

THE FAMILY MODEL

Domain 3: Family Relationships (parenting & marital interactions)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Visiting young children in London hospitals survey

At the time, was severely restricted. Visiting hours were:

- Guy's Hospital, Sundays, 2-4pm
- St Bartholomew's, Wednesdays 2-3.30pm
- St Thomas's Hospital, first month no visits, but parents could see children asleep between 7 and 8pm
- Westminster Hospital, Wednesdays 2-3pm,Sundays 2-3pm
- West London Hospital, no visiting
- Charing Cross Hospital, Sundays, 3-4pm
- London Hospital, under 3 years old, no visits, but parents could see children through partitions. Over 3 years old, twice weekly.

Munro-Davies, H.G. (1949) 'Visits to Children in Hospital', Spectator, 18 March

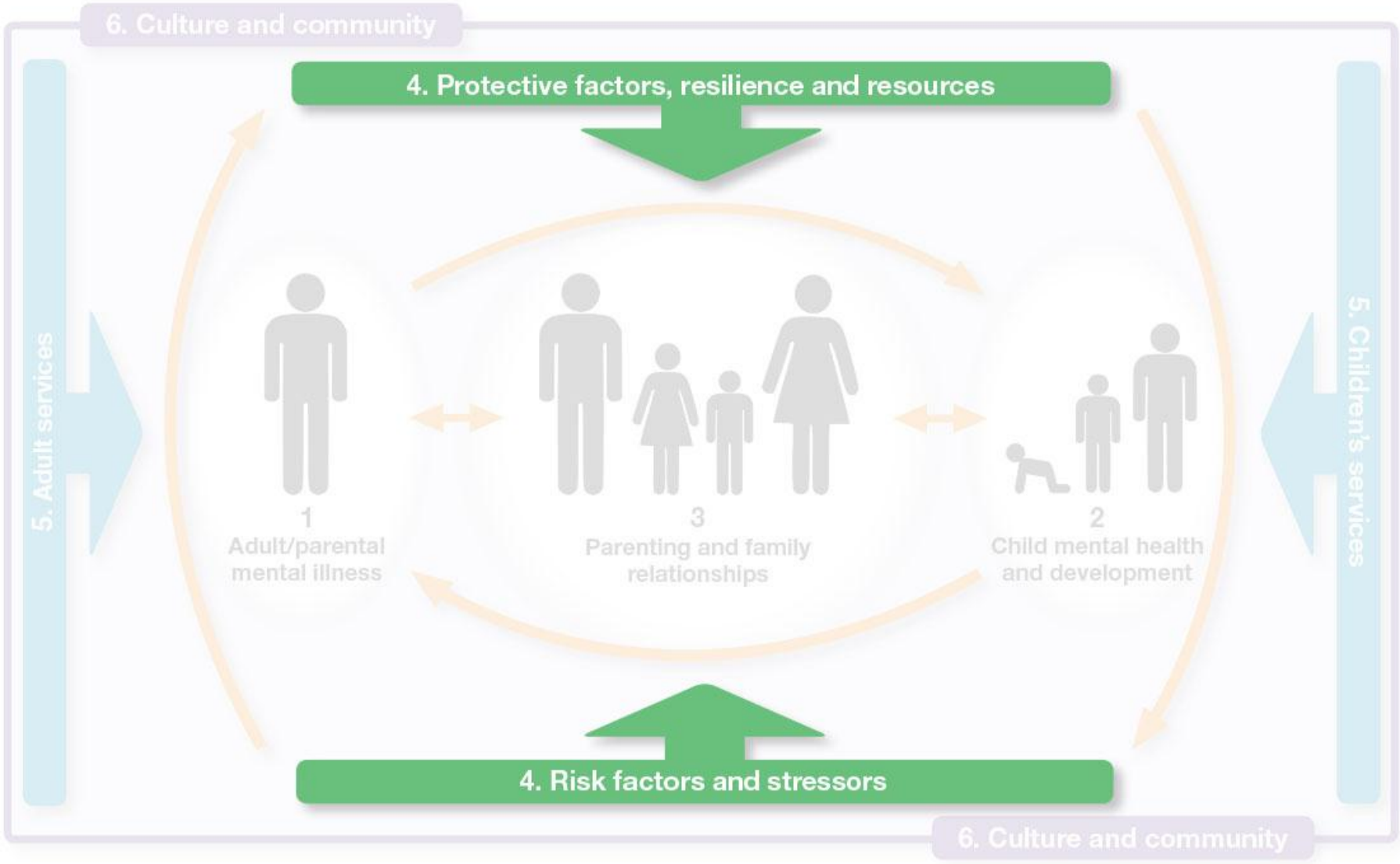
Paternal roles

- A significant proportion of fathers living with their naturally, adopted, step or foster children experience mental illness
- Psychiatric illness in fathers can have a devastating impact on children's' wellbeing and even milder forms of PMI can have a serious developmental effect on children
- While several pathways linking PMI with good child outcomes have been identified, fathers' impaired parenting is an important, potentially malleable factor
- Clinicians can assist fathers with MI & their families by pro-actively enquiring about children and by exploring fathering-focused psychological support.

Fletcher, RJ et al. (2012) MJA Open Supplement - 16th April, 2012

THE FAMILY MODEL

Domain 4: Risk & Protective Factors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Interactive Risk and Protective Factors

Risk factors and protective factors are:

1. Additive
2. Cumulative
3. Interactive

Impacts on Children

Statistical Risk Liabilities

- Aggregated data indicate that these children have a 70% chance of developing at least minor adjustment problems by adolescence
- With 2 MIPs there is at least a 30 – 70% chance of becoming seriously mentally ill (Rubovits)
- Regarding specificity, a child with an affectively ill parent has a 40% chance of developing affective disorder by age 20, compared to 20-25% risk in the general population (Beardsley)

4. Risk & Protective Factors

Parental Illness

Vulnerability

- Severe, chronic, recurrent, early onset illness

Resilience

- Circumscribed, time ltd illness
- Good engagement & adherence

Risk & Protective Factors

Child MH & Development

Vulnerability

- Intrauterine – stress hormones, alcohol, drugs, meds, diet
- Prematurity
- Low birth Wt

Resilience

- Older age at onset of parental illness
- More sociable, able to engage adults, easier temperament
- Greater cognitive abilities
- Discrete episodes of parental illness with good return of skills & abilities between episodes
- Alternative support from adults with whom child has positive, trusting relationship

Risk & Protective Factors

Family relationships

Vulnerability

- Marital discord, domestic violence, separation
- Lone parent, ill, unsupportive partner

Resilience

- Supportive, harmonious relationships interparental
- Secure attachments
- Warmth

Risk & Protective Factors

Depression Risk Factors

Specific

- Extensive family history of depression, especially parents
- Prior history of depression
- Depressogenic cognitive style
- Bereavement

General (Risks for many disorders)

- Exposure to trauma
- Poverty
- Social isolation
- Job loss
- Family breakup
- Loss of community
- Dislocation / immigration
- Historical trauma

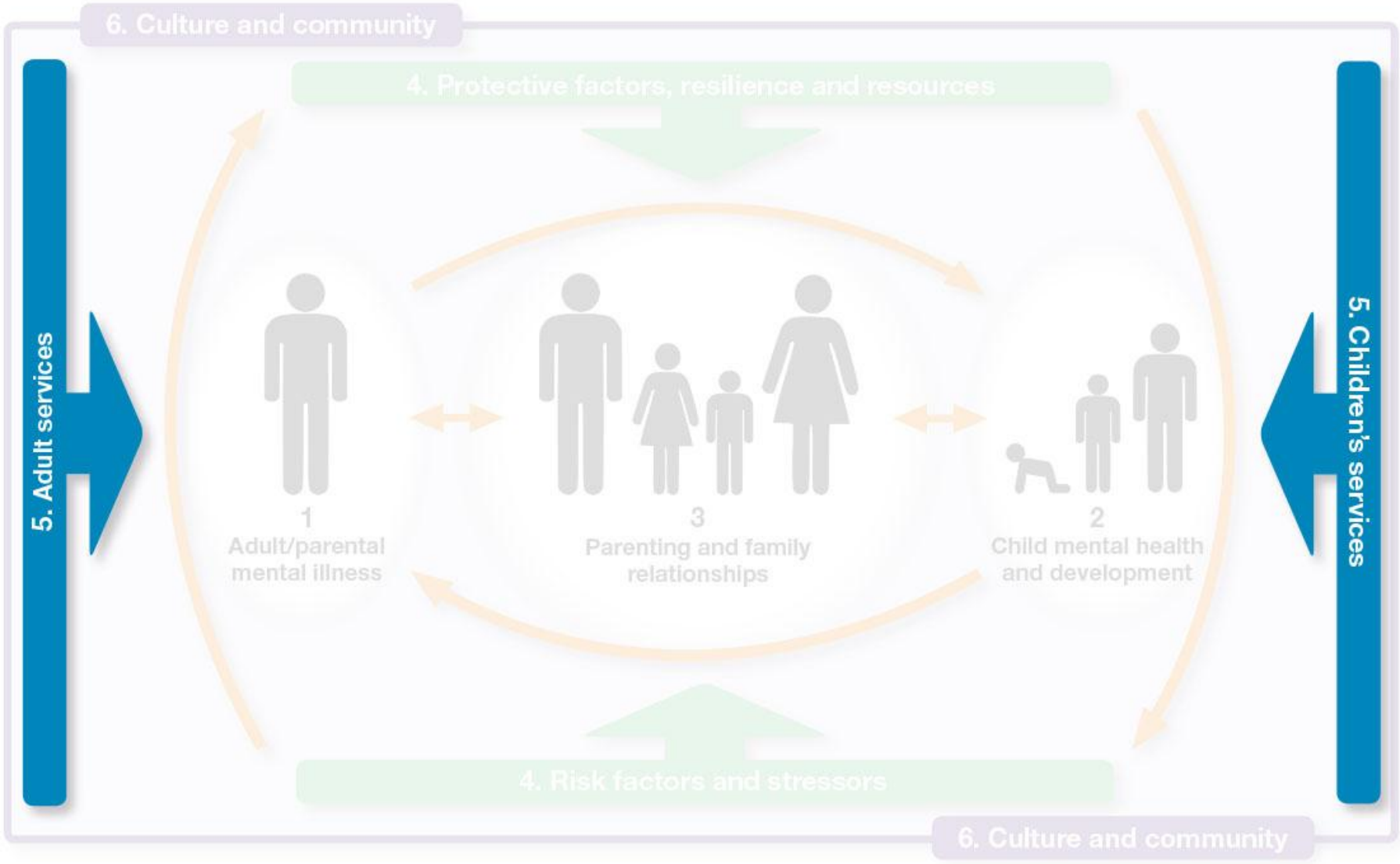
The Family Genes

Recurrent, early onset Major Depression

- Onset depr in chhood – a single MDD assoc with nearly 50% chance of recurrence in future (Kovacs 96)
- Chhood dysthymia – 78% chance of subsequent MDD (Kovacs 96)
- A parent or sib with MDD has 2-3 fold greater risk for depr compared to gen popn risk (10%)
- If the relative has severe, earlier onset (childhood / teens / 20s), recurrent MDD the risk becomes 4-5 X greater
- About 50% of predisposition / heritability accounted for by genes
- Multi locus patterns of inheritance
- ***Genetic vulnerability coupled to early adversity (abuse and neglect), life events and loss imposes even greater levels of risk***

THE FAMILY MODEL

Domain 5: Services for Children & Adults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2
Child mental health and development
4. Risk factors and stressors
6. Culture and community

FaMHLiS
Talking Together

- Child psychiatrist:

'Do you worry you might upset your children if you talk to them about your difficulties?'

