

Jane McNamara
Family Sensitive Practice Project¹
Partnership project between Hunter Mental Health and ARAFMI Hunter

Families/Carers in Partnership with Mental Health Services: Promoting Family Sensitive Practice

Collaboration means shared problem definition, shared decision making, and shared responsibility with final decisions reflecting a balance of the needs of all those involved. It means working with people rather than doing things to them

Hatfield, 1994

Introduction

In this paper we discuss some of the progress that has been made in the Hunter region with developing partnerships with families in mental health services. In the first section we will briefly outline some of the familiar history of family and professional relationships. We will then go on to describe some of the events and changes which has lead to establishing a partnership between ARAFMI and Hunter Mental Health and parallel them to changes documented in the literature. We will finish with a discussion of what we see as the benefits and problems with the partnership model.

It is well known that the provision of treatment in the community has impacted heavily on families and carers of people with a mental illness. On a day-to-day basis, families and carers are providing the bulk of support for people with a mental illness. For example, it has been estimated that carers for someone with a mental illness contribute 104 hours per week (Mental Health Council of Australia and Carers Association of Australia, 2000). SANE Australia cites research that suggests that “*approximately half of those with psychiatric disability live with, or with the support of carers*” (SANE, 1999). The full experience of families is captured in Lefley’s model (1996) of the *Cumulative Sources of Stress for Family Caregivers*. (p.66)

Despite all the research and literature about the “burden of care”, families and carers have consistently struggled to have a collaborative relationship with mental health services and professionals. Indeed, early studies of this relationship indicated that families had a profoundly negative relationship with service providers (Hatfield, 1994). Studies have shown dissonance between the expectations and views of families and professionals (McElroy, 1987) Families were looking for a partnership with professionals, whereas some professionals were still looking at how to treat families. A video produced by ARAFMI Brisbane in 1988 offers a snapshot of the issues as expressed by families around this time (Relatives are Carers Too). What families want from mental health professionals has been well and truly documented by researchers with Bernheim (1996) summarising the findings:

What families want from mental health professionals

- Information and education about the illness;
- Specific suggestions for coping with the patient’s behaviour;
- Emotional support;
- Access to people who face similar problems;

¹ c/- ARAFMI 15 Church St Newcastle 2300. Ph. 4924 6862
Email: Jane.McNamara@hunter.health.nsw.gov.au

- Timely crisis intervention;
- Respite services;
- Alternative living options;
- Meaningful involvement in treatment, discharge and rehabilitation planning; and
- Information and education about the mental health system.

Other research suggests that the messages from families are being heard and the relationship between families and professionals is slowly changing. For example, Tessler, Gamache and Fisher (1991) reported more positive than negative views in their study of patterns of contact between professionals and families of recent patients at state hospitals in Ohio, USA. Bernheim & Switalski's (1988) study at the New York state psychiatric hospital found that staff were generally positive about involving families in treatment even though the majority of staff spent less than one hour a week with families. *"They wanted to be helpful to the families, but they lacked both the skills and the administrative structures that would allow them to be"* (p.68).

Some clinical staff have implemented training for other professionals. Zipple, Spaniol and Rogers (1990) conducted a training program, in the community mental health centre of Massachusetts, USA that utilised families to educate mental health practitioners. This training program was successful in changing attitudes but subsequent staff contact with families was still insufficient. This was found also in a later Australian study (Farhall et al, 1996) which measured changes in staff practice with families before and after family sensitive training which included families in the training. The study found that the positive effects of training wore off after a time period, however it did stimulate services to make some improvements.

