



**The 'Can Do' Initiative:  
Managing Mental Health and Substance Use in General Practice**

*'Can Do' for Families and Carers  
Facilitator's guide*

***Presentations and facilitator's notes  
Case studies and facilitator's trigger questions***

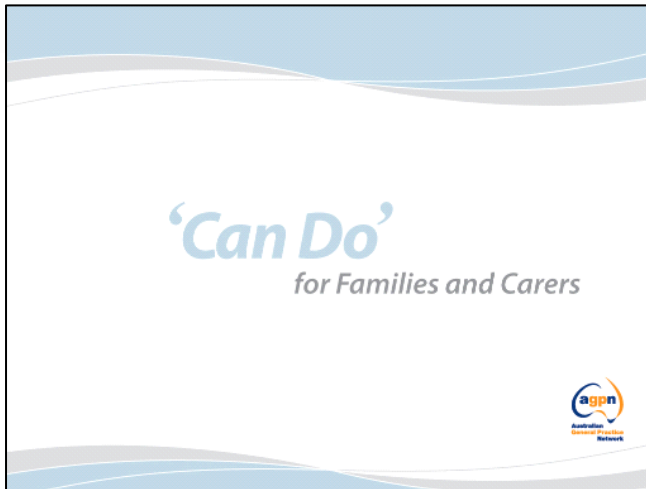
Joint learning module for general practitioners, allied health practitioners and other service providers involved in the provision of care for families and carers of people at risk of or experiencing mental health and substance use issues.

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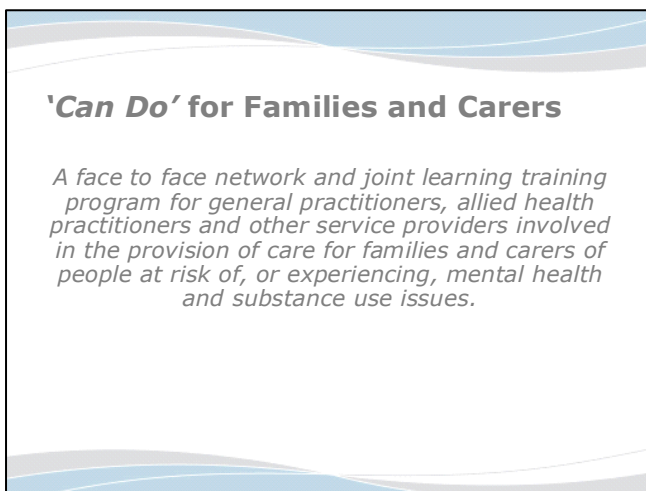
## Slide 1: Title page



This is the title slide for the session. It is a good idea to have this slide up as participants are entering and during welcome.

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## Slide 2: About the training module



### **The focus of this unit is on:**

- This unit focuses on the families and carers of:
  - young mothers,
  - rural men
  - CALD people
  - Older People
  - Veteranswho have a mental health and substance use issue.
- Who are the carers?
- Why are they important?
- What do they experience?
- How can they be most effectively supported?

### Slide 3: About the unit

#### About the unit

- 'Can Do' is part of a three year education and training program funded by the Federal Government
- This series of 'Can Do' units offers population specific learning opportunities
- This unit aims to provide information about the specific needs of the families and carers of:
  - Young mothers
  - CALD people
  - Veterans
  - Rural men
  - Older people

with co-existing mental health and substance use issues

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#### Key points

- The 'Can Do' initiative is a three year education and training program, funded by the Australian Government Departments of Health and Ageing and Veterans' Affairs
- This series of 'Can Do' units offers population specific learning opportunities
- This 'Can Do' unit for families and carers unit has been developed to provide information about the specific needs of families and carers of young mothers, rural men and CALD individuals with co-existing mental health and substance use issues
- A multidisciplinary team focus has been taken with the aim of involving a range of health and community service providers
- The unit aims to provide an overview of the topic area and encourages interactive learning, via discussion of the 'stories' of two family members / carers as well as the opportunity to network and 'map' local service providers.
- It has been developed for a range of professionals and provides the opportunity to increase awareness and local network and referral pathways
- The unit may be used in conjunction with other 'Can Do' Network Training units.