- Adult psychiatrist:

'Do you worry you might upset yourself?'

Barriers

- Despite the breadth (of evidence about need, impact & burden), multiple barriers remain, within & across services, agencies, sectors, regions & countries
- Individual
- Service
- Systems

Service barriers...

Not mine, not trained, too busy, too risky

Individual

- Early specialisation in training
- Individual focus in design delivery & funding of services
- Few routine comprehensive skills-based training in fam work
- Individual reactions & desire to KIS – system more complex than individual

Service barriers...

Not mine, not trained, too busy, too risky

Team / service

- Lack of confidence in dealing with greater complexity that family work brings - > 1 individual; competing needs; confidentiality etc
- Multi-directionality of impacts & influences (1 affects all & all affect 1)
- Meeting targets vs meeting need – role of carers & consumers ‘lived experience’
- Models – individual / disease vs biopsychosocial

System

- Culture of risk & blame

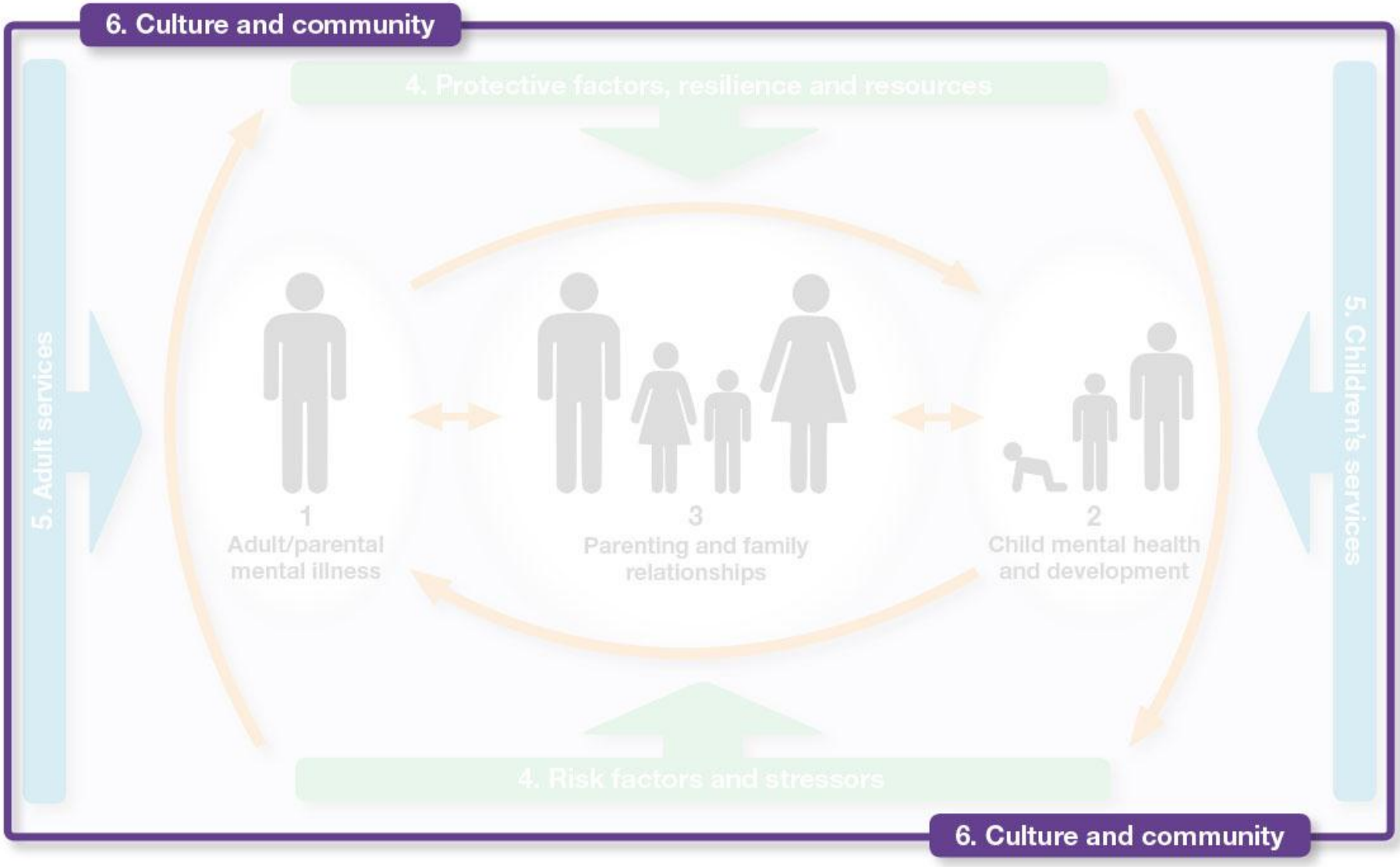
Structure, function, process yes, but…

- Structure
  - Professional hierarchies, administrative boundaries
  - Workforce structures & pay rates
  - Budget silos
- Function
  - Different roles, histories, powers & priorities, procedures
  - Ideologies, KPIs & targets
  - Standards of accountability, management, & decision making
  - Communication – confidentiality, reporting lines
  - Professional, organisational culture

Necessary, not sufficient - the finest protocols, policies & plans have to be implemented & delivered by … PEOPLE!

THE FAMILY MODEL

Domain 6: Cultural & Community Influences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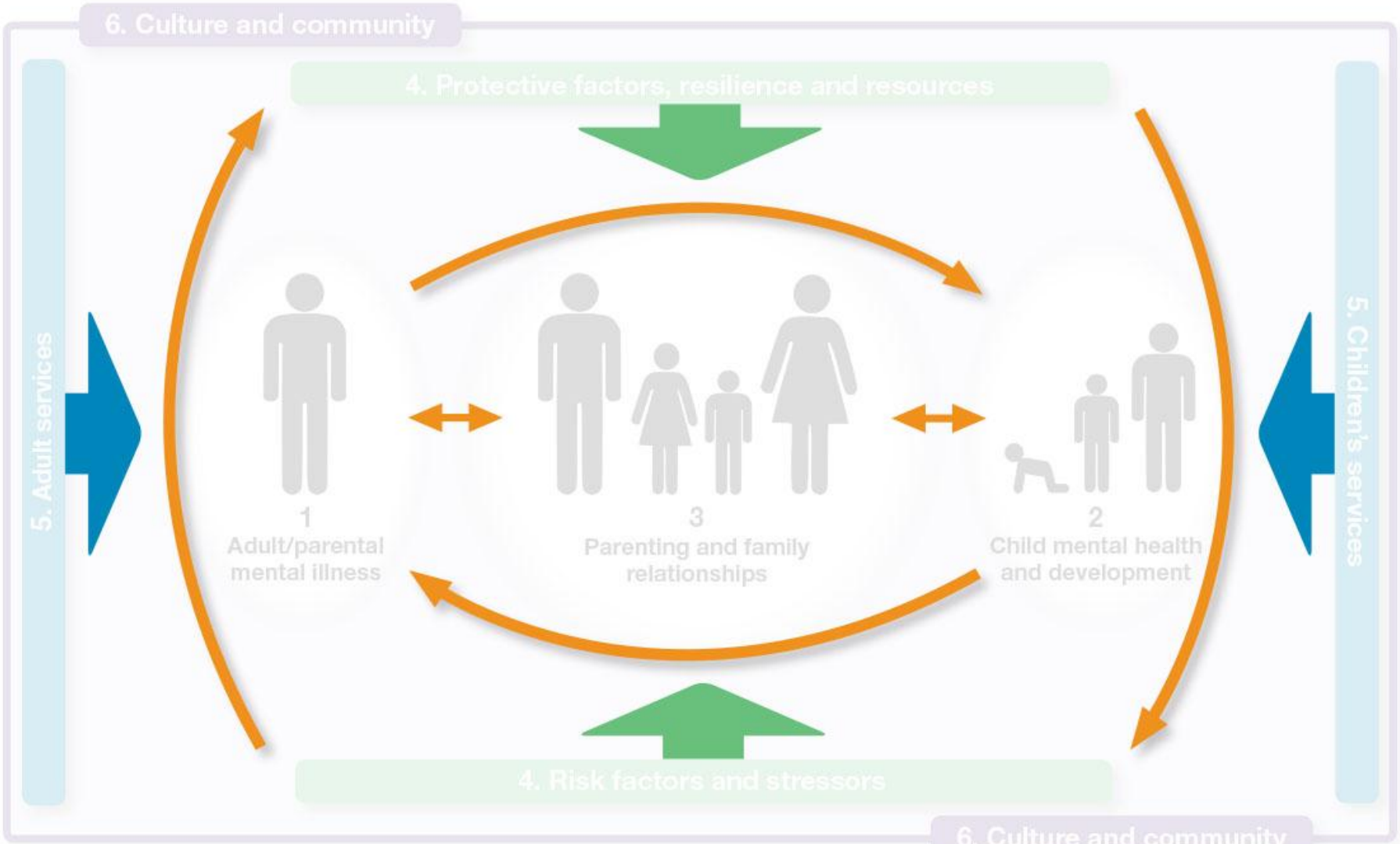
THE FAMILY MODEL

