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Families with complex needs: Developing an evidence based model of care

**A/Prof Darryl Maybery, Melinda Goodyear,
Dr. Andrea Reupert & Ingrid Vet**



**ON TRACK
Community Programs**

Monash University
Medicine Nursing and Health
Sciences



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- In delivering this talk and discussion I would like to recognise the elders of this land past and present
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- Research assistant- Melinda Goodyear,
- Data collection and input [Marillyn Harkness](#) -



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Background –

**An integrated, early intervention
program for families with complex
needs**



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- Approximately 23% of Australian children live in a household where one parent has a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2009);
- 13% of children are exposed to a binge drinker; 2.3% live with a cannabis user; and 0.8% live with an amphetamine user (Dawe et al., 2007)



Some families where a parent has a mental illness are characterised by

- Diagnosis in itself does not cause problems; many factors lead to problematic parenting
- Low family cohesion poor communication patterns (Dickstein et al., 1998).
- The potential for family crises, for example, when a parent is hospitalised,
- Impact on parenting
 - Associated with less competent/sensitive parenting (Oyserman, et al., 2000)
- Less family cohesion and poorer communication (Warner, Mufson & Weissman, 1995)



- Compared to other children, children whose parent has a mental illness:

- Greater risk of developing mental illness
- Higher infant mortality rate
- More likely to be taken into care
- Insecure infant attachment

(Leschied, Chiodo, Whitehead, & Hurley, 2005; Maughan, Cicchetti, Toth, & Rogosch, 2007)



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Families where a parent has a dual diagnosis

Research is limited in this area though available research shows that:

- 33 % of cases of neglect and abuse involve substance abuse (DHS, 2002)
- Families with parental dual diagnosis experience higher incidences of domestic violence, offending and imprisonment, poverty, housing issues and isolation than other families (Heggarty, 2005)



For children of a parent/s with DD

- **Reduced parenting supervision and parenting sensitivity**
(Dawe et al., 2008)
- **Children are at higher risk of entering or staying longer in care** (Semidei et al., 2001)
- **In-utero exposure** (Gruenert et al., 2004)



Continued:

- Children can experience:
 - Birth complications
 - Developmental delays
 - School issues
 - Acting out/depression/suicide
 - Own substance abuse issues(Heggarty, 2005; Finkelstein, et al., 2005)



Limitations

- Evidence gap in the literature for families where a parent has a dual diagnosis
- Few rigorous outcome intervention studies for families in either group
- Existing, community developed programs tend to be strength and family focused (Hinden, et al., 2006; Reupert ,et al., in press) though often have problems with evaluation (Reupert, et al., in press) (exception being mother-infant programs for mothers with mental health issues)

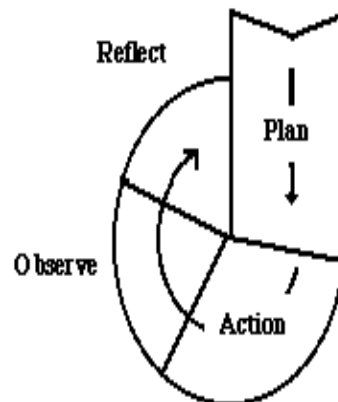


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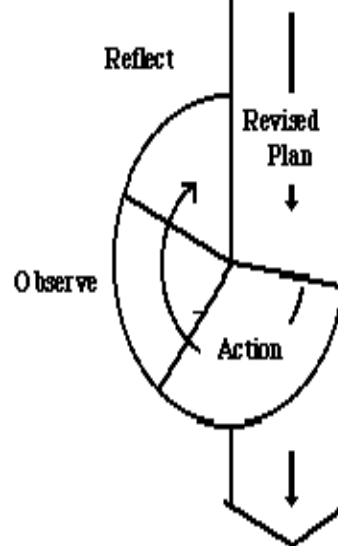


Developing a
program for families
with complex needs
using
action research

CYCLE 1



CYCLE 2





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Northern Kids Care –Model of Care

- The Northern Kids Care Project is an integrated, early intervention service that supports families with children and young people (0-18) where the parent has a mental illness or a dual diagnosis. The program has been implemented using an action research model.
- The program operates in Coffs Harbour, Lismore and Tweed Heads and is a voluntary program.