Hatfield (1994) posited that perhaps the problem of involving families is less about attitudinal issues and more about providing protocols for family work. This view was supported by research done by Wright (1997) in Indiana, USA, who found little evidence *"that provider's attitudes about families influences the amount of contact they have with families"*. He suggests that organisational issues have more influence on whether partnerships with families are formed:

"The extra role nature of working with families means that during periods of organizational dissatisfaction and stress, clinicians will be less able and less likely to involve family members because working with families is not a central or rewarded component of standard clinical work"

Models of Service Provision

A framework for working with families and descriptions of models of service provision which include work with families is readily available in the literature (Hatfield, 1994; Lefley, 1996; Bernheim, 1994; Marsh 1994, Bland, 1994, EPPIC 1997) These models outline clinical and non clinical approaches within the framework of a coping and adaptation model and are summarised below (Table 1).

In depth research has been conducted into family psychoeducation showing that multi family groups have positive outcomes for consumers as well as their families. This evidence has been available for many years. (For a recent literature review see Corcoran, 2000.)

Clinical Approaches	Non Clinical Approaches
---------------------	-------------------------

<ul style="list-style-type: none"> ▪ Individual counselling or psychotherapy (grief and loss issues) ▪ Relationships counseling (or family/marital therapy) ▪ Multiple family groups ▪ Psychoeducation: <ul style="list-style-type: none"> - An empathic, validating, non blaming, task oriented alliance with the family - Comprehensive family assessment - Education about mental illness and its management - Training in specific skills and competencies eg: problem solving, communication, reducing stress - Contact with other families 	<ul style="list-style-type: none"> ▪ Education and Support Programs which include the following: <ul style="list-style-type: none"> - Didactic educational component - Family process component - Emotional component (grief/loss) - Social component (mutual support) - Skills training in communication, conflict resolution, problem solving, assertiveness, behavioural management, stress management
--	--

Table 1: Common features of models of service provision for family caregivers

Policies and Guidelines

In addition, this framework is supported by current policy. Guidelines to practice in mental health including the *National Mental Health Standards* and the *Australian Clinical Guidelines for Early Psychosis* spell out approaches to service provision which are inclusive of families and which address needs of families for psychoeducation, information and support.

Government policies in the form of the *Second National Mental Health Plan*, (1998) *Commonwealth Mental Health Statement: Rights and responsibilities of carers and advocates* (1995) and *Caring for Mental Health: A framework for Mental Health Care in NSW* (1998) support and advocate partnerships with consumers and carers. Reports into the state of professional and carer relationships have been produced. (Mental Health Council of Australia and Carers Association of Australia, 2000)

Developing Partnerships in the Hunter Region

So with all this knowledge, theory, policy, models and advocacy from the family movement where are we in the Hunter region? I would argue that partnerships have been running informally on all levels. However I would also dare to say that we are struggling like most regions to achieve organisational change. The story described above is similar to that of changes in our area. ARAFMI Hunter celebrated its 22nd anniversary as an organisation this year. It began with groups of relatives meeting in care and share groups. It then received funding from NSW Department of Health since 1987 to employ a coordinator. Over the years, ARAFMI has become involved in a number of partnerships on different levels with Hunter Mental Health.

Family Policies and Practices Committee

This Committee made up of ARAFMI members and Hunter Mental Health staff met over several years to work on furthering a family sensitive approach in Hunter Mental Health services. Some of the achievements were:

- Family Sensitive Service Plan - a document detailing the key interventions of information, psychoeducation and group programs for families;

- Area policies on *Assessment of Family Needs, Providing Information to Families* and *Family Education Groups* were developed;
- A program involving families as volunteers was trialled in the hospital; and
- The committee put in a submission through the National Mental Health Strategy to fund a Project Worker to implement their plan. This resulted in the Family Sensitive Practice Project.

Joint work with HMH staff

- Early Psychosis Family Information and Support groups;
- Maximising Family Strengths Workshops; and
- Registrar training.

Representation on Hunter Mental Health Committees

- Early Psychosis Liaison; and
- Hunter Mental Health Board.