Interactive Influences: Linking the key domains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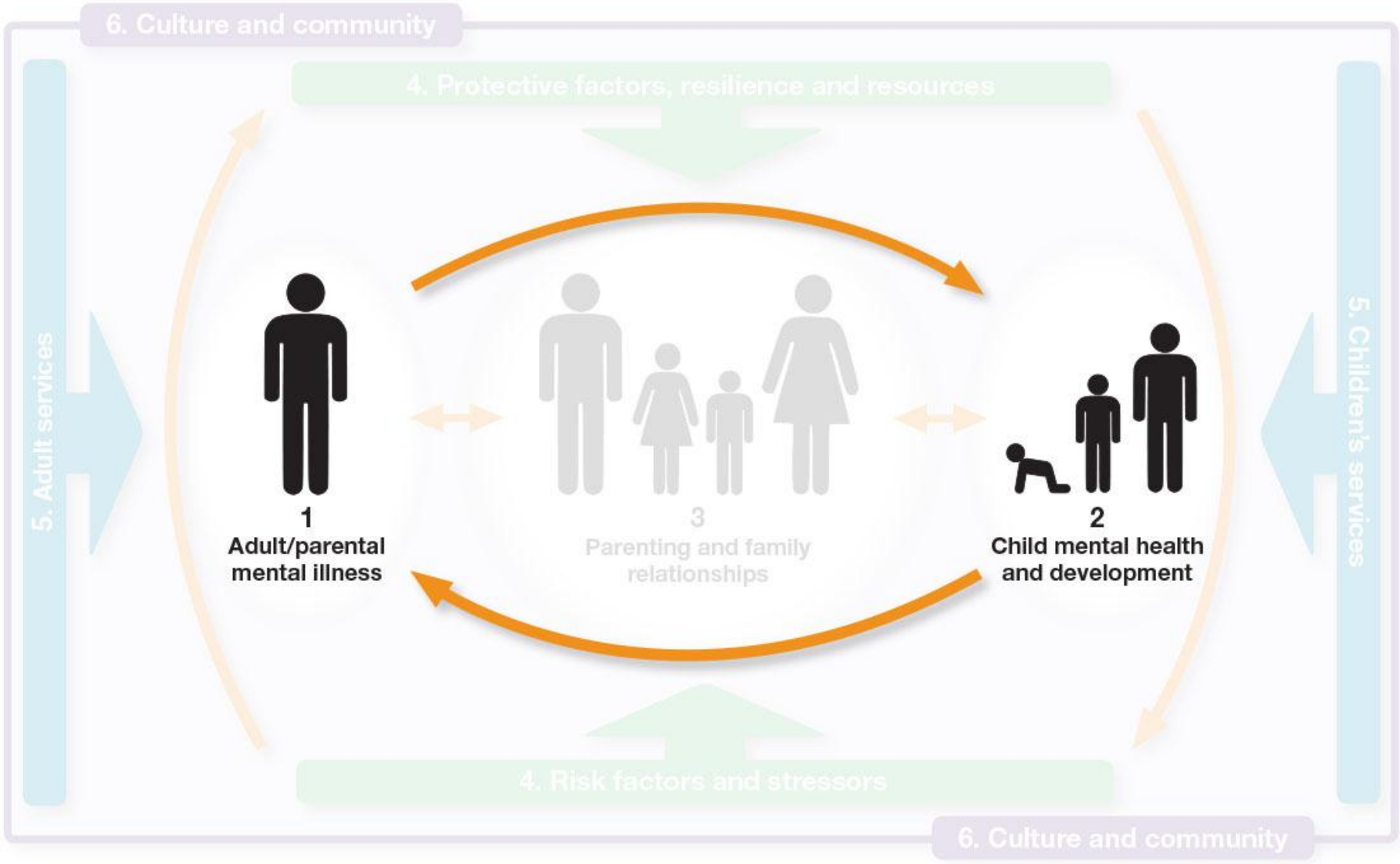
Good Relationships Protect

Good relationships – from early on in life - individuals, families, peers, neighborhood, are a powerful determinant of social support quality and hence the onset, duration, intensity and episode & disorder pattern…

The quality of interactions between service providers, consumers & carers is a very powerful determinant of an affected individuals prognosis…