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Strength based approach to parenting, and family problem solving

Has been found to reduce inpatient days and improve clinical outcomes for individuals

(Cowling, 1996; Nicholson, et a., 2001)



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Outreach family case management

- Northern Kids Care (NKC) uses a 12 month strength based, family systems, assertive case management model to facilitate
 - improved family and child resilience,
 - develop problem solving and coping skills; and
 - assist the family and family members to access other community service organisations
- A FoPMI (Family of parents with mental illness) service plan conducted with each family



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Why use a family centered approach to case management

- Some evidence that indicates interventions solely aimed at the child increases the likelihood of perceived conduct disorders in the child by the parent (Maybery, Reupert & Goodyear, 2006)
- The family centered approach builds family resilience by identifying dysfunctional responses to stress and emphasising the effective family processes and dynamics (Heriot, 2009)
- Using a family systems approach means that interventions focus on the contextual sources of the issue, rather than just a child adolescent outcome (Reupert & Maybery, 2009).



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Young people's group work

First level skills

- Kids Time_for 6-12 year old and Smiles program 8-12 year olds (Coffs, Lismore and Tweed)
- PATS/Koping for 13-18 year old (Coffs, Lismore and Tweed)

Group content

Information regarding mental illness, Stress, coping mechanisms, normalising and emotional identification



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Group work continued

Second level skills

Stepping Up and Moving Forward group 13-18, 6-12 years
all sites

Group content

Emotional management, problem solving skills, Crossing the line in media social networking, managing relationships and setting boundaries



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Continued

- Parent support Group – Parenting and mental health management
- Workplace Capacity Building - in promoting family inclusive practice – All sites



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Research process

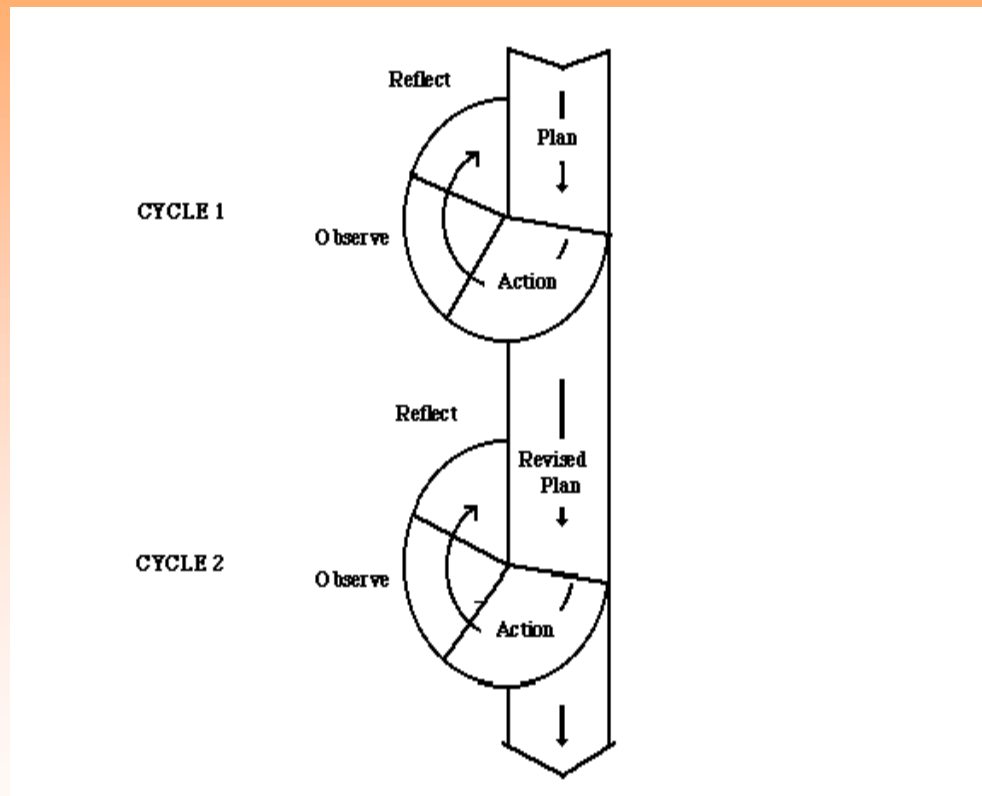
- More specific to the On Track project, action research was used to inform the program, service delivery and to identify implementation issues when working with families with complex needs.
- The following continual steps were undertaken throughout the two years of the project:



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Developing a program for families with complex needs using **action research**





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Research Methodology

- Monash University research team undertook interviews with:
 - Parents throughout the two years of the project
 - Children throughout the two years of the project
 - Workers throughout the two years of the project
- Data de-identified and analyzed by research team
- Analyzed data reported back to workers and management every six months and asked ‘What are the implications of this data for service delivery? For the organisation?’



