This workshop is proudly presented by the COPMI national initiative* and was developed in partnership with Lived Experience Representatives: Kerry Hawkins, Louise Salmon, Jane Grace and John Clark.

Family-centred practice visual representations designed by Genevieve Flynn.

Contact: CNLEF@copmi.net.au

*The Children of Parents with a Mental Illness (COPMI) national initiative is funded by the Australian Government.
Following the presentations please note the following:

<table>
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<th>Examples of service-centred approaches</th>
<th>Examples of family-centred approaches</th>
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Key points to remember:

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What would you like to change in your situation/practice as a result?
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How can you make this happen (even if only ‘baby steps’)?
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Session Three
Interview with Rose Cuff

How did this session relate to:

Systems (policy, processes, funding, etc)?

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Workforce (skills, education, knowledge, etc)?

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Families (their roles and responsibilities)?

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What would you like to change in your situation/practice as a result?

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How can you make this happen (even if only ‘baby steps’)?

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Session Four
Interview with Amanda Waegeli

How did this session relate to:

Systems (policy, processes, funding, etc)?
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Workforce (skills, education, knowledge, etc)?
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Families (their roles and responsibilities)?
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What would you like to change in your situation/practice as a result?
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How can you make this happen (even if only ‘baby steps’)?
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Session Five
Interview with Cathie Knox

How did this session relate to:
Systems (policy, processes, funding, etc)? ____________________________________________
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Workforce (skills, education, knowledge, etc)? ________________________________
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Families (their roles and responsibilities)? ______________________________
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What would you like to change in your situation/practice as a result?
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How can you make this happen (even if only ‘baby steps’)?
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Session Six
Kerry Hawkins’ presentation

How did this session relate to:
Systems (policy, processes, funding, etc)?
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Workforce (skills, education, knowledge, etc)?
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Families (their roles and responsibilities)?
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What would you like to change in your situation/practice as a result?
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How can you make this happen (even if only ‘baby steps’)?
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### Area of change | Barriers | Enablers | Opportunities
---|---|---|---
Systems, workforce or families? | What currently prevents a family-centred approach? | What currently supports a family-centred approach? | What can you do?
Please use this space for your own notes or drawings


• Scott D. Think child, think family. Australian Institute of Family Studies. Family Matters; 2009; 81: 37-42.

• Cowling V. Meeting the support needs of families with dependent children where the parent has a mental illness. Family Matters 1996; 45: 22-25.


• Ning L. Building a ‘user-driven’ mental health system. Advances in Mental Health 2010; 9: 112-115.


• Shepherd G, Boardman J, Slade M. Policy paper: Making recovery a reality. Sainsbury Centre for Mental Health; UK; 2008.


Family-centred practice...

Contrasts with service-centred approaches which do not place people with mental illness and their families at the core of their organisation
Family-centred practice means...

*People with mental illness and their families* working together in partnership with professionals.
Family-centred practice means...

*Systems* based on a paradigm which puts the needs, participation and leadership of families at the forefront of planning, communication, values and practice.
Family-centred practice means...

Research with and by people with mental illness and their families to inform evidence-based practice and practice-based evidence.
Family-centred practice means... Services which are built from the ground up by people with mental illness and their families, including children.
Family-centred practice means...

Professionals who understand that people with mental illness are part of diverse families, which may include children, and who use that understanding to guide everything they do.

Feel free to reproduce these diagrams, but please acknowledge COPMI:
‘Children of Parents with a Mental Illness (COPMI) www.copmi.net.au ’
Appendix
Putting families and children at the centre of recovery

Role Plays used in Sessions 1 and 2

Not Family-centred

Baz – That Matt’s being a bit of a wuss

Gaz – Yeah hasn’t been out with the guys for a while – says his Mrs is crook – depression or something.

Baz – Matt should tell her to pull herself together. Take a cup of cement and harden up.

Gaz – There was no depression in my Mum’s day – take a Bex and get on with it.

Family and User-centred

Worker 1 – Matt said he’s really struggling to know what to do to help his wife Trish. Her bipolar has been really difficult to manage and he said she seems to push him away and he just feels powerless.

Worker 2 – Yes, he said he wants to be there and let her know that he’s there for her, but doesn’t know how.

Worker 1 – I’m not sure how he’s handling the kids when she’s unwell. We need to think how we can work with Matt and Trish to see what they need at the moment to get through.

Worker 2 – Yes, a session with them might unlock some things that can help them ride out this tough time for them. Giving Matt some support and encouragement about how he’s going with Trish and the kids could be helpful. Some sort of respite might be good for him too - and maybe some resources for the kids. Let’s see what they think.
Not Family-centred

**Worker** - Well I’m all out of ideas on how to deal with Linda!

**Supervisor** - She seems very up and down and her medication doesn’t seem to be working well. I think she may need to go into hospital to get things worked out.

