FAMILY FOCUSED PRACTICE in Adult Mental Health Care

A Guidance Document for the Development of Family-Focused Practice across Galway/Roscommon Adult Mental Health Services

HSE Mental Health Services

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Developed by: The Mental Health Social Work Department
Galway Roscommon Adult Mental Health Service

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FOREWORD

Mental Health services in Community Healthcare West (CHW) have a strong commitment to promoting Family Focussed Practice within the service - and our Mental Health Social Workers have taken a lead role in developing and implementing these services.

The first Family Peer support Worker service in Ireland (known as Bealach Nua) was developed within CHW in 2015. The service was established by the Mental Health Social Work Dept in Mayo. Initial funding was secured from Genio and Service Reform Funding.

Since 2015, the Family Peer Support Worker services have provided support to up to 490 family members across the Community Healthcare Area. The National Office have supported this service, by funding four permanent posts nationally in 2021. In Community Healthcare West we now have three Family Peer Support Worker posts permanently funded - and an additional four part-time posts with temporary funding.

A further demonstration of our commitment to supporting and involving family members in care and treatment is our implementation of a Family/Carer Involvement Policy. This has recently been up-dated and adopted across Galway/Roscommon. The policy requests that staff are pro-active about engaging with family members and providing them with relevant information and support. The implementation of this policy will be supported by Raising Awareness training for all staff – delivered by the Social Work Department.

While all disciplines are involved in working with and supporting families our Mental Health Social Work staff have a lead role in delivering evidence based interventions including Behavioural Family Therapy; Family Talk; Family Connections and Eolas Programmes. Social Workers also deliver training in relation to these intervention, and provide support and supervision to all disciplines delivering them.

I wish to commend the work of the Social Work department in capturing the work currently being undertaken to promote Family Focussed Practice across Galway/Roscommon Mental Health services – and I will endeavour to find opportunities to support their initiative.

Charlie Meehan

Charlie Meehan
(Head of Service – Mental Health Services Community Health Care West).

INTRODUCTION

Family Focussed Practice is a method of care delivery that emphasises the family as a unit of attention as opposed to mental health practitioners working with an individual's care needs alone (Grant et al., 2018; Foster et al., 2016).

For the purpose of this document, Family Focussed Practice (FFP) refers to interventions that identify and address the needs of parents, adult siblings (siblings over 18 years) and children in relation to parental/adult mental illness.

Research in relation to the effectiveness of Family Focused Practice found that:

- It improved outcomes for parental mental illness, reduced the subjective and objective burden of care for families, and provided a preventative and supportive function for children (Foster at al., 2012, p.7).
- It reduced the likelihood that parents will experience a relapse of their mental illness (Bauml et al.., 2006).
- It reduced the need for hospitalisation for treatment of their mental illness (Hylan et al., 2008).
- A meta-analysis of 13 individual, group, and family interventions for families with parental mental illness has found a reduced risk of children developing the same illness as their parents by 40% (Siegenthaler et al., 2012). These interventions have been found to increase parenting skills, strengthen knowledge of parents' mental disorders, and strengthen resilience factors among adolescents (Siegenthaler et al., 2012).
- Systematic reviews of prevention programs for the children of parents with substance abuse problems have found preliminary evidence on reducing children's problems and improvements in positive behaviours, coping skills, and feelings, especially in longer programs that involved both parents and children (Broining et al 2012, Jarkestig, Beggeren and Hanson 2015).
- Similarly, a systematic review of 19 psychosocial interventions for families with parental cancer found most interventions helpful (Inhestern et al., 2016). The interventions were found to support more open communication in the families and children reported to talk more openly about parental illness and have better coping strategies (Inhestern et al.., 2016). Studies also showed improvements in parents' and children's quality of life, mental health or distress (Inhestern et al., 2016).
- A 2006 Cochrane Review of the effectiveness of Behavioural Family Therapy reported that individual family approaches gave a reduction in relapse rates, reduction in hospital rates, better adherence with medication, and reduced costs of care (Pharoah et al., 2006). The 2014 NICE guidelines in relation to the treatment of psychosis and schizophrenia in adults – recommends family treatment as a core treatment (Kuipers et al., 2014). It recommends

that the family intervention is offered as early as possible and that it can be started during the acute phase.

- Between 2018 and 2021 mental health services in the Republic of Ireland funded PRIMERA to undertake the first randomised control trial in relation to an evidenced based intervention – known as *FAMILY TALK*. A total of 86 families [139 Parents, 221 Children – across 15 sites] - took part in the study. According to Mulligan, et al. (2021) 'over two thirds of the families reported substantial benefits from participating in Family Talk, including reduced stigma, giving children and partners a voice, increased service-user confidence, and improved family communication/relationships' (p.2).

They reported key **enablers** identified by families who participated included:

- the intervention being delivered by competent, non-judgemental clinicians
- the whole family approach
- families readiness to engage

Barriers highlighted by the study included:

- stigma
- family crisis/relapse
- service constraints
- impact of Covid 19,
- need for families to have greater support around the engagement and follow up phase.

(**PRIMERA** - **P**romoting **R**esearch and **I**nnovation in **M**ental **H**ealth Se**R**vices for **F**amilies) https://cmhcr.eu/primera-programme

Norway, Finland and Sweden introduced legislation in 2010 to 'promote mental health and disorder prevention for dependent children in health services for adults' (Solantaus et al., 2010, p. 891). 'Family Talk' developed by Beardslee (2012) has been adapted in Norway and Finland to assist with implementing statutory requirements.

Additional studies highlight greater work satisfaction for professionals engaging in Family Focussed Practice as a consequent of a more collaborative approach to working with families (Toikka and Solantus 2006; McDonald et al.., 2012).

This document outlines the Galway Roscommon Adult Mental Health Social Work Department's (GRMHSW Dept) contribution to the development of Family Focussed Practice over the past five years. It makes recommendations for future development as well as identifying the resources required. Our aim is to ensure it becomes embedded in practice, across Adult Mental Health Service.