Interviews

Number of parents with a MI 11

Number of parents with a DD 11

Number of kids whose parent has a MI 11

Number of kids whose parent has a DD 11



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Outcomes of interviews

- **Parents with a mental illness**
 - Lack of quality time with children
 - Tiredness, not leaving the home, financial constraints
 - Children become self-carers
 - Children can be fearful and confused
 - Concerns re keeping the house tidy
 - Lack of social networks



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Parents with a mental illness

- Feedback on case management model
 - Responds to all family members and their individual needs
 - Helps children understand mental illness
 - Improves relationship with school
 - Provides peer support through attending groups



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Parents with a dual diagnosis

Parents self report re the impact of dual diagnosis

- Difficulties with parenting
 - Appropriate parenting response, problem solving
- Unavailability
 - Tiredness
- Concerns re keeping the house tidy
- Lack of social networks
- Complex health issues



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Parents with a dual diagnosis

- **Feedback on case management model**
 - Improves family communication and r/ships
 - Improves r/ship with school
 - Peer support through attending groups
 - Responds to all family members and their individual needs
 - Referral pathways are strong
 - Families linked with multiple agencies
 - On-going check-ins are good



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Interview results

Children living with parent who has MI

Impact of parental mental illness

- Caring for self and organising the parent

“It’s different than having a normal parent. They are not always responsible and don’t remember everything. I have to be more organised and get stuff ready when I do stuff. When I play netball, I have to get mum ready so you get there on time”.



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Impact of parental mental illness

- Parent sometimes unavailable
 - Parent can be sleepy or moody
- MI is unpredictable

“It’s very hard and worrying. You don’t know what could happen. You have to deal with the mental illness and worry. It can be scary.”



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Children living with parent who has DD

Impact of parental mental illness

- More fighting at home
 - Child thinks they need to make sure they are good
- Parent sometimes unavailable

Impact of AOD use

- More unavailable
- Get angry easily
 - Child thinks they have to ignore it and be good
- A lot of the children find it difficult to tease out the differences between MI and AOD



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Children living with parent who has DD

They get on your case. Sometimes he loses his cool more than what other fathers would who are not on drugs. You have to not argue and take it.”

“

He is not always available and it gets me angry. It's better to let it go and ignore it than to try and fight with it. It doesn't go away.”

“He gets angry when he is drinking. You have to be careful.”

“



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Continued

She's always in her room when doing it. You don't get to see her. I leave her alone. I wish she wasn't taking drugs and alcohol. I get angry that she's doing it."



Needs

Children where the parent has a MI

- Having someone to talk to
- More communication with parents and emotional support generally
- Less family stress

Children where the parent has a DD

- Less fighting/stress and more fun things together
- More time with friends
- Financial support
- Less drug taking



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The model of care

Children where the parent has a MI

- Education about mental illness
- Coping with emotions
- Regular visits, esp. when parent is unwell
- Make new friends

Children where the parent has a DD

- Manage anger
- Doing fun activities
- Less fighting at home
- Someone to talk to about problems



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Outcomes of the research

- More defined inclusion criteria for
 - Parents with a dual diagnosis
 - Parents with a mental illness
- The inclusion of parenting capacity as a goal in the fopmi plans
- In-depth and extended discussions within the team about
 - *Effective* assessment, mental health assessment
 - case management -strength based interventions



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Continued

- Parenting support groups became more focused on parenting issues (e.g. managing children's behaviours)
- A psycho-social and education framework was developed to ensure consistency in group work education material across the region



Continued

- The identification of indicators for case management readiness in families.
- The need to prepare the family for discharge – *Assisting families to engage with other services, safety net plans for children and young people and the development of problems solving skills in family members*
- Increased home visiting time when a parent had a dual diagnosis - *increased from 12 months to 15 months*



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- Increased home visiting time when a family had more than three children – *with each additional 3 children in household – home visiting is increased by extra 3 months*
- Every family needs to
 - be referred to at least three services,
 - the FOPMI plan must include strategies around parenting capacity and goals for both the parent and children in each review.
 -
- There needs to be a shared agreement between the parent and case manager on “how” a particular goal in the fopmi plan is to be addressed



Workforce issues

- It cannot be assumed that workers understand what a family centered approach is.
- To ensure workers feel supported, there needs to be appropriate supervision and support from
 - External supervisor and
 - The line manager

This needs to be included in the budget and program funding

- There must be opportunities for debriefing. In team meetings reflective practice is implemented as an agenda item.
- It is preferable to have two workers in each site. This is an OHS issue, as it ensures safety during the first home assessment visit. Two workers also provide more input and insight to the effect of mental illness/dual diagnosis on individuals and family dynamics.



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- See interview outcomes