**Worker** - She freaked out when I told her I thought she would need a stay in hospital for a while. She’s pretty irrational at the moment. Do you think I should speak to her psychiatrist about getting an involuntary treatment order if she’s going to be so difficult?

**Supervisor** – Yes and she’s a single mother so you may need to call in Child Protection whilst she is in hospital.

Family and User-centred

**Worker** – Linda says that she is really finding it hard to settle on her new medication. She really wants to be there for her kids but is finding it a real struggle to get up in the morning and make sure that her kids lunches are packed, uniforms clean and pressed and homework done. She feels pretty stressed about getting the kids to school late because she is so drowsy from her meds.

**Supervisor** – What services or supports has she accessed previously when she was stressed about getting everything done?

**Worker** – I’m not sure. She is pretty isolated I think. She was in foster care herself and really doesn’t want that for her kids. She’s having a really hard time at the moment. I’m not sure what to do.

**Supervisor** – Have we asked her what specifically she would like from us? That way we can offer her the support she really needs, that we might not have thought of.
Putting families at the centre of recovery

User-driven services
Historically mental health treatment services focussed on treating people’s illness and symptoms, in isolation from their families and communities. The capability of people with mental illness to work, learn, form relationships, raise children and live independently was underestimated.

Today, recovery and wellbeing principles encourage people’s resourcefulness and self-determination, and support individuals to build their own support system around their personal goals, needs and priorities. Recovery is not necessarily getting back to life as it was, but is instead, a discovery of a new life. The term ‘user-driven’ (sometimes called ‘consumer-led’) in treatment and support services is central to recovery and can mean a number of things:

- People who use services having choice, influence and control over their lives.
- Services that are driven by users’ needs, priorities and expectations.
- Peer support services being accessible to all who need them.
- People who use services and their families being able to participate in policy development, service planning and development, evaluation and research.

Family-centred practice
While a personal recovery approach is important, the acknowledgement of families where a parent has a mental illness emphasises the need for family-centred practice, including extended family members. Approaches to family-centred practice include:

- Services that work with the family to strengthen their individual resources.
- Services and policies that work with the whole family as a unit.

Core elements of family-centred practice
There are four core elements of family-centred practice:

- The centrality of the family as the unit of attention.
- An emphasis on maximising families’ options and choices.
- A strengths, rather than a deficits, perspective.
- Cultural and spiritual sensitivity.

Also important is the impact of the illness on the individual as well as on the whole family, and the need to support all. It is essential to acknowledge that all family members are potentially service users (for their own issues) and service providers (by providing support to the person with the mental illness).

Recovery, strengths and vulnerabilities
A recovery approach is a crucial element of family-centred practice. Indeed, parental functioning can be intimately related to the recovery process. It has been found that children can give parents the strength and will to ‘keep going’ and provide parents with meaning and purpose, both key elements to recovery.

Parenting may also provide opportunities for meaningful interactions and activities with others in the community.

Focusing on family strengths does not mean that problems can be ignored. The vulnerabilities of families need to be openly and sensitively discussed in order to help families develop strategies to enhance their strengths and overcome the vulnerabilities they may experience. At the same time, a focus on family vulnerabilities and strengths also needs to acknowledge the responsibility of services and the community to provide appropriate resources and support.

Being truly family-centred
Sometimes what is described as family-centred practice is really mother-centred practice (ignoring fathers), it can be nuclear family-centred (ignoring the role of extended family members such as grandparents), it may be parent-centred (rendering children invisible and inaudible) or it may be child-centred (reinforcing...
References

8. Allen RI, Petr CG. Rethinking family illness. Stepney: Australian Infant Child Adolescent and Family Mental Health Association; 2004
15. Cowling V. Meeting the support needs of families with dependent children where the parent has a mental illness. Family Matters 1996; 45: 22-25.

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Enablers for workers:

- Reflect on values. Values based on compassion, respect, integrity and self-determination are the foundation of family-centred practice, while personal qualities include a high level of emotional intelligence, interpersonal skills and self-awareness.
- Feel and display optimism as this will nurture hope in families.
- Develop an equal and creative relationship between people using services and their families.
- Engage in reflective supervision in order to consolidate worker strengths and partner with supervisors to work on areas that need development.

COPMI

Keeping families in mind

The Children of Parents with a Mental Illness [COPMI] Initiative is funded by the Australian Government. Further resources and information about the initiative can be found at www.copmi.net.au | © AICAFMHA 2013
Thank-you for your participation in the COPMI TheMHS workshop 2013.

For more information on the COPMI national initiative go to:

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