Current Status of the Partnership

The Project has been looking into the level of family sensitive practice in Hunter Mental Health Adult services. There are some pockets of excellence in Hunter Mental Health and some dedicated staff. Some directions from management to services about providing about family psychoeducation are a positive step. In a series of interviews with managers and staff I found positive attitudes towards family work but also a general view that family work is not yet a core part of our service delivery. Consultations with families and consumers showed that attitude is important and that simple changes would make a difference. Some changes have occurred quickly in parts of the service. For example, the Project brought together staff in services for people with early psychosis who have committed their service to running regular Family and Friends Sessions as part of their service provision. Mindfulness of the need for family interventions has meant that this has been considered in the appointment of newly funded positions in Allied Health and Nursing. Mainstream education programs for Registrars and Nurses open to introducing modules on family work. However some of the evaluative activities of the Project has shown that there is some distance to go. For example:

Family Carer Questionnaire

The Project set out to establish a baseline for how consistently family members receive information, psychoeducation and support from staff in Hunter Mental Health. One of the activities undertaken was a questionnaire with 37 families of patients at James Fletcher Hospital. Drawing on the standards and guidelines in policy, literature and direct feedback from families, a questionnaire was designed to be used in an interview with family members and carers. Most questions were closed, requiring yes/no responses. Some open questions were included to gain family member's opinions. A scaled question was used to gauge staff attitudes towards families.

The results revealed the following:

Access of Families to Information, Education and Support

Interventions	Family members who reported receiving this
Orientation information	43 %
Written Information about mental illness	24 %
Verbal information about mental illness	43 %
Information about type of medication	62 %

Information about medication side effects (psychoeducation)	32 %
Education about coping with behaviour, symptoms (psychoeducation)	24 %
Information on follow up arrangements	57 %
Information about support groups	49 %

Level of collaborative approach to families

Interventions	Family members who were involved in these
Family given staff contact details	57 %
Family interviewed for patient history	51 %
Family Meetings	35 %
Discharge planning	38 %

The interventions occurring the least were provision of written information and psychoeducation. These types of interventions fall into the category of planned, time consuming interventions. Providing information on follow-up arrangements and the type of medication prescribed may be the sorts of information provided fairly quickly "in the corridor" or by telephone. Many families commented that they were usually the ones to initiate contact. For a very small percentage of those who did have a family meeting during the course of the admission, 23 % reported that their needs were not met in the meetings indicating crosspurposes for holding meetings.

Attitudes

In describing their perception of how staff treated families/carers generally:

- 54 % had positive comments only;
- 16 % had negative comments only;
- 22 % had both positive and negative comments; and
- 8 % had neutral comments.

The main negative comments centred on not being consulted and not being given any educational information. The results show that there is some progress to be made in all areas of family sensitive practice in our service.

Discussion

In this paper we have talked about partnerships between families and clinical staff in the delivery of care to people with a mental illness. It is also important to look at the broader picture, at how families are consulted and included in service provision.

Problems

Some of the barriers to partnerships raised by people involved in the Project were:

Management Perspective

- Lack of a structured approach to working with families, from assessment through to discharge planning;
- Leadership and direction about working with families;
- Awareness of staff to family issues; and
- Time and resources to deal with the needs of families.

Clinicians Perspectives

- Lack of time to deal with needs fully;
- Complex problems of families;
- Engaging families when a service is offered; and

- Surprisingly, confidentiality arose as a fairly minor issue.

Barriers to practice raised by families/carers

- Lack of understanding and acknowledgement of the role families/carers play;
- Mis-use of confidentiality rules;
- Negative, blaming attitudes towards families from some professionals; and
- Systemic problems in service provision for clients which make the carer's job more difficult.

Other concerns

Resources: Several of the initiatives for carers and families have been driven by family members through groups like ARAFMI and staff with a commitment to families. It is difficult to sustain new programs without support and resources from mental health services. Often once a key staff member or family member leaves, programs finish. We will be advocating in our area for continuation of a family project worker to ensure that new activities initiated by the project will be sustained.

True partnerships

Coming back to the definition at the beginning of the paper:

Collaboration means shared problem definition, shared decision making, and shared responsibility with final decisions reflecting a balance of the needs of all those involved. It means working with people rather than doing things to them.