What we do, when we do it and how we do it matters…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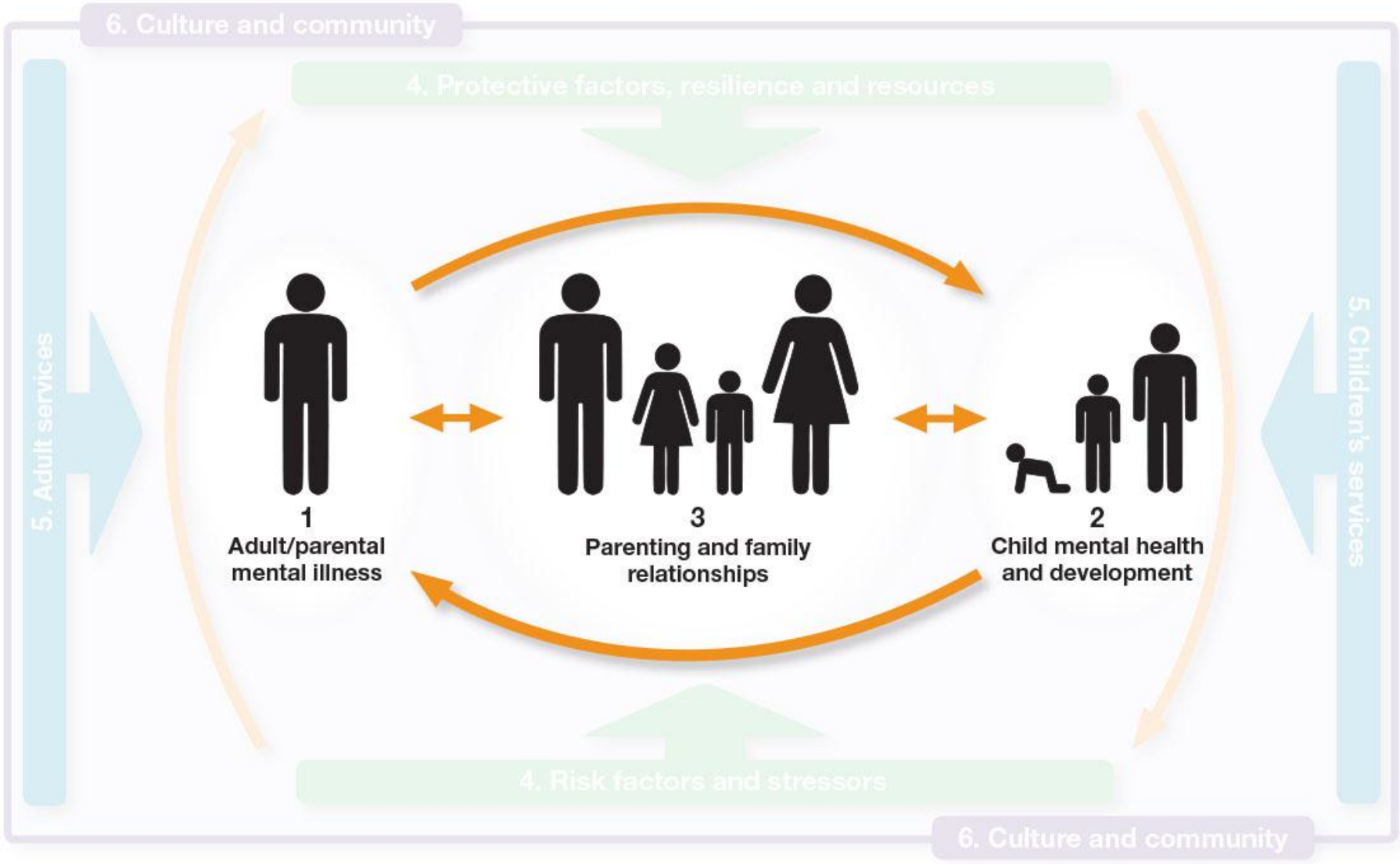
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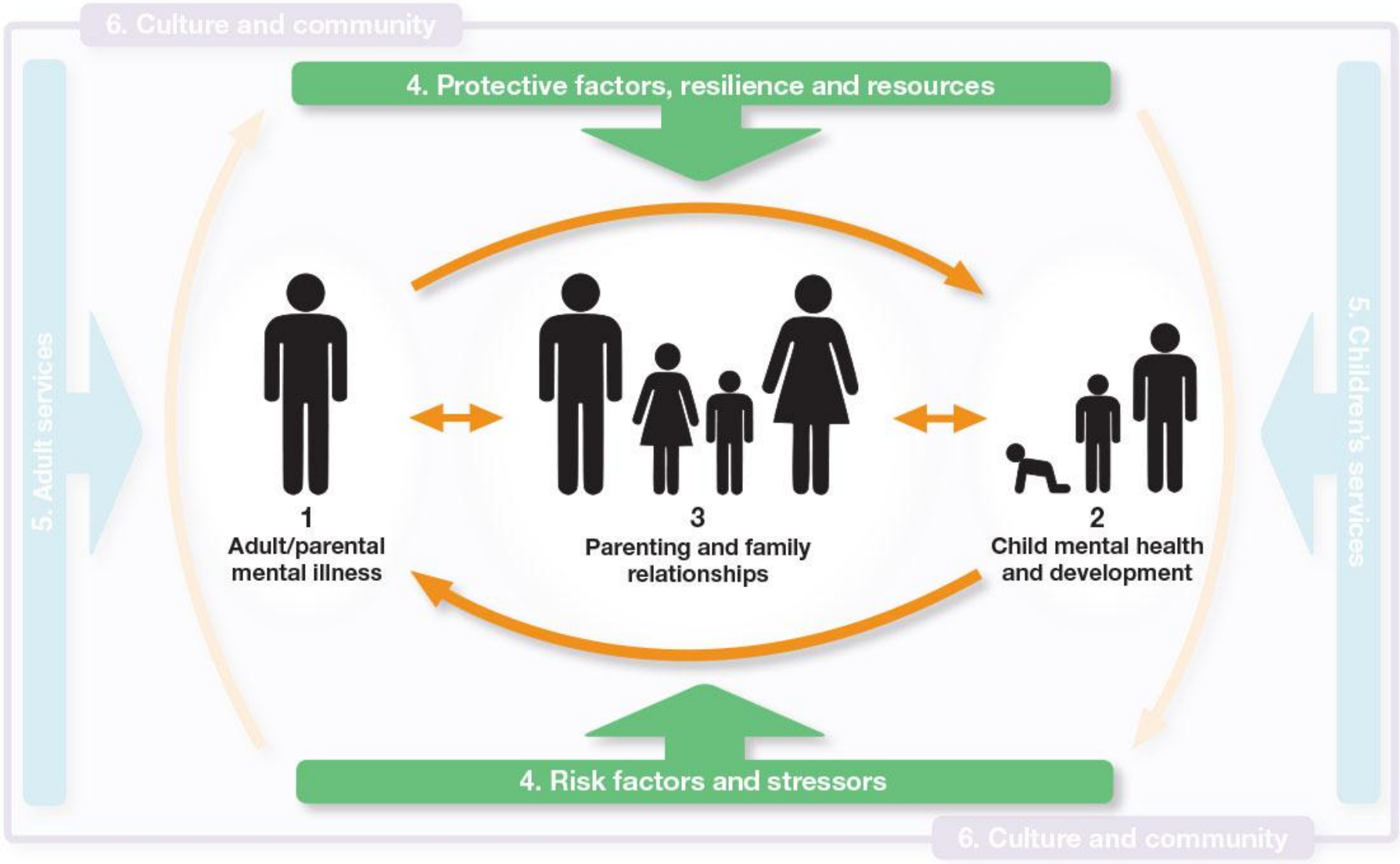
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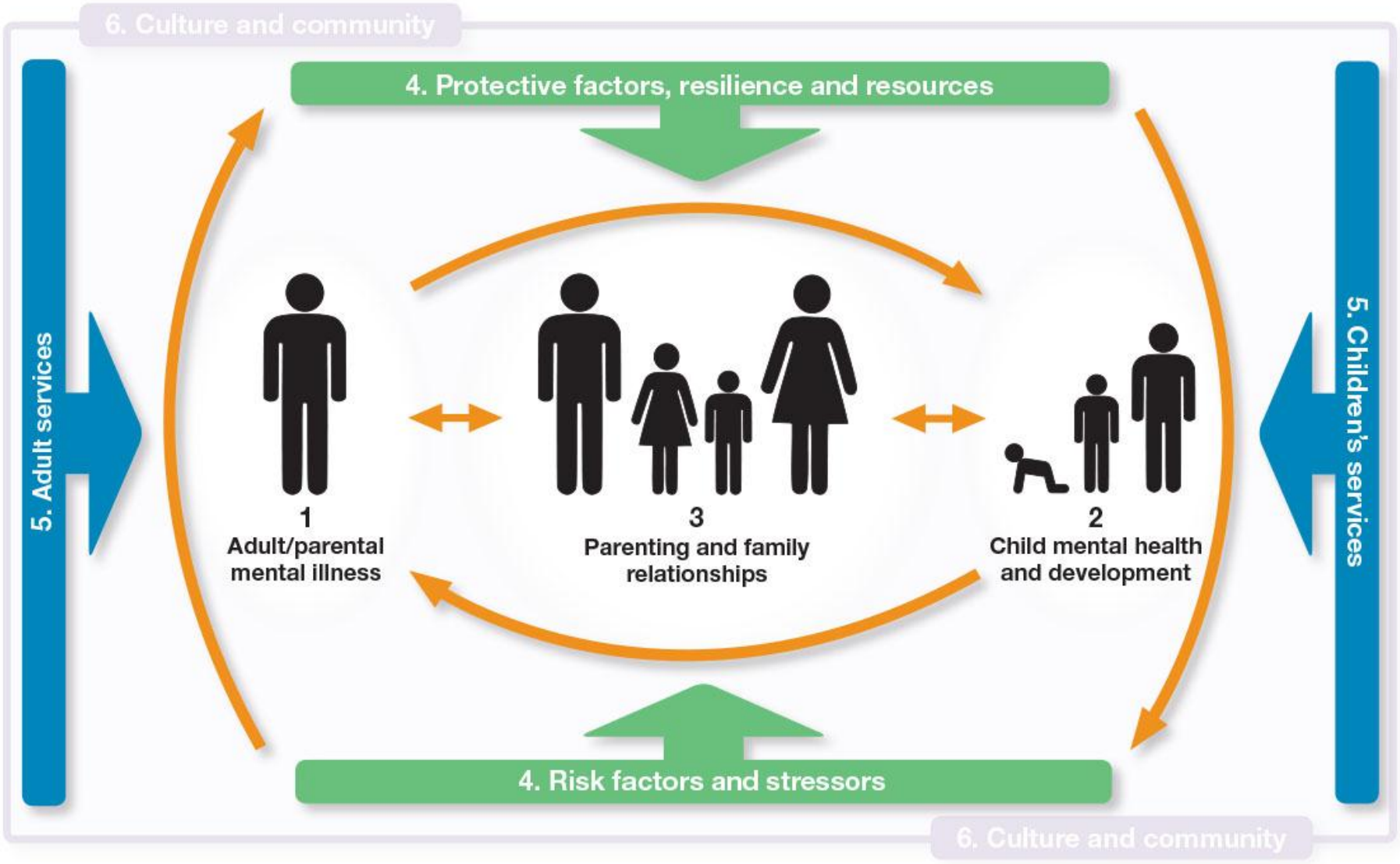
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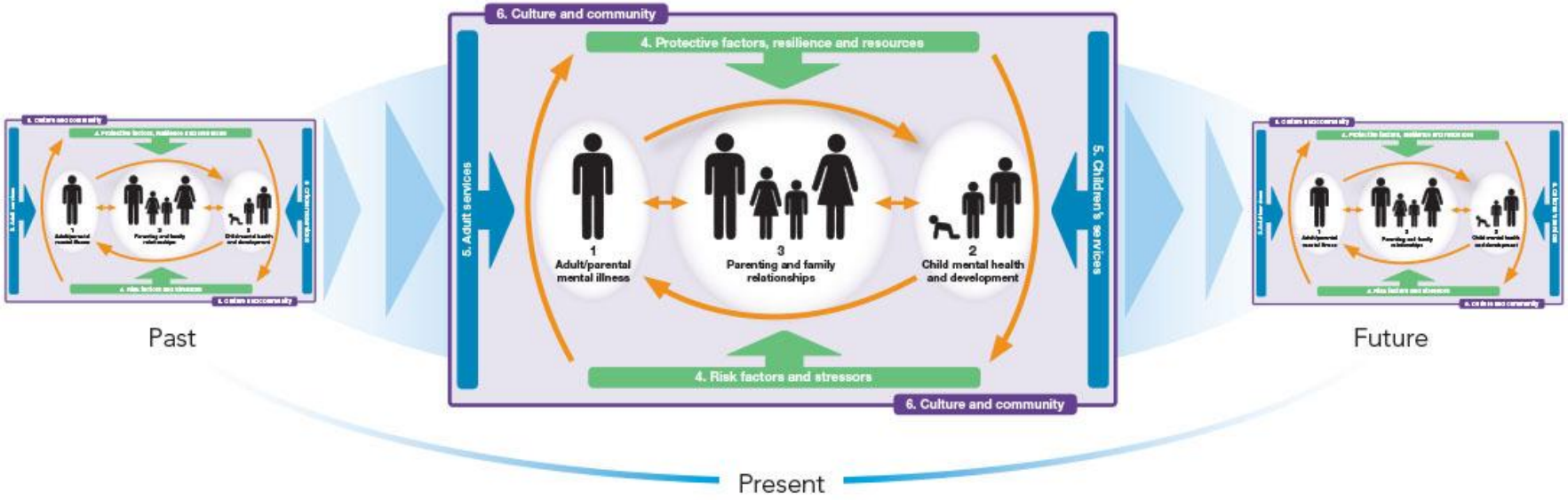
Longitudinal perpective

- Looking at the present
  - Living with mental illness
- Looking back
  - Childhood origins of adult psychopathology
- Looking ahead
  - Early intervention (early & quickly)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Past
Future
Present

THE FAMILY MODEL

Skills enhancement

Looking at the present – current child, parent & family assessment issues

Assessment - Key Areas

- **Who** to assess
  - The child
  - The ill parent
  - Partners & other family members
- **What** to assess – key domains
  - Parenting
  - MI &/or SA in parent (MS; risk harm to self/other; diagnosis; Rx; Prognosis; service/need match – availability of resources; broader social needs)
  - Safety, wellbeing & health of children
  - Prevention options
- **How** to assess
  - Talking with children whose parents are MI or abusing substances
  - Talking with parents/carers who are/may be MI

Assessment – Key Topics

- Children's awareness & understanding of PMI
- Role of partners, fathers
- Dual diagnosis, comorbidity & complexity
- Exchange of information & confidentiality
- Early intervention & prevention
- PMI & child protection
  - Parental self harm, OD, suicide, homicide
  - Young carers
  - Domestic violence
  - Parental capacity to meet children's needs (emotional malRx)

Children's Questions
Jimmy, aged 6

1. What's mum's illness called?
2. Will mum get completely well?
3. Will mum get ill again?
4. List of worries
5. What helps mum stay well?

Children's Understanding

During a meeting with his family, *Jumai*, a 7 yr old described a conversation with his father:

'We were talking about her and dad said about the controller - you know, for the TV. If you press all the buttons all the time very quickly and it jumps about all over - going crazy - that's like what was happening in Mum's head. She was in hospital.'