PART 1

What is Family-Focused Practice in a Mental Health Context?

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Family-Focused Practice (FFP) is the provision of psycho-social supports to the family as a unit. This may be through working directly with the person with mental illness and/or with the child/ren, partner or other family members (Foster et al., 2012). Overall, the aim of family focused practice is to improve the emotional and psychological wellbeing of the family unit and the home environment.

Foster et al.., (2016) identified six core and overlapping practices within family focused practice:

1. family care planning and goal setting;
2. liaison between families and services, including family advocacy;
3. instrumental, emotional and social support;
4. assessment of family members and family functioning;
5. psychoeducation and
6. a coordinated system of care (e.g. wraparound, family collaboration, partnership) between family members and services.

Marston et al.., (2016) provided a similar analysis of the main components as psychoeducation; direct treatment and support for mental health and/or substance misuse; a focus on parenting behaviour; child risk and resilience; family communication; and family support and functioning.

The stigma associated with mental illness often leads to family members being unable to talk about it, and how it affects them. This silence can lead to fractured relationships, disconnection and isolation. In a 2011 review of the concept of Recovery, Leamy et al., 2011, identified connectedness as one of five complementary processes that people said were instrumental in their recovery. Family Focussed Practice is often about supporting the healing of fractured relationships, reducing isolation, and re-establishing connectedness and hope.

PART 2

Rationale for Family Focused Practice in Mental Health Services

Given the prevalence and burden of mental illnesses in families (including the high risk of intergenerational transmission) it is imperative that we identify effective and cost-effective interventions that are capable of being implemented within routine service settings'

(Furlong et al., 2021, p.15).

Parenting with a Mental Illness

Adults who are parents, and also coping with a mental illness, have to juggle the demands of managing their own mental illness and, in some cases, the additional responsibilities of managing their children's difficulties (Falkov, 2012; Hine et al.., 2017).

Studies indicate that 25 to 68% of adult mental health service users are parents, and that 35% to 60% of children presenting at Child and Adolescent Mental Health Services have a parent with a mental illness (Nicholson et al., 2002; Nicholson 2010). Mulligan et al., (2021) report that in the Republic of Ireland (ROI) 20% of adults experience a mental illness and it is estimated the 280,000 children are dependent on parents who have a mental illness.

In the UK, two million children are thought to live in households where at least one parent had a mental health problem (Parrott et al.., 2008); while in Australia, it is suggested that there are 1, 082 403 children living in 577 507 families with a parent with a mental illness (Maybery et al., 2015).

Carers Supporting an Adult with Mental Illness

In 2006, A Vision for Change, Ireland's mental health policy, asserted that "family, friends, colleagues, neighbours and community members are important sources of support for service users and have their own unique insight into mental ill health and the provision of mental health services" (Dept of Health and Children, 2006, p.24).

Carers supporting an adult with mental illness highlight a critical need for their involvement in the individual's care and treatment in order for care to be effective (Wilson et al.., 2015). Ishikura, et al.., (2014) found that establishing a trusting relationship with families, may prevent disengagement from services, in the initial stages of treatment. Research tells us that service users value the involvement of their families in their care, both in the early stages of psychosis (Lester et al., 2011) and where the difficulty has been present for longer (Cohen et al., 2013). According to the NICE Guidelines (2009) regarding Schizophrenia, 'family intervention should be offered to all families who live or are in close contact with the service user' (HSE, 2019 p.4).

The mental state of carers is crucial and affects their ability to offer practical and emotional support to those in their care. In a 2008 survey of Irish carers, 40.8% reported experiencing stress or nervous tension in the previous twelve months with comparatively high levels of anxiety (22.6%) and depression (17.6%) (O'Sullivan, 2008).

Furthermore the 2019 National Carers Strategy identifies including 'carers in care planning and decision making for those that they care for' as a key objective (Dept of Health, 2019 p.12).

Children of Parents with Mental Illness

'While the overwhelming majority of children living with an adult with mental health problems are loved and well cared for, that does not mean that the circumstances such children find themselves in, including those who live with adults who use of substances is problematic, does not have an impact on them' (Devaney et al.., 2020, editorial p.1).