Hatfield, 1994

Families and carers will need to have access to information, training and support to become true partners at all levels of mental health services. Mental Health Workers need workplaces which support and encourage partnerships, skills training to enable them to respond to families in an empowering and supportive way. Models such as that used by the Bouverie Centre in Victoria for training consumers, families and professionals together have demonstrated the possibility of such a partnership.

Benefits of partnerships

We see the following benefits coming from a partnership between family support services like ARAFMI and mental health services:

- Representation of family issues in mental health committees, service planning;
- Keeping family issues on the agenda;
- Cross fertilisation of ideas;
- Opportunities to improve communication;
- Shared resources; and
- Shared expertise.

It needs to be recognised too that family support organisations like ARAFMI offer something which mental health services may not be able to offer: mutual support from other families, advocacy and lobbying.

References

Bernheim K F, Switalski T, *Mental Health Staff and Patient's Relatives: How they view each other* Hospital and Community Psychiatry, Vol. 39 No. 1, January 1998

Bland R, *Supportive Approaches to Families in Australia: Drawing Conclusions from Practice* in Hatfield, A (Ed) *Family Interventions in Mental Illness: New Directions for Mental Health Services* No. 62, Jossey Bass Inc. Publishers 1994

Corcoran J and Harakal - Phillips J, *Family Treatment with Schizophrenia*
Evidence based social work practice with families: a life span approach, Chapter 11
Springer Publishing Company, USA, 2000

EPPIC Statewide Services, *Working with Families in Early Psychosis*, Manual 2 in a series of manuals, Parkville, Victoria, 1997

Farhall J, Webster B, Hocking B, Leggatt M, Riess C, Young J, *Training to Enhance Partnerships Between Mental Health Professionals and Family Caregivers: A Comparative Study*, *Psychiatric Services* Vol. 49 No. 11, Nov 1998

Hatfield A, *Psychological costs of schizophrenia to the family* *Social Work* September pp. 355 – 359, 1978

Hatfield A, Lefley H P, (eds) *Families of the Mentally Ill: Coping and Adaptation*, The Guildford Press, 1987

Hatfield A, *The Family's Role in Caregiving and Service Delivery* in Lefley H and Wasom M, (eds) *Helping Families Cope with Mental illness* Harwood Academic Publishers, 1994

Hatfield A, (Ed) *Family Interventions in Mental Illness* *New Directions for Mental Health Services*, No. 62, Jossey Bass Inc. Publishers 1994

Holden D, Lewine P, *How families evaluate mental health professionals: Schizophrenia Bulletin* 8: 626 – 633, 1982

McElroy E M, *The Beat of a Different Drummer* in Hatfield A B and Lefley H P, *Families of the Mentally Ill: Coping and Adaptation*, The Guildford Press, 1987

Tessler R, Gamache G, Fisher G A, *Patterns of Contact of Patient's Families with Mental Health Professionals and Attitudes Toward Professionals*, *Hospital and Community Psychiatry*, September 1991, Vol 42 No. 9

Mental Health Council of Australia and Carers Association of Australia (2000)
Carers of People with Mental illness – Final Report. Canberra, ACT. Commonwealth Department of Health and Aged Care
Mental Health Council of Australia (2000) *Enhancing Relationships between Mental Health Professionals and Consumers and Carers* Final Report. Canberra, ACT. Commonwealth Department of Health and Aged Care

SANE Australia, 1998 'A long way to go': National Survey of Services of Carers of People with a Mental Illness

Wright, D *The impact of organisational factors on mental health professionals involvement with families* *Psychiatric Services* Vol 8 No. 7, July 1997

Zipple A, Spaniol L, and Roger E S, *Training Mental Health Practitioners to Assist Families of Persons who have a Psychiatric Disability* *Rehabilitation Psychology* Vol. 35, No. 2, 1990