Partners - Potential sources of:

- Alternative care & support (confiding relationships protect)
- Additional burden because they may also show evidence of MISA
- Direct harm for children if the partner has abused children & MISA prevents a parent from adequately protecting children
- Indirect harm for children (eg domestic violence)

THE FAMILY MODEL

Skills enhancement

Looking ahead: care planning & risk management

Policy to Practice

The non-science of implementation

- Australian Context
- Policy & Legislation (Must v Should)
- Vision
- Implementing Fam Focused MH services in W Sydney
  - Local context
  - Achievements & challenges
  - Looking ahead
- The Service model (What we are doing - Policy Framework; CIC Plan; Min stds; KPIs)
- The Service process (How we are doing it - CIC; MoC; MH Procedure; monitoring mechs; id, assess, intervene review; menu of interventions; workforce training; service Evaluation)
- KPI monitoring v evaluation
- Non-Science of implementation - some reflections & questions about organisational change in MH services

From ‘Thinking’ to ‘Doing’

Implementing Family Focused MH services in W Sydney

‘Most things out there are designed to stop you making a difference. All the biggest bets in life are on the status quo. Plenty of people think they would like to change things but lack the energy or the imagination to clamber over, or beat a path through, the status quo… only the few determined and inspired ones will make a real difference.’

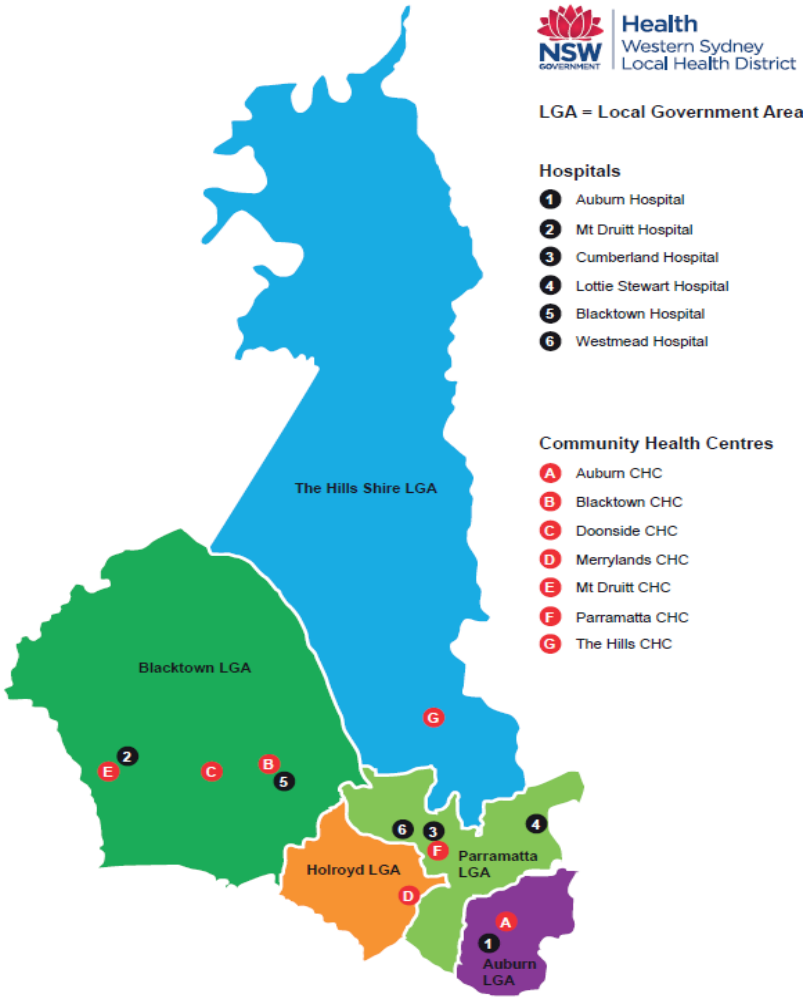
Paul Keating – the power of the status quo - Occasional address – UNSW, 15 April 2003

Australian Context

- **Federal Gov**
  - 4th NMHPlan "Expand the level & range of support for families & carers of people with MI & MH problems, *including children of parents with a MI*" (Priority area 2: P&EI)
  - AICAFMHA National initiative www.copmi.net.au
- **NSW Gov** (MHDAO, MH-Kids – Copmi program)
  - Copmi Policy Directive – Framework for MH services (2011-2015)
  - MH Structured Clinical Documentation (FFA)
  - Perinatal psychosocial screening
  - Family & Carers program
- **NSW Area Health services** (eg WS&NBM LHDs)
  - Copmi Implementation Committee
  - Copmi Coordinators, Champions

WSLHD context

- Encompasses 5 LGAs
- 774 km^2 with estimated population of 846,389 (70% of Wsydney popn)
- Includes Westmead, Auburn, Blacktown, Mount Druitt and Cumberland Hospitals
- > 175,000 young people aged15-24 yrs (123,500 in WS LHD)
- Higher than state average youth D&A use and high & v high psychological distress in young people
- Significant Aboriginal community, high % culturally and linguistically diverse backgrounds including recent arrivals and asylum seekers



WSLHD ‘E. Cluster’ CMH services

- Adult population 350 000 (40% of W Sydney & increasing)
- Staffing (FTE) total 80.5 = 20% vacancy rate (April 2012)
- COPMI Coordinators (3 FTEs)

Children of Parents with a Mental Illness (COPMI) Framework for MH Services

Document Number PD2010_037
Publication date 17-Jun-2010

The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services aims to:

1) Foster the continuing development of Area Mental Health Services for children of parents with a mental illness and their families; and

2) Assist Area Mental Health Services in the ongoing development of collaborative approaches with key partners and agencies working with children and their families.

Policy Framework for MH Services
Strategic Directions 2010 – 2015

1. **Promote wellbeing & reduce risks** assoc with MI for infants, children, adolescents & their parents/carers & families
2. Identify & provide **responsive services** for families where a parent has a MI
3. Increase & strengthen capacity of **IA partners** to recognise & respond to needs of copmi problems
4. Support ability of **workforce** to provide appr fam focused interventions & care to parents with MI, their children & families

WS&NBM COPMI Implementation Committee

Major focus of the Policy Directive is to

"reduce the impact of PMI on all family members through a timely, coordinated, developmentally informed, preventive, family focused approaches"

http://www.health.nsw.gov.au/policies/

WS&NBM Copmi Framework
Implementation Committee

- To facilitate family focussed practice in WS&NBM LHNs & improve outcomes for parents experiencing mental illness, their children, partners & other family members

- To provide MH Exec with appropriate information to prioritise implementation of the 4 key strategic directions & associated actions in the Framework (2010-20150)

CIC
Implementation Plan

Strategic Direction 1, Priority Action 1.7: ***COPMI Families to receive developmentally appropriate & disorder relevant information…***	**WS LHD (east)**		**WS LHD (central)**		**NBM**	
	I	**C**	**I**	**C**	**I**	**C**
• Scope & gather relevant materials for suite of potential items for inclusion, including reviewing all items for relevance, accessibility and cost						
• Ensure materials made available for use by all MH teams & units across WS/NBM LHD's						
• Provide information & training to all staff about availability, use , distribution & monitoring of materials						
• Add to inpatient & community admission / discharge checklists						
Strategic Direction 2, Priority Action 2.1, 2,2 & 2.4 : ***Systematic identification & recording of COPMI families***						
• Systematic use of FFA as part of the assessment of all clients of MHS who identify as adults with dependent children						
• Develop careplans which are inclusive of parenting responsibilities, and children's needs including the needs of young carers and relapse prevention .						
• Develop protocols to facilitate collaborative care pathways and care planning and access for families within MH (AMH / CAMHS / Youth)						
• Develop recommendations regarding COPMI inclusive fields in relevant electronic databases, ie SCIMHOAT for Community Adult Mental Health						
• Ensure training & education to raise awareness & improve skills in use of SCD focussed on family needs within MH service (family sensitive practice)						

CIC Achievements

- **Implementation Plan**
- **Minimum service standards**
- **"Family Focus" KPI's**
- **COPMI Model of Care (draft)**
- Communication strategy
- Systematic identification families (inpatient & community AMH), Mandatory electronic reporting & recording
- **Workforce** recruitment, roles & tasks
  - Copmi Coordinators (strategic role)
  - Copmi Champions (Inpatient and Community AMH)
  - Managers & Team Leaders
- **Education & training**
  - COPMI Champions skills based training:
  - TFM; Cont of Need; FFA
  - Modules (eLearning; how will I know; talking with children)
- **Clinical consultation** (Family Focused Practice)
  - Routine agenda item
  - Systematic identification, recording
  - Clinical review (FFA)
  - Month
- Evaluation
  - **Audit**
  - Workforce practice survey
  - Monthly manager reports
- COPMI clinic
  - Managing risk
  - Early intervention (children's understanding

CIC

Key Documents

- Minimum Standards For MH services
- MH Procedure
- FFA (Family Focused Assessment) & ‘How will I know?’
- Family Model
- “Continuum of need”
- MoC

Implications for practice

- Identification
  - Admin documentation, SCD
- Assessment
  - FFA
  - Talking with children, parents
  - Screening, referring
- Intervention, recovery, early intervention
  - Collaborative practice, Consultation
  - Joint work, information
  - Childrens understanding
- Evaluation
  - Consultation
  - Provision of information

CIC documents

Family Focused Care
in
Mental Health Services

Minimum Standards for all staff in WS & NBM LHDs

Version 2 DRAFT 1.0

CONFIDENTIAL

CIC

Minimum Standards

All adult mental health professionals ***must***:

- Identify / screen for parental status - what questions to ask & when
- Talk with their patients/clients /carers about their role as parents
- Be able to have a conversation with children
- Inquire about the impact of parental symptoms & behav (what to ask & when; use of screening instruments, prompts etc)
- Have good knowledge of local services, related resources & CP
- Provide understandable information to parents about their diagnosis, prognosis & treatment

Workforce
Key roles & tasks

- MH staff – minimum standards & competencies
- COPMI Coordinators – Redefined role
  - Clinical consultation & partnerships,
  - advocacy & leadership
  - Ed & training
  - Evaluation
- COPMI Champions – New role for existing staff
  - Id, Assess, Intervene, Review
- Team Leaders – Min stds, training, supervision, support
- Sector managers – Min stds, KPIs & performance

Core Clinical Challenges

Assessment, support & intervention

- *How will I know?*
- *What should I do?*

SCD – COPMI Module
The Family Focused Assessment

- *Identification*
  - adults who are parents / have childcare responsibility / contact with children
- *Assessment*
  - aspects of parental mental state that may impact the child
  - Child's current functioning
  - Protective and risk factors in key domains
- *Intervention*
  - Care planning & protection

NSW HEALTH

Mental Health

Site

FAMILY FOCUSED ASSESSMENT (COPMI)

SURNAME | MRN

OTHER NAMES | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Where parental/carer status has been determined and the child is aged 18 years or less, this module assists the identification of current issues where a face-to-face assessment has already been completed with the parent/carer, child and corroborative information obtained. This module may be used at assessment, review and discharge. Please attach to relevant base module and summarise in relevant components e.g. if completed at assessment, document in 'Risk Assessment', 'Formulation' and 'Initial Management Plan'.