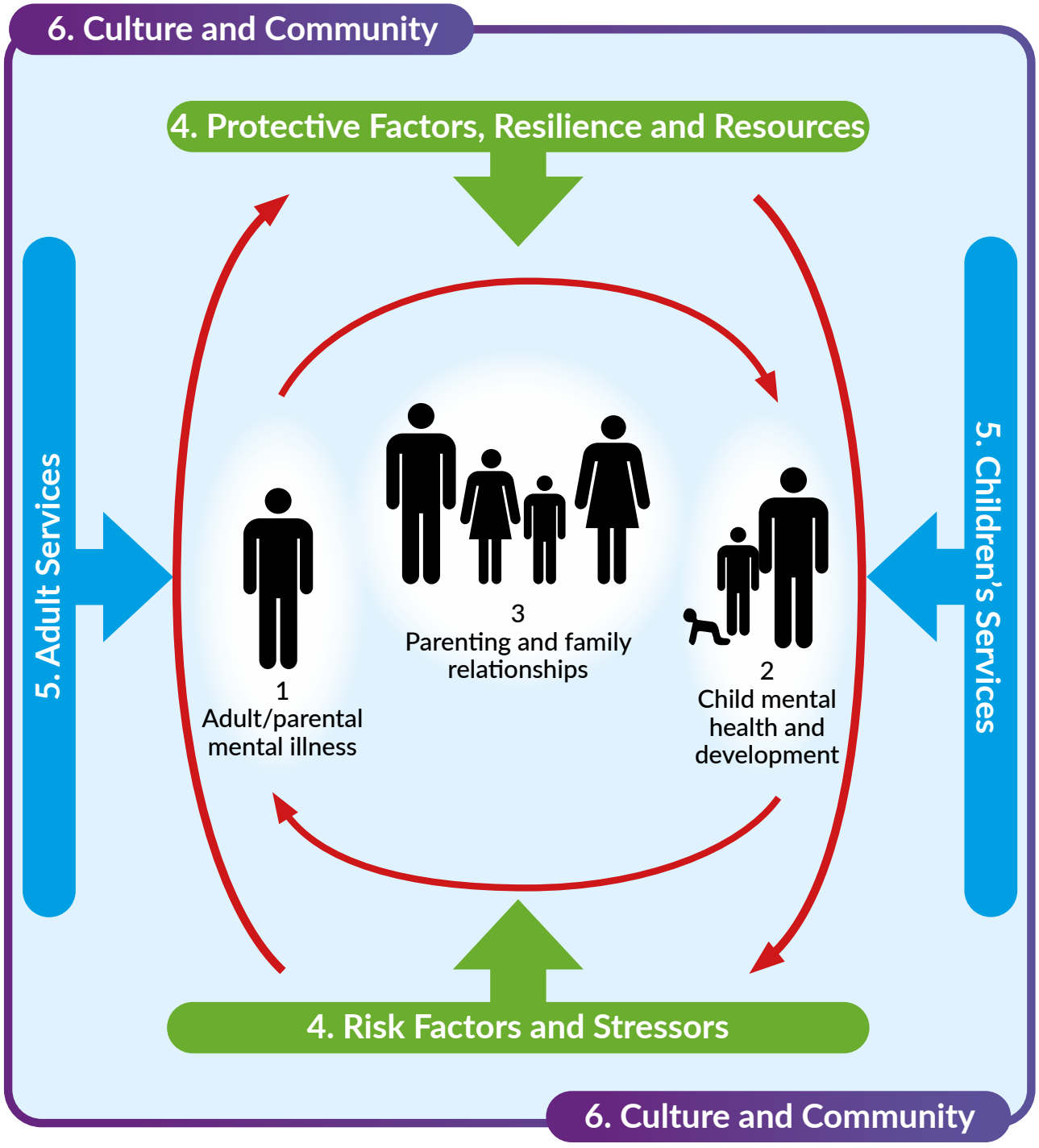
The research literature highlights that children of parents with a mental illness are at elevated risk for a range of adverse outcomes including infant mortality, developmental delay, attachment problems, neglect, medical illness, mental health difficulties and impaired educational and occupational prospects (Hosman et al., 2009; Weissman et al. 2006; England and Sim, 2009). Beardslee et al., 2012, identified an association between stress experienced by parents who have mental illness, and depression and anxiety in their children.

Children typically report a lack of communication about their parent's mental illness – and they commonly fear that their parent will never recover, will die, that they are to blame for their parent's condition and that they too will inevitably develop a mental disorder. They frequently undertake considerable caring duties, experience isolation, shame, stigma and report impaired peer interactions and school engagement (Somers, 2006; Mordoch et al., 2008; Murphy et al., 2011).

The Family Model

'Think Child, Think Parent, Think Family'

– The Northern Ireland experience



In the U.K. in 2004, the Social Care Institute for Excellence (SCIE) was commissioned to work in this area following a Social Exclusion Unit report which identified parents with mental health problems as a group that was sometimes poorly served by health and social care. In 2009, SCIE developed a *'Think Family, Think Parent, Think Child'* Guide for health care professionals working with children and adults. This guide was based on published literature from 1985–2005 and a practice survey of five sites in England. From 2009 to 2011, SCIE worked with a total of six sites, which included Northern Ireland, to develop, monitor and evaluate its implementation of a Think Family Approach. In 2011 SCIE recommended the Family Model as a useful conceptual framework to help staff consider the parent, the child and the family as a whole 'when assessing the needs of - and planning care packages for - families with a parent suffering from a mental health problem' (SCIE, 2011, p. 18).

The **'Think Child, Think Parent, Think Family'** concept, is a family focused initiative based on Falkov's Family Model (Falkov, 2012). Adrian Falkov, an Australian Child and Adolescent Psychiatrist with extensive experience in family focused practice, developed this framework to illustrate the ways parental mental illness can impact on children and families. Six domains, are identified within the model, and the links and influences of the domains are illustrated above. The six domains comprise the adult/parental mental illness, child mental health and development, parenting and family relationships, risk factors and stressors, protective factors and resilience, adult/children services, culture and community. Falkov proposes that the visual nature of the Family Model aims to generate discussions among family members and clinicians to aid treatment and promote recovery.

The Think Family approach considers the whole family with an ethos of 'no wrong door' at point of entry to services. It emphasises the need to consider the child, the parent and the family with adult and children's services working together to meet the needs of the family, as a whole rather than a focus on an individual.

In 2005, Madeleine O 'Neill, who was in receipt of mental health services in Northern Ireland, took the life of her nine-year-old daughter Lauren, and then killed herself (WHSSB & EHSSB, 2008). As a direct result of the O'Neill Inquiry, the Department of Health, Social Services and Public Safety (DHSSPS) funded two project managers to lead a three-year project to pilot the recommendations of SCIE's Guide 30, 'Think child, Think parent, Think family' - as a way to improve communication across the interface between children's and mental health services. This initiative also covered associated departments such as maternity services, A&E, Health and Social Care services, and 16 psychological therapies in promoting a Think Family culture across Northern Ireland health and social care provision.

In Northern Ireland the Health and Social Care Board (HSCB) has spent the last decade promoting Family Focused Practice in all aspects of Adult Mental Health and Children Services.

Local Champions were identified across services to promote a 'Think Family' approach in order to enhance communication and collaboration across children and adult services. In 2018 Grant et al.., reported on a review of this policy implementation.

Their recommendations included:

- A *THINK FAMILY* Northern Ireland Strategy be developed.
- That The Family Model (Falkov, 2012) be formally adopted as the future basis for development of *Think Family Northern Ireland.*
- Engagement with bodies that validate Health and Social Care qualifications to request that teaching about the Family Model and FFP is included in professional training.
- That Think Family practitioner roles are introduced to services.
- Home visiting is viewed as an important enabler of Family Focused Practice.

The 10 messages for Mental Health Practitioners who come into contact with a parent with mental health difficulties :

In 2007, a group of young carers in Merseyside, (Liverpool, U.K.) came up with the following 10 messages as a simple checklist for practitioners who come into contact with families where a parent has mental health problems:

1. Introduce yourself. Tell us who you are. What your job is.
2. Give us as much information as you can.
3. Tell us what is wrong with our mum or dad.
4. Tell us what is going to happen next.
5. Talk to us and listen to us. Remember it is not hard to speak to us. We are not aliens.
6. Ask us what we know, and what we think. We live with our mum or dad. We know how they have been behaving.
7. Tell us it is not our fault. We can feel really guilty if our mum or dad is ill. We need to know we are not to blame.
8. Please don't ignore us. Remember we are part of the family and we live there too!
9. Keep on talking to us and keeping us informed. We need to know what is happening.
10. Tell us if there is anyone we can talk to (Barnardo's, 2007).

PART 3

The Republic of Ireland Context

In their review of ***A Vision for Change in 2015 – 'Nine Years On'*** – Mental Health Reform welcomed the fact that the Irish Health Service Executive had demonstrated their commitment to service user and family member involvement in service delivery – by employing people with 'lived experience' at senior and staff grade levels throughout mental health services. However, they highlighted that while families valued the roll out of psycho-education for them – they still experienced barriers to involvement in their loved one's care plan, and the absence of any legislation to support this (Mental Health Reform, 2015).

The recent Recovery Framework document developed for Mental Health Services (HSE, 2017) and ***A Family, Carer and Supporter Guide*** (HSE, 2018), appear to focus primarily on the adult members of families when recommending that staff be proactive about supporting families. The literature already highlights how the segregation of adult services from children services often leads to adult services not seeing children as part of their remit (Gopfert et al., 2004; Munro, 2011). Grant and Reupert's 2016 study with Irish nurses highlighted an absence of any organizational or policy requirement to engage in whole family approaches when working with parents who had a mental illness.

In 2014 The Department of Children and Youth Affairs (DCYA) produced a policy framework for children and young people, ***'Better Outcomes Brighter Futures'***, which sets out the need for interagency initiatives to improve outcomes for children. Subsequently the DCYA funded the establishment of Children and Youth Services Committees (CYSC) at national and local levels. These include representation for a range of government departments and voluntary organisations. It recognised the 'importance of parental mental health in supporting children's early social and emotional development' (p.54). The first reference to children by a document developed for adult mental health services is in a supplementary guidance document ***'Family Recovery Guidance Document 2018 -2020'*** (HSE, 2018). It recommends that 'the support needs of young people or children within the family' be considered as part of a 'Needs Assessment for Family members' (p.14).

Furthermore, in 2018 the national mental health division agreed to fund a national research project to evaluate interventions to families where parents are suffering from a mental illness. With this funding the Centre for Mental Health Research at Maynooth University established the PRIMERA research project (**P**romoting **R**esearch and **I**nnovation in **M**ental h**E**alth se**R**vices for f**A**milies) (CMHCR, 2018). There were 15 sites nationally involved in the project. The majority of the sites evaluated Family Talk. Family Talk is a seven week evidence-based programme – which supports the whole family to gain a better understanding of the parent's mental illness, facilitates family members in talking about their worries and fears, and how best to harness the family's strengths and build resilience.

In the scoping out process of the evaluation of Family Talk, in the Republic of Ireland (RoI), Furlong et al., 2021, reported on factors identified by mental health services as barriers to recruiting families to the research which included:

- 'practitioner workload and turnover
- a persistent perception amongst some AMHS and CAMHS personnel that FFP is a luxury preventative issue and that family support is not their priority or their remit' (p.15).

Furlong et al., 2021, also expressed the concern that parents might be reluctant to volunteer to take part in the research because of the 'double stigma of having a mental illness and revealing struggles in parenting'.....'and a common but inaccurate belief that their children do not notice their symptoms' (p15. Furlong et al., 2021).

The study is one of the few Randomised Control Trials of Family Talk worldwide and the first of its kind in Ireland – where it is a key component of the first systematic national drive to develop and implement FFP for Children of Parents with a Mental Illness (COPMI). The other key strengths of this study is its involvement of parents, partners, children and service providers as participant informants – and an economic analysis of the costs of implementation. The inclusion of partners is particularly important as previous studies suggest they often feel unsupported by mental health services with regard to the care and support they provide, and their desire to be more involved in the treatment of their loved one (Afelizus et al., 2018).

Galway/Roscommon Evaluation Site for Family Talk 2019/2021

An expression of interest from the Principal Social Worker in Galway/Roscommon Mental Health Services – led to Galway/Roscommon being identified as one of the 15 sites nationally, to take part in this research. The local Children and Youth services Committee had established a sub group to explore the impact of Parental Mental Health on families. The group included representatives from AMHS, CAMHS, Primary Care Psychology and TUSLA services. This group later became known as Crosslinx West. Crosslinx was an interagency service initiative, initially developed in Mental health Services, in the east of Ireland, to address the impact of parental mental illness on children and families (Killion, 2020).

In order to promote Family Talk as an intervention these services, led by the Mental Health Principal Social Worker, came together to design and deliver Raising Awareness Training for professionals working with families in a range of services in the area. The primary focus of the training was in relation to the impacts of mental illness on families and how to access mental health services. The training was delivered in 2019/2020, in three sites in Galway, Roscommon and Mayo. In conjunction with the School of Social Work at NUIG (National

University of Galway) the Dept evaluated this Training and the findings were published in 2020 (Golden, C. Killion, MG. and McGregor C., 2020).