CURRENT PARENTAL/CARER FUNCTIONING: SYMPTOMS, BEHAVIOUR THAT MAY IMPACT ON THE CHILD

BEHAVIOUR *UK=Unknown	Y	N	UK*
Clinically significant behavioural disturbance *(e.g. disorganised, obsessive-compulsive rituals)*	☐	☐	☐
Behaviour frightens, confuses or embarrasses the child	☐	☐	☐
Other *(specify)*	☐	☐	☐
MOOD AND AFFECT			
Clinically significant affect disturbance *(e.g. emotionally withdrawn; inappropriate; flat; restricted; labile)*	☐	☐	☐
Expressing hostility towards the child *(e.g. critical/negative comments; lack of praise; ignoring child)*	☐	☐	☐
Child is witnessing significant irritability/anger *(e.g. marital disharmony; domestic violence)*	☐	☐	☐
Other *(specify)*	☐	☐	☐
SPEECH, THOUGHT, PERCEPTION AND COGNITION			
Delusional thinking targets and incorporates child	☐	☐	☐
Hallucinations target and incorporate child	☐	☐	☐
Poor concentration and/or memory *(e.g. distractible, unable to focus on child's needs)*	☐	☐	☐
Other *(specify)*	☐	☐	☐
INSIGHT AND JUDGEMENT			
Lacks insight into their illness	☐	☐	☐
Treatment non-adherent *(e.g. lack of attendance at appointments, poor engagement)*	☐	☐	☐
Denies that their symptoms/behaviour are affecting their ability to look after their child	☐	☐	☐
Other *(specify)*	☐	☐	☐
COMORBIDITY			
Abuses alcohol or drugs	☐	☐	☐
Has a diagnosed personality or other mental disorder	☐	☐	☐
Has significant intellectual/cognitive deficits	☐	☐	☐
Other *(specify)*	☐	☐	☐
SELF REPORTED PARENTAL/CARER CONCERNS			
Concerned about their ability to meet the needs of the child, including safety	☐	☐	☐
Concerned about the impact of their mental illness/disorder on the child *(e.g. neglect, irritability)*	☐	☐	☐
Has fears about seeking help *(e.g. fears that the child may be removed)*	☐	☐	☐
Concerns about their partner/spouse *(e.g. domestic violence)*	☐	☐	☐
Concerns about the amount and quality of social support *(e.g. social isolation)*	☐	☐	☐
Other *(specify)*	☐	☐	☐
CHILD'S CURRENT FUNCTIONING			
PHYSICAL AND PSYCHOSOCIAL HEALTH AND DEVELOPMENT			
Concerns about:			
Child's health, growth and physical development	☐	☐	☐
Child's cognitive and language development	☐	☐	☐
Recent changes in the child's behaviour *(e.g. bedwetting, oppositional, clingy, withdrawn, angry)*	☐	☐	☐
Impacts of recent life event/s on child *(e.g. hospitalisation, illness, bereavement)*	☐	☐	☐
Child's educational attainment *(consider school attendance)*	☐	☐	☐
Child's emotional and behavioural development	☐	☐	☐
Child's identity and self esteem *(e.g. shame re parent's illness; feelings of inadequacy)*	☐	☐	☐
Family and social relationships *(e.g. conflict, level of warmth and support)*	☐	☐	☐
Social skills, self-care and general presentation	☐	☐	☐
Other *(specify)*	☐	☐	☐
SELF REPORTED CONCERNS			
Concerns about their parent's/carer's illness *(e.g. anxiety, anger, confusion, guilt, lack of understanding)*	☐	☐	☐
Concerns about the nature and amount of their own carer responsibilities *(e.g. looking after parent, siblings)*	☐	☐	☐
Child has expressed other concerns *(e.g. isolation, stigma, fears of inheriting illness)*	☐	☐	☐
Other *(specify)*	☐	☐	☐
CONCERNS EXPRESSED BY OTHERS REGARDING CHILD'S WELLBEING & SAFETY			
Concerns have been expressed	☐	☐	☐
Specify:			

Staff Name: Signature: Designation: Date:

FAMILY FOCUSED ASSESSMENT (COPMI) SMR025.060

NSW HEALTH

Mental Health

Site

FAMILY FOCUSED ASSESSMENT (COPMI)

SURNAME

OTHER NAMES ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SUMMARY OF CHILD, PARENT/CARER AND FAMILY RISK AND PROTECTIVE FACTORS

This page assists in the collation and analysis of assessment information and determination of urgency of response. Please attach to relevant base module and summarise findings in relevant components e.g. if completed at assessment, document in 'Risk Assessment', 'Formulation' and 'Initial Management Plan'.

KEY DOMAINS	STRENGTHS/PROTECTIVE FACTORS	VULNERABILITIES/ RISK FACTORS
Parental/carer mental health history		
e.g. psychiatric diagnoses, treatment adherence, level of engagement with services, response to treatment	*e.g. insightful, good treatment adherence*	*e.g. lack insight, poor treatment adherence*
Parental/carer drug and alcohol history		
e.g. current substance use/abuse status, level of engagement with AOD services, level of insight response to treatment		
Family medical history *(consider parental and child issues)*		
e.g. significant chronic or acute medical illness, treatment adherence, response to treatment		
Parental/carer background and childhood *(parent's/carer's family of origin experiences)*		
e.g. cultural issues, childhood trauma, adversity & loss, stability & quality of care received as a child, social/recreational functioning, educational functioning		
Child's developmental and personal history		
e.g. perinatal & childhood development, past social/ recreational functioning, intellectual/ cognitive functioning, past abuse/ neglect experiences		
Parental/carer current functioning and supports *(consider Parental/carer symptoms and behaviour issues noted on page 1)*		
e.g. financial & employment status, parenting skills, social & other supports, marital/inter-parental relationship, parent-child relationship, past DoCS notification		
Child's current functioning and supports *(consider child's current functioning issues noted on page 1)*		
e.g. exposure to parental symptoms/ behaviour, living situation, family relationships & other supports, peer relations, educational functioning, self esteem, age appropriate responsibilities, role models		

OVERVIEW

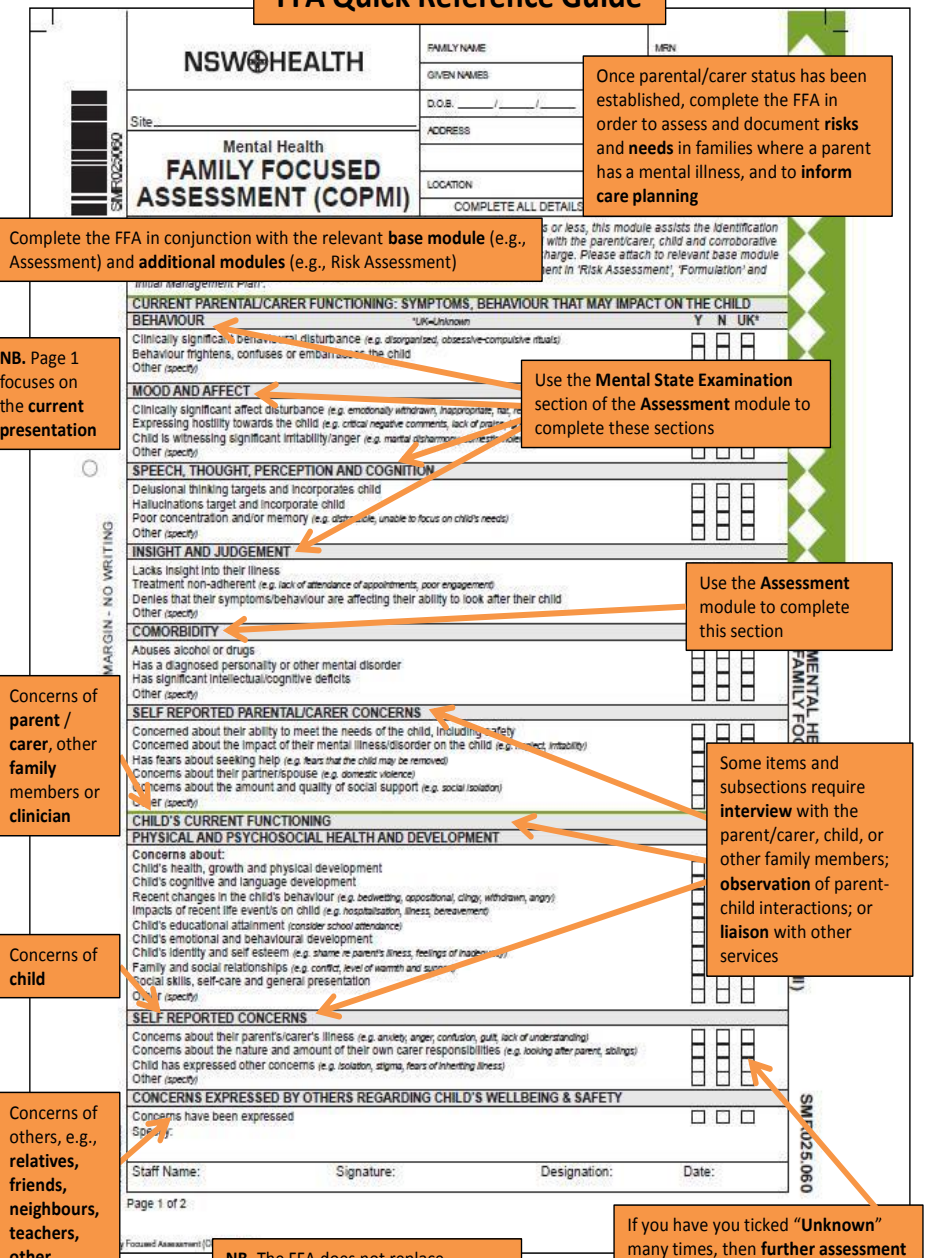
Parent's/carer's current symptoms and behaviour interfere with undertaking parental and/or essential household duties ☐ Yes ☐ No