A Senior Social Worker within the department co-ordinated the referrals for Family Talk – and was the main point of contact with PRIMERA in relation to families taking part in the research. This Social Worker also retained a log of all training certs for staff who completed Family Talk training – which ensured only staff with a minimum of 3 years experience in mental health services were involved in delivering the intervention.

A total of 98 families were recruited for the research nationally. Five sites recruited 90% of families. The Galway/Roscommon site recruited 30 of these families.

The PRIMERA Research Group also undertook a qualitative study with 41 clinicians in relation to the experience of delivering Family Talk. 24 of these clinicians were Social Workers and a further 6 were Social Work Managers reflecting that approximately 75% of the staff delivering Family Talk during the period of the research project were social workers. According to Furlong et al., 2021 these Social Workers reported that their professional training equipped them to be more persistent with family work compared with other disciplines – 'they felt more competent in assessing families readiness for Family Talk; establishing a positive relationship with families before and during Family Talk; and in working with multiple family members' (p.7).

Furlong et al., 2021 highlighted important insights provided by these practitioners in relation to key enablers for delivering family talk and embedding it in to practice which included:

- the availability and drive of an FFP champion with managerial support;
- promoting interagency collaboration among AMHS, CAMHS, primary care and child protection services in the area (p.18);
- engaging in regular awareness-raising and buy-in efforts with management/colleagues (e.g. FT on weekly MDT agenda and offered as part of care plan during initial assessments);
- encouraging clinicians to participate in FT training;
- setting up referral and supervision structures, and allowing clinicians sufficient time to engage in FT promotion, recruitment and delivery activities (p.15).

PART 4

The Current Picture:

Family Focused Practice in Galway Roscommon
Adult Mental Health Services
- Adult Mental Health Social Work Department

The Galway Roscommon Adult Mental Health Social Work Department has 22 staff members across the area. The section below will look at role of a Mental Health Social Worker and what family focused practice and initiatives have been developed by the Mental Health Social Work Department in the past five years.

The Role of a Mental Health Social Worker

Mental Health Social Workers are registered practitioners with CORU. They must also engage in continuous practice development and hold a Level 8 or above on the NQAI framework. Social work in mental health seeks to address the social and environmental factors impacting on the person and family's mental health, working in partnership with the person and their family/ support person/ support service. The role of the mental health social worker includes but is not limited to:

Clinical Case Management: responsibility for coordinating care for a caseload of service users, ensuring appropriate psychosocial supports, providing therapeutic interventions and psychoeducation to individuals and families, and liaising with community services as required. Mental Health Social Workers work both with service users in the community as well as in acute inpatient care settings.

Psychosocial Assessment: Mental Health Social Workers specialise in Psychosocial assessments – they are trained to look at the psychosocial issues impacting on the individual and family. They are trained to assess and work systemically with service users, families/ significant others and with the wider community.

Mental health Assessments : Many Mental Health Social Workers also provide core assessments (biopsychosocial assessment). Mental Health Social Workers may also train as an authorised officer (S.9 of Mental Health Act 2001). This involves mental health assessment and managing care in the community or making a recommendation for an involuntary admission.

Role of Advocate/ inter-agency work/mobilisation of resources: Social Workers encourage individuals to advocate for themselves and/or also advocate on their behalf where needed. Social workers aim to build on people's strengths and skills. They have particular skills in advocating with other service providers in the area of housing, social welfare, mobilising community supports, to ensure that service users and their families obtain maximum resources and services where possible, recognising the impact on social and environmental factors on a person's well-being and that of their family.

Trauma-Informed Care: Social Workers work from a trauma informed lens. They are trained in client centred, solution focused, strengths-based counselling interventions which are part of their core training. In addition, to this, many Mental Health Social Workers (MHSW) have additional training in, for example: Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Behavioural Family Therapy and some may also be dual qualified as fully accredited Psychotherapists and Family Therapists.

Family-Focused Practice: This approach is about involving families and carers/support persons in the delivery of care for the service user. Family-focused care is widely acknowledged as a crucial aspect of effective mental healthcare delivery (Foster and Isobel, 2018). MHSW's provide a 'whole-of-family' approach, providing an assessment of family members and family functioning, provision of psycho-education and emotional and practical support, family care planning and liaison and advocacy.

Mental Health Social Workers also provides specialised family work with families with more complex needs, often working with families and individuals in crisis. They provide specialist interventions (therapeutic work and advocacy) in cases where individuals experience intimate partner violence, and with marginalised groups in society.

Specialist Facilitation of Family Meetings and Complex Case Conferences

The co-ordination and facilitation of Family Meetings is a frequent task for a Mental Health Social Worker. In addition, Mental Health Social Workers provide specialised family work with families who present with more complex needs. These interventions also often involve the facilitation and chairing of family meetings, where family members and service users meet with the multidisciplinary team or indeed at times, with other agencies in case conferences. Family meetings are an evidenced-based practice to clarify goals of care and support communication between families and the healthcare team. Evidence from literature supports three components for effective family meetings: (1) meetings are best held proactively; (2) meetings are based on adherence to a step-by-step process; and (3) meetings must incorporate communication techniques that support family decision making (Lyn Ceronsky, 2011). Mental Health Social workers are trained to facilitate such meetings. A central task for that facilitation is to identify and respond effectively to verbal and nonverbal communication cues.

Family Focused Practice Service Developments in Galway/Roscommon Adult Mental Health Services

There are a number of programmes currently operating in Galway Roscommon Adult Mental Health Services coordinated by the Mental Health Social Work Department. Below is a description of those evidence based programmes.

The EOLAS Project

The EOLAS Programmes are Mental Health Information and Learning Programmes for Service users who have experienced psychosis with a parallel programme for their families and close friends.

The EOLAS programmes were developed in sites across the country in 2010 by a consortium of service users, family members, mental health practitioners' working with the HSE and voluntary agencies. It was initially funded through the GENIO Trust, a charitable organisation that supports innovation in mental health services.

The EOLAS programme reflects the collaborative perspective on service provision - recommended by Vision for Change (2006) and the involvement of service users in every aspect of service delivery with a view to enabling the recovery process (Department of Health and Children 2006).

The programme is 8 weeks in duration and aims to deepen understanding of Bi-Polar Affective Disorder and Psychosis, and the possible impact on the person themselves and their family and friends. The programme describes how mental health teams work and provide guidance on what supports are available to relatives. The EOLAS programme is co-facilitated by a person with lived experience of mental health difficulties, and a H.S.E Mental Health professional.

In 2017 The Social Work Dept sought approval from The Galway Roscommon Area Management Team to introduce EOLAS across Galway and Roscommon. Training was provided to staff (10 Social Work staff and 3 nurses, and an Occupational Therapist), and family members and peers (9).

Two Senior Social Workers now co-ordinate the roll out of EOLAS across Galway/Roscommon. EOLAS was on hold with COVID-19 restrictions. It recommenced in the Spring of 2022. To date in Galway Roscommon 57 individual service users availed of the 8 week programme and 64 family members have availed of the EOLAS Programme. In order to assist families with ease of access to the programme, it is facilitated in the evenings after working hours.

Behavioural Family Therapy

Behavioural Family Therapy (BFT) is an evidence based intervention delivered to families by trained Mental Health Staff. BFT is a practical skill-based intervention for the whole family that usually takes 10-14 sessions – and should be offered to families of individuals experiencing first episode of Psychosis. Research has shown that BFT is effective in reducing stress for service users and their families and that it can significantly reduce relapse rates and hospitalisations, and promote recovery (HSE, 2019).

The following principles underpin practice and take account of the relationship of main carer and the person with psychosis:

- Families are valued and their role in supporting the service user is acknowledged by teams at the first appointment.
- A collaborative working relationship between families and services
- All families are informed about and offered a BFT intervention as standard in accordance with best practice
- BFT is delivered by qualified/competent staff on CMHTs who attend monthly supervision

The Irish Health Service Standard Operating Procedure for the Early Intervention Psychosis highlights that one of the main advantages of BFT is that 'apart from its flexibility to adjust to suit each family, is its ability to create joint understandings, developing agreed relapse prevention plans, and problem solving which occurs with service users and their families - thereby making it more likely that stress, tension, felt burden reduces, and a shared pathway forward is created' (HSE, 2019, p 5).

In 2018 two Senior Social Workers were trained as BFT Trainers by Meriden in the U.K. Five additional staff received BFT Training in Jan 2020. The BFT Lead continues to provide supervision to all staff in Galway/Roscommon Mental Health services providing BFT. As one of the BFT Trainers moved to a new post – a Senior Social Worker is now being trained to replace this individual. An EOI was sent out to all disciplines for this Train the Trainer Course – and one person (a Senior Social Worker) expressed an interest. The absence of a First Episode Clinical Programme in Galway Roscommon, as well as a Social Worker's capacity to provide training and supervision within existing resource – has limited the potential benefit BFT could offer families.

Family Talk

Family Talk is an evidenced based, 7-session, psycho-educational, whole family approach designed to enhance family communication and understanding of parental mental illness, improve family interpersonal relationships, and promote child resilience and utilisation of social supports (Christansen et al., 2015).

Studies demonstrate Family Talk's effectiveness for a range of psychiatric diagnosis, including anxiety, bi-polar disorder, psychosis, substance abuse, post-traumatic stress disorder, eating disorders, and personality disorders (Pihkala et al., 2012; Christiansen et al., 2015; Pihkala et al., 2017). There is evidence that Family Talk may also promote the parent's mental health recovery. For instance diagnosis of parental affective disorders reduced from 90 to 66% at 4.5 year follow-up, and from 43 to 31% at for non-affective disorders (Beardslee et al., 2007).

To date sixteen staff (Social Workers 12; Psychologists 2; Occupational Therapists 1, Nurses 1) have trained to deliver Family Talk. We have agreed that professionals delivering Family Talk must have three years experience of working in mental health services – in order to be able to respond competently to the complexities that can arise in some families.

A Peer Supervision Group for clinicians delivering Family Talk has been established – and is facilitated by the Principal Social Worker. This group is also developing a protocol for the roll out of Family Talk within services; including information leaflet for families and professionals; referral criteria; evaluation template; and template for a report on the intervention for the service user's clinical file.

To date a total of 55 families have been referred for Family Talk. As mentioned 30 of these families took part in the research conducted by PRIMERA.

The researchers were particularly impressed with the **implementation process** applied in the Galway/Roscommon site – which as outlined above included:

- the initial establishment of a Steering Group (Crosslinx West);
- the submission of a Project Plan to the Project Management Office for the roll out of Raising Awareness Training and Family Talk – which means this process has been tracked should it need to be replicated by other services
- the development of Raising Awareness Training – which was inter-agency designed and delivered;
- he establishment of a Peer Supervision Group for clinicians delivering Family Talk – which is supporting it to become embedded in practice

The Family Connections Programme
(part of Dialectical Behaviour Therapy DBT)

Family Connections (FC) is a group based treatment programme for family members/ significant others of people with a diagnosis of Borderline Personality Disorder (BPD) or Emotion Regulation Disorder. Families/significant others are often the first line of care for their relatives and have assumed multiple roles such as advocate, caregiver, coach, and guardian. Research indicates that stress associated with having a relative with BPD can result in increased sense of responsibility (often termed 'burden' in literature), depression, grief, and isolation.

The challenges facing family members/significant others of individuals with BPD are often of such magnitude that they can, over time, deplete the family members'/significant others' capacity to cope effectively, compromising their health and life agenda. FC aims to help people reduce their stress, distress and pressure to assume responsibility, while increasing education and effectiveness in self-care. This has benefits for the individual themselves and their relative with BPD.