Parent's/carer's current symptoms and behaviour is having a negative impact on the child ☐ Yes ☐ No

SPECIFIC ISSUES TO BE ADDRESSED IN MANAGEMENT/CARE PLAN *(consider current & longer term issues)*

Staff Name: Signature: Designation: Date:

FFA Quick Reference Guide



Once parental/carer status has been established, complete the FFA in order to assess and document **risks** and **needs** in families where a parent has a mental illness, and to **inform care planning**

Complete the FFA in conjunction with the relevant **base module** (e.g., Assessment) and **additional modules** (e.g., Risk Assessment)

NB. Page 1 focuses on the **current presentation**

Use the **Mental State Examination** section of the **Assessment** module to complete these sections

Use the **Assessment** module to complete this section

Concerns of **parent / carer**, other **family** members or **clinician**

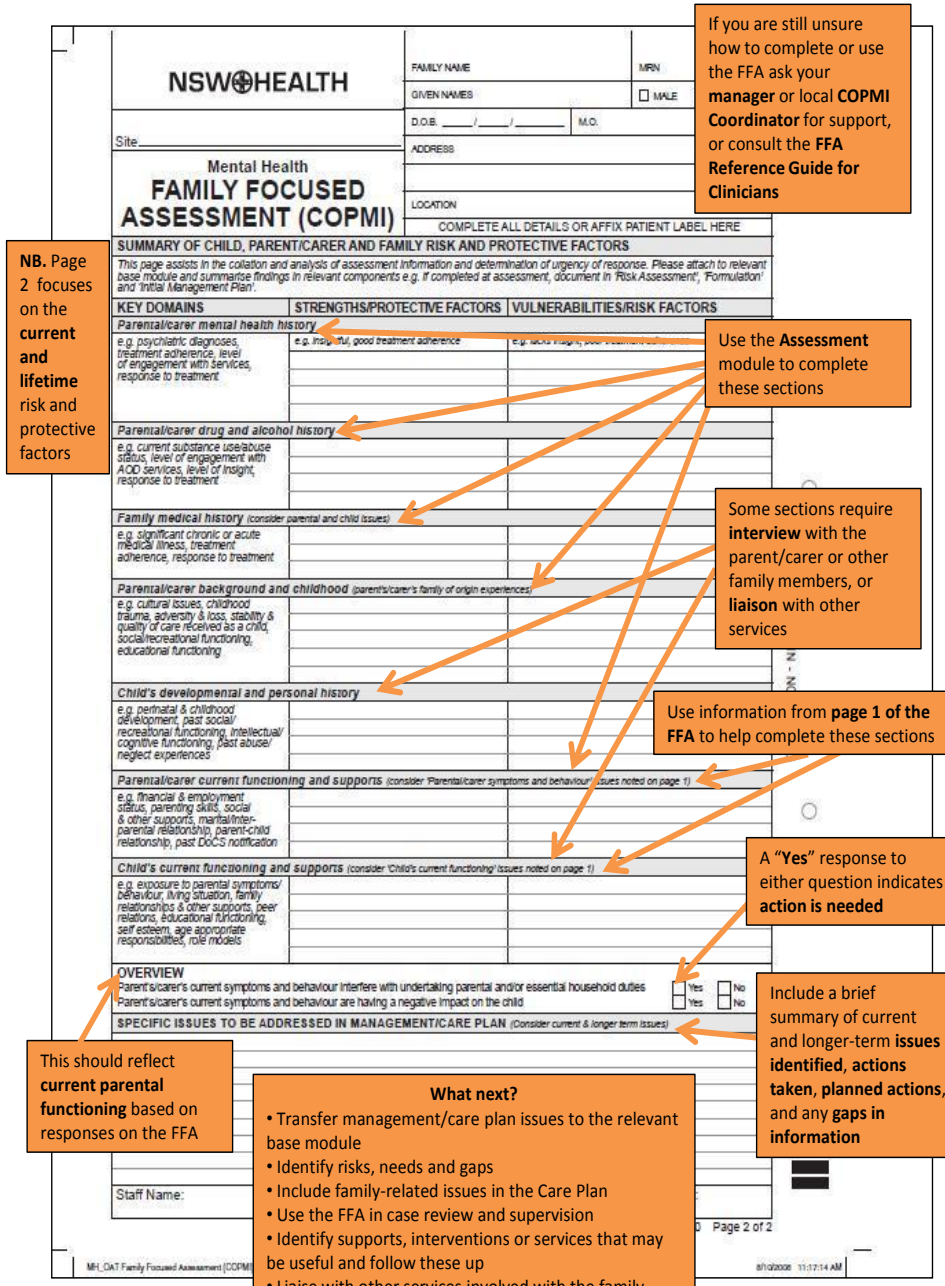
Some items and subsections require **interview** with the parent/carer, child, or other family members; **observation** of parent-child interactions; or **liaison** with other services

Concerns of **child**

Concerns of others, e.g., **relatives, friends, neighbours, teachers, other services**

If you have you ticked "**Unknown**" many times, then **further assessment** is needed

NB. The FFA does not replace **mandatory child protection** procedures



If you are still unsure how to complete or use the FFA ask your **manager** or local **COPMI Coordinator** for support, or consult the **FFA Reference Guide for Clinicians**

NB. Page 2 focuses on the **current and lifetime** risk and protective factors

Use the **Assessment** module to complete these sections

Some sections require **interview** with the parent/carer or other family members, or **liaison** with other services

Use information from **page 1 of the FFA** to help complete these sections

A "**Yes**" response to either question indicates **action is needed**

This should reflect **current parental functioning** based on responses on the FFA

Include a brief summary of current and longer-term **issues identified, actions taken, planned actions**, and any **gaps in information**

What next?

- Transfer management/care plan issues to the relevant base module
- Identify risks, needs and gaps
- Include family-related issues in the Care Plan
- Use the FFA in case review and supervision
- Identify supports, interventions or services that may be useful and follow these up
- Liaise with other services involved with the family
- Conduct regular reviews of family issues using the FFA

“How will I know what the family needs?”:

The Family Focused Assessment (COPMI) Module

Reference Guide for Clinicians

Dr Melanie Mence, COPMI Project Officer, Clinical Psychologist

Dr Adrian Falkov, Chair WS&NBM LHD COPMI Implementation Committee, Child & Adolescent Psychiatrist

Online Learning Module

"Talking with Children & Families" for MH Staff

http://swahs.moodle.com.au/course/view.php?id=164

Evaluation
CMHT Audit (2011/12)

- **Prevalence of parenthood in AMH services**
  - Casenote ascertainment of MH staff usage of SCD regarding
  - Identification, assessment & intervention for families known to CMHTs in W Sydney (8/15 teams)
- **Impact profiles – parenting matters**
  - Adequacy of casenote content regarding parenting, child protection and wellbeing
- **Education & training of MH staff**
  - Comparison of SCD/casenote recording quality before (T1) and after (T2) training. Pre / post comparison of staff who received training with staff who did not

Findings

Prevalence of parenthood

- T2 total referrals = 676
  - located casenotes = 549 (81%)
  - **Parents = 182 (33%)**

- File audit (T1+T2) = **280 files**
  - 2/3 mothers, 40% cohabiting
  - 60% episode of care < 1 month
  - 557 children
    - Residential status recorded in 77%
    - 68% of whom living with MIP

Findings
Parenting issues

- Parenting issues Id in 63% case notes:
  - NB contributors to presenting problems in > 50%

    Eg Coping with parenting; CP; children's behav problems; young carer; custody, separation issues

  - Parenting Interventions documented in 55%

    CP ref; children's services ref; Parenting mgmnt (by MH case manager); ref to private services

- Better recording of need:
  - Mothers > fathers
  - Ch living with Id parent
  - Married/cohab > single/sep/divorced

Findings
Ed & Training

- Low uptake of SCD generally
  - Assessment (mandatory module) 57%
  - **FFA 3%**
- No differences in case manager documentation of need pre & post CBNSW training (Methodology, sample size)

Implications

Identification

1. Parents constitute significant proportion of adult CMH services – at least a third pts known to CMHTs in W Sydney are parents
2. Gender effects - Poorer identification of males who are parents, esp non custodial (sep & loss)

Documentation

1. Low uptake of SCD generally, FFA in particular (3% FFA)
2. Poor documentation of even basic details about children
3. Parenting issues – low documentation of needs in single fathers where children not living with patient
4. Parenting issues NB contributors to presenting problems and meeting service thresholds

Training

KPI monitor

ID; Assess; Support & Ivn; Disch Plan

ID KPI

"All adults in contact with AMH services who have dependent children are identified"

Report mechanism:

- 2012 = T/Leader managers monthly reports
  - Jan – Dec 2012 N=421 (total OSRequests = 2338) = **18%**
  - Jan – May 2013 N=133 (total OSR = 763) = **17%**

Assm KPI

"FFA module completion"

- 2012 **=** T/Leader managers monthly reports
  - Jan-Dec 2012 (N=143) = 34%
  - Jan-May 2013 (N=13) = 10%

KPI		Reporting mechanism	Results- Community AMH 2012	Results, Community AMH 2013
Clinical			**Jan-Dec 2012**	**Jan-May 2013**
1. Identification	**All adults in contact with AMH services who have dependent children are identified**	2012: T/L Managers Monthly reports	421 (Total open SR's=2338) 421/2338= **18%**	133 (Total open service requests = 763 **17%**
2. Assessment	**FFA module completed for all children once parental status established**	2012: T/L Managers Monthly reports	Total: 143 (143/421) **34%**	13/133 **10%**
3. Intervention **adults identified as parents of dependent children receive:**	**AMH Team / COPMI Consultation**	2012: T/L Managers Monthly reports	Total – 49 (49/120) – **40%**	Total – 12/40= **30%**
4. Discharge planning	**Documentation of family's needs (parenting and children's needs, current issues and recommended follow up treatment/actions included in discharge plan**	July 2013 COPMI Dashboard		

COPMI data recording

Amendments to eSystem

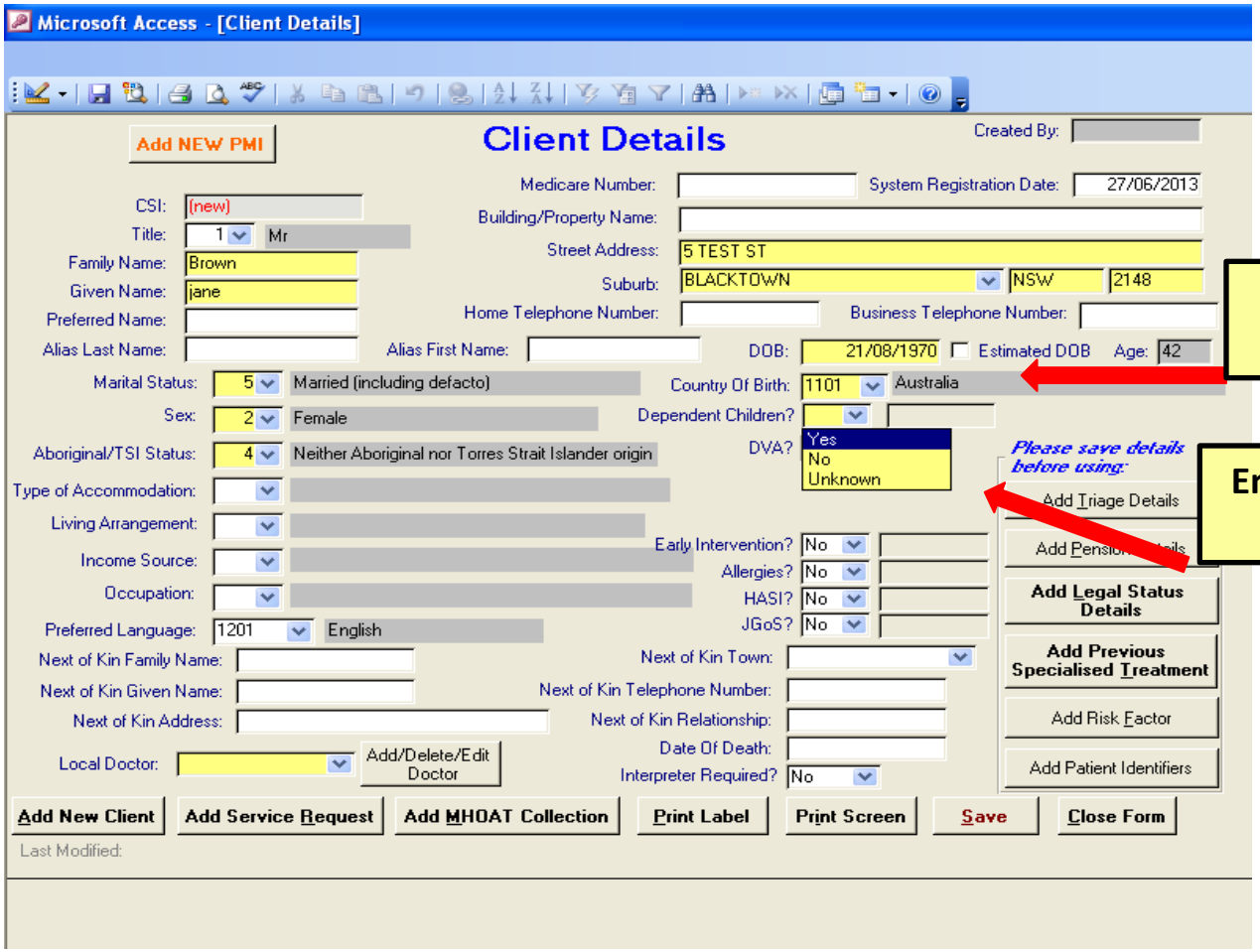
- The SciMHOAT system has been amended to include improved functions to provide ‘Family focused/COPMI’ specific activity and monitoring feedback.
- Amendments guided by:
- WSLHD Procedure: Mental Health: Children of Parents with a Mental Illness (COPMI) Minimum Standards for Family Focused Care
- WSLHD COPMI KPI’s (Community and Inpatient AMH)

Identification

"all adults in contact with (community and inpatient) services who have dependent children are systematically identified and information routinely recorded".

(Procedure: Mental Health: Children of Parents with a Mental Illness (COPMI) Minimum Standards for Family Focused Care)

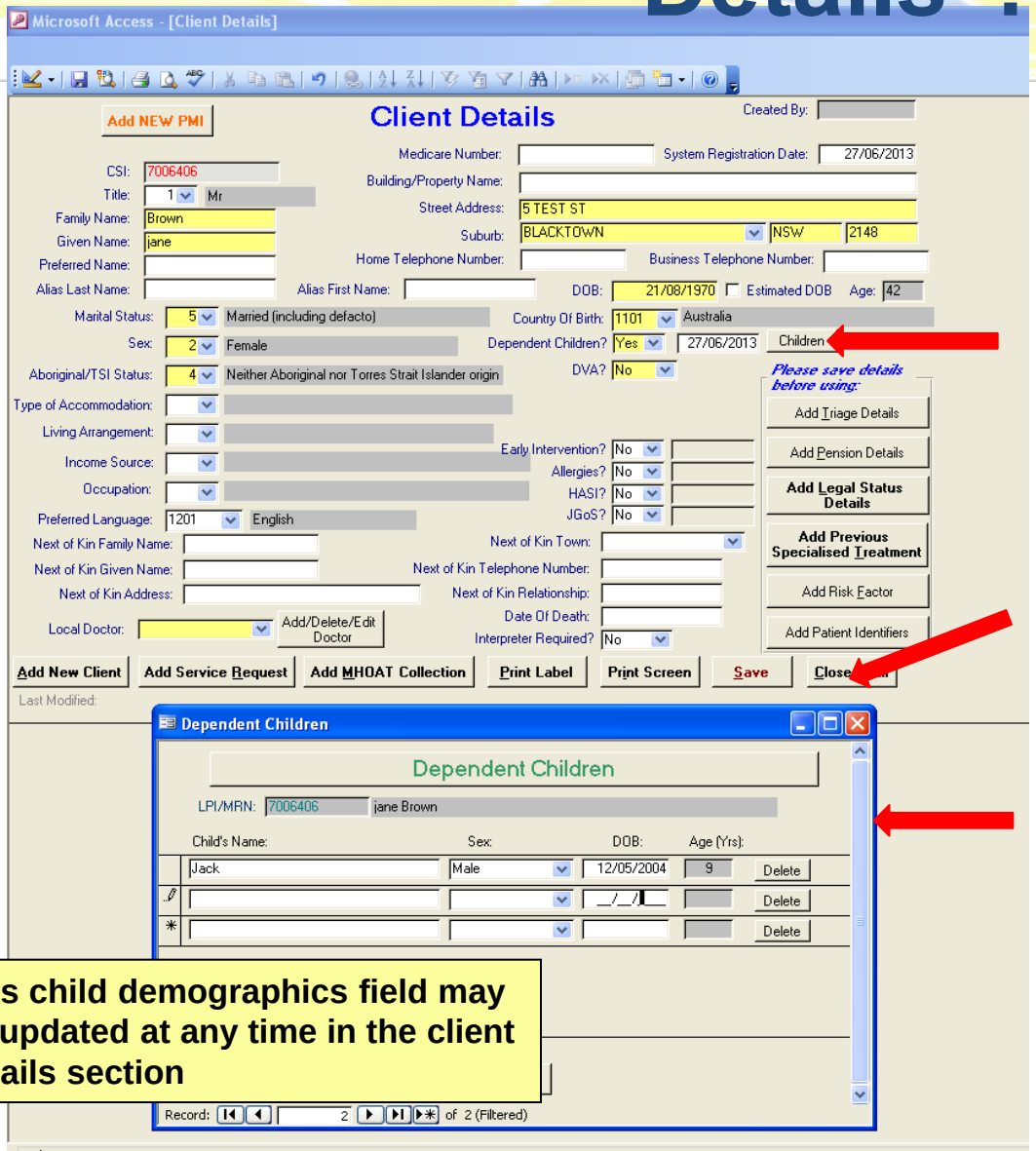
IDENTIFICATION: How to record parental status in “Client Details”:



‘Dependent children’ field mandatory

Enter parental status: Yes, No, or Unknown

IDENTIFICATION: How to record child/ren demographics in “Client Details”:



If dependent children checked ‘yes’, click on ‘children’ tab.

Activates dependent children demographic field

Allows you to enter as much information as you know, ie if DOB unknown, may enter name and sex, and information will be saved.

This child demographics field may be updated at any time in the client details section

Non-Science of Implementation

Refers to real world conditions, not a coherent, logical, stepwise process, & a lack of organisational coherence. There is a notable absence of readily available, standardised, reproducible models & approaches, for this particular service setting & clinical population as well as the:

- need for building the evidence base (for organisational, service development issues)
- diversity of organisational structures, standards, models of care, stages / cycles of service development
- multiple factors that impact on & influence the culture of MH services, many of which cannot be controlled for or taken account of in a carefully controlled, 'scientific' way.
- unpredictability of change management & progress in MH services

Resources

- Better use of existing resources (eg CChampions)
- Better data to advocate for new investment – economic, population-based public health leverage
- The approach must, of necessity, be phased, incremental, multimodal and multilevel to ensure that the various systems, barriers and levers can be appropriately and realistically tackled
- Change takes time – sustainability & persistence

Working Better Together

- Thinking family when talking with individuals
- Supporting adults whilst ensuring the wellbeing & safety of children
- Better identification and recording of vulnerable children, assessment of their needs and interventn according to assessed need
- Improving children's & parents understanding of and communication about MI (& SA)
- Identifying strengths

Heide's 10 messages

Domain 1

- Parents, mental illness, children & professionals - 'Good relationships protect'
- Early intervention & prevention – 'getting in early, getting in quickly'
- Parenting – 'Lifelong challenges & rewards'

Domain 2

- Provide age-appropriate information
- Manage separation & loss

Domain 3

- Changing times, changing lives – 'It's good to talk'
- Helping parents helps children helps parents; Helping children helps parents help children

Domain 4

- Trust is the basis for good relationships

Domain 5

- Little things make a big difference – Continuity of care and a Safe Space to be ill

Domain 6

- Abide by the Native American Code of Ethics & use the Family Model

Q & A Session

CYPSP
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Conclusion

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