The treatment model of Dialectical Behaviour Therapy (DBT) is an evidence-based treatment that has shown to be effective in treating Borderline Personality Disorder and related problems such as emotional instability, suicidal thoughts, self-harming and self-destructive behaviours.

What Does The Family Connections Programme Involve?

Family Connections is a 12-week multiple family members/ significant others group programme. Each session includes specific practice exercises and homework. The programme is designed to meet 3 needs of family members/ significant others:

1. Education about BPD and interpersonal functioning
2. Individual and interpersonal skills, to help with managing their own negative reactions, and building better and more satisfying relationships
3. Social support from other group members who have lived through similar experiences and are living with similar situations.
4. Family Connections is designed to bring family members/ significant others together with two main goals:
   - Supporting them in their efforts to be emotionally involved with their relative in more effective ways
   - Increasing their own wellbeing which may in turn have a positive effect on the wellbeing of their loved one
5. To date three Social Workers have completed this training.

Family, Friends and Support Person's Group in Galway Acute Inpatient Psychiatric Unit

This is an information group for family members, friends and support persons to attend when their relative/friend has been admitted to the Adult Acute Mental Health Unit in Galway City (AAMHU). This group is a once off session that is facilitated by two Mental Health Social Workers. There is a Senior Social Worker working full-time in the Inpatient Psychiatric Unit in Galway City.

The group session addresses the following issues:

- Information on the Mental Health Service
- Details of each member of the MDT team.
- Information on Community Support Services for families and carers
- General information on various mental health presentations/diagnosis
- Skills/tool for managing stress and self-care
- Group discussions, peer support and sharing of experience and knowledge

Information Booklet for Family Members Carers/Supporters of Inpatients

Galway/Roscommon Adult Acute Mental Health Unit

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Mental Health Services

Information for Family Members, Carers & Friends

A booklet for families, Carers and Friends who have a loved one attending the Adult Acute Mental Health Unit was developed by the Social Work Department in 2019. It was co-produced with family members. The booklet contains information specifically about the Galway/Roscommon service; about the multidisciplinary team; what to expect when a relative is admitted to the Inpatient Psychiatric Unit; about the possible impact on family members; and what therapies are provided within the service. The booklet outlines supports to families regarding their own wellness, sign posting to other community services in Galway and Roscommon, such as counselling and various mental health voluntary groups.

Specialist Intervention and Support with Intimate Partner Violence

Domestic Abuse (Intimate Partner Violence)

Social Workers have expertise in the assessment and providing therapeutic interventions with service users experiencing Intimate Partner Violence (Domestic Abuse).

Research outlines that Intimate Partner Violence (Domestic Abuse) has been shown to be associated with a range of mental health problems, including depression, post-traumatic stress disorder (PTSD), suicidal ideation, substance misuse, functional symptoms, and the exacerbation of psychotic symptoms (Howard et al.. 2013). Indeed, research has shown that there is a strong association between domestic abuse and mental disorder, with evidence of bi-directional causality (Trevillion, 2013).

Mental Health Service users are at increased risk of domestic abuse but their experiences are often undetected by mental health professionals (Howard et al.. 2013). Alongside the identified barriers to disclosure for victims of domestic abuse, Rose et al.. (2011) identifies that a major barrier to disclosure is that service users are not asked by healthcare professionals. There are a myriad of reasons for this including lack of confidence among staff, the focus on symptoms and domestic abuse not being a priority in assessing and treating mental health difficulties (Howard et al., 2013, a).

Social Workers have expertise in the assessment and therapeutic intervention with service users experiencing Intimate Partner violence. The Galway Roscommon Adult Mental Health Services conducted a piece of research recently looking at the prevalence of domestic abuse amongst service users attending our Mental Health services (GR 1-3). Findings show that 70 percent of respondents were never asked if they were experiencing abuse.

The research recommends that training needs to be developed and rolled out across all MDT teams to raise awareness in this area. As Mental Health Social Workers with expertise in this field, we recognise a role for us as a profession in developing and rolling out that necessary training.

Family Focused Practice Research

- As outlined above, the Social Work Department completed a piece of research in 2021 to measure the prevalence of Domestic Abuse in the experience of service users attending the services (GR1-3) with a view to enhancing best practice in this area.
- Also as mentioned earlier - the Dept also led out on the design and delivery of Raising Awareness Training about Family Focussed Practice. In conjunction with the School of Social Work at NUIG (National University of Galway) the Dept evaluated this Training and the findings were published in 2020 (Golden, C. Killion, MG. and McGregor C., 2020).

Family Involvement Policy

The Social Work Department has had a significant involvement in developing a Family Carer Involvement Policy for Galway/Roscommon Mental Health Services. The Dept will provide Raising Awareness training to staff to support the Implementation of this Policy.

Protocol for Facilitation of Meeting with Families Post a Serious Incident

The Social Work Department are currently developing a guidance document on communicating with families following a serious incident/families bereaved by suicide in the service. This will be in conjunction with the suicide prevention office. A need for training for key staff in communicating with families post a serious incident has also been identified.

Supporting Service Implementation: Family Peer Support Worker Service 2020 -2021

Bealach Nua

As part of our commitment to promoting Family Focussed Practice we agreed to provide line management and case supervision to a new Family Peer Support Worker Service. The Family Peer Support Worker service was first developed in Mayo Mental Health Services and is known as the Bealach Nua Model. It was introduced to Galway/Roscommon in Aug 2020. There are currently three half time Family Peer Support Workers working in the Galway/Roscommon Area. Mental Health Ireland is the host employer for two of the posts and the third post is funded permanently by the HSE.

The role of the Family Peer Support Worker is:

- to support the family member/carer to focus on their own self-care;
- to undertake a Carers Needs Assessment with the family member;
- to support them in communicating their concerns to the treating team;
- to encourage them to improve communication and their relationship with their relative;
- to sign-post them to relevant services (e.g. Counselling; Women's Aid; MABs; Dept of Social Protection, Addiction Services, Men's Sheds).

They also support the work of Recovery Colleges in providing education on the benefits of positive family involvement in care and treatment. They can co-facilitate (with experienced professionals) EOLAS information sessions and support groups for Family members.

The Family Peer Support Worker is not a member of the multi-disciplinary team – and provides a service somewhat 'independent' of the treating team. Hence the importance of safe governance in order to protect the needs of the service user; the family member; as well as those of the staff and the overall mental health services.

To date there have been a **total** of **54** referrals. Four referrals were **self-referrals** and the remainder were referred by social work staff **(41)** and by nursing staff **(9)**.

In 2021 Feedback was sought from a random group of family members who received the service since Nov 2020. Their feedback highlighted:

- their need to be able to talk to someone who understands what it is like to be a carer of a relative with a mental illness
- for some, their frustration of not being offered an opportunity to communicate with the treating team
- confusion about their relative's diagnosis
- that it's 'OK' to look after their own self-care needs
- that their relative benefits when they 'pull back' and begin to look after themselves.

The following structures and processes were put in place by the Principal Social Worker to address these issues. In the majority of cases the referring discipline is already working together with the Service User and their Family Member and have identified that the Family Member would benefit from the support of a Family Peer. In a very small number of cases relations between the Family Member and Service User are fractured – and the Family Member may not know whether their Relative is still engaged with mental health services. The referring discipline then needs to inform the Service User that their Family Member has expressed an interest in availing of the Family Peer Support Service – and seek their consent to confirm with the Family member that they are currently involved in the service. This is essential in terms of our requirements to protect Service Users right to confidentiality. If the Service User does not wish to provide consent then the Family Member is advised that we cannot offer them a service at this time. The Family Member will be signed posted to voluntary organisations and other agencies who provide support services to Family Members such as SHINE and AWARE.

Where this consent has been secured from the Service User then Team Social Worker meets with the family member and identifies their needs:

- in terms of addressing their own self care;
- any communication or relationship difficulties with their relative who is attending the service;
- the information they have in relation to their relative's illness.

The Social Worker identifies if there is a need for them to undertake some family work with the family member and their relative to address some of these issues. They then return to

the Service User/Relative to seek their consent and interest in engaging in this therapeutic work. In addition, they will support the Family Member in sharing information or concerns with relevant team members.

Resources Required To Continue Promoting And Developing Family Focussed Practice Across Galway Roscommon Mental Health Services

Our updated Mental Health Policy 'Sharing the Vision: A Mental Health Policy for Everyone' highlights the importance of involving family members in care and treatment in line with the National recovery Framework. It also emphasises the importance of early intervention (p.26); timely access to evidenced based interventions for service users and family members/carers/supporters (p.34); and the provision of additional supports for children who have been exposed to Adverse Childhood Experiences (ACEs) such as domestic violence, alcohol or drug abuse, mental health difficulties and bereavement' (p.27).

A Family Member/Carer Involvement Policy has recently been updated and adopted for Galway/Roscommon Services. Raising Awareness training for all staff will be necessary to support the implementation of this policy. The MHSW Dept recommend that additional resources are put in place in order to support Family Focussed Practice to become embedded in service delivery.

We recommend that three dedicated FFP Co-ordinators across Galway/Roscommon Mental Health Services need to be put in place to provide the following:

- Deliver staff training in respect of the policy.
- In addition deliver inter-agency training to raise awareness about the impact of MI on families and the value of a 'Think Family' approach.
- Resourcing Continuous Professional Development of Social Workers to maintain high standards in clinical practice and the delivery of FFP.
- Facilitate the Peer Supervision for staff delivering Family Talk.
- Facilitate Supervision for Staff trained in Behavioural Family Therapy (must have completed train the Trainer course for BFT).
- Train facilitators for Eolas Psycho-education groups.
- Co-ordinate clinical metrics in relation to the different evidence based intervention.
- Develop Research studies to evaluate the effectiveness of FFP and contribute to the evidence base for FFP.
- Develop interagency initiatives to support FFP across services where professionals are working with Parents and Children (e.g. Crosslinx Model).
- Contribute to co-production of Recovery Modules with recovery Colleges.

Embedding Family Focussed Practice

'Combining the authority of senior managers and the dynamism of the voluntary sector and users is the most effective way of supporting staff seeking to put whole family approaches into practice. Embedding the messages into induction, training, supervision and performance management can help promote the work, and altering assessment and recording tools, can prompt people to Think Family' (SCIE, 2011, p.7).

A recurring theme in the international literature on family focused practice is that it requires an enabling and authorising policy environment, and the support of senior managers (Wong and Cummings, 2010). In addition, embedding family focused practice is a process, involving the adoption of a systemic approach to how we think about the needs of families, and the organisation and operation of services.

International experts committed to promoting Family Focussed practice identify that the main components of a 'Think Family' policy/practice standards must include:

- mandatory auditing of the parenting status of adult mental health users;
- balancing the priority given to patient confidentiality with unmet family needs;
- increased collaboration between traditionally segregated AMHS and CAMHS services and; other children services
- equipping clinicians with time and resources to undertake FFP (Grant et al., 2016; Mayberry and Reupert, 2009).

In the Irish context Mulligan et al., (2020) identified the need to benchmark existing conceptualisations and practice in relation to family focused practice, and to use this to guide the development of new policy and practice initiatives (Fitzsimons 2020; Golden et al., 2020; McVeigh, 2020). In 2021 Mulligan et al., highlighted that the longer-term sustainability of Family Focussed Practice in Ireland, and elsewhere, requires a multi-level public-health response to address enduring political, cultural, organisational, and family barriers to change. They identified that such a response would include: 'think family' policy/practice standards; dedicated funding for FFP; managerial support to implement FFP; initiatives to reduce mental health stigma and recruitment barriers; and a continuum of FFP to broaden its capacity to identify families (p.15).

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