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#### About each of the populations covered in this series of units:

- The population group, **young mothers**, encompasses females from 12 to 25 years of age. However, this group can be further divided into adolescent women (12 to 17 years of age) and young adults (18 to 25 years of age).
- **Rural men** encompass a wide range of ages, backgrounds, professions and cultural groups and face a number of issues and challenges related to both their location and their individual context (i.e. profession, family, socio-economic status). To provide appropriate care, practitioners need to be aware of the specific and unique context of both rural men, and their families. Population is the main criteria used to determine a rural or remote area. However, past definitions have also included characteristics such as socio-demographic and cultural features, as well as land use and economic activity (Black, et al, 2000).
- The population group, **Culturally and Linguistically Diverse**, encompasses those born overseas in a non-English speaking country as well as those born in Australia, but with one or both parents or grandparents born overseas in a non-English speaking country.

However, this group can be further divided into voluntary migrants, people who have been drawn to Australia for their own personal reasons, and involuntary migrants (refugees and asylum seekers, who have felt 'pushed' out of their country of origin). Australia's immigrant population has grown enormously in recent decades. Millions of people from more than 150 different countries, and from diverse backgrounds, have settled with much success: in the year 2005–06, 119,564 immigrants from non-English speaking countries settled permanently in Australia (Australian Government Department of Immigration and Citizenship, 2008).

- **Older people** are defined as people aged over 65 years, but can be broken down into the sub-groups of 65 – 85 years as 'young old' and 85+ years as 'old old'. It is also recognised that there is a group of 'early onset' older people (aged 55+ years) relevant to some populations including but not limited to ATSI, homeless, chronic psychiatric disability, intellectually disability and those with chronic disease and particular life experiences.
- **Veterans** are defined by the **Department of Veterans' Affairs** as a member of the defence force established by a British Commonwealth or allied country, who has rendered continuous full time service during a period of hostilities, in connection with war or warlike operations in which the Australian defence force was involved. This includes active service and peacekeeping duties. The families and carers of veterans are also important. The Department of Veterans' Affairs is responsible for identifying the benefits that both veterans and their families are entitled to and also coordinates Veteran and Veteran Families Counselling Services in each state and territory and has a memorandum of understanding with the Defence Force Community Association, which provides support services for families of veterans. More information can be found under 'Can Do' for Veterans at [www.agpncando.com/veterans.htm](http://www.agpncando.com/veterans.htm).

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## Slide 4: Learning objectives

**Learning objectives**

Participants will:

- Understand the needs and roles of families and carers
- Encourage multidisciplinary approaches to care
- Share information with other service providers
- Explore ways to work together
- Map local services and identify local networks
- Identify appropriate referral pathways

*'Can Do' is about working together for better health and social outcomes*

This slide describes the learning objectives of this unit. The overarching goal of the unit is to inform attendees about the specific needs of families and carers of the population groups addressed in the other units in this series: young mothers, rural men and CALD individuals with co-existing mental health and substance use issues. The intended audience for this unit is general practitioners, allied health professionals, other service providers and carers.

The goal of this unit is to provide general practitioners, allied health professionals and other service providers with specific knowledge and skills to work with families and carers of these groups, and to ensure both the carer's and the individual's health and wellbeing.

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### Key points

The unit aims to:

- Increase participant awareness of the needs and roles of the families and carers of people with co-existing mental health and substance use issues, particularly young mothers, rural men, from CALD backgrounds, older people or veterans.
- Increase confidence in providing the support and understanding required by families and carers of people with mental health and substance use issues.
- Encourage multidisciplinary approaches to care by exploring ways of working together.
- Share information with other service providers.
- Explore ways to work together.
- Increase knowledge about local services for families and carers by mapping services and identifying local networks.
- Identify appropriate referral pathways.

The following are the desired key outcomes of 'Can Do' for Families and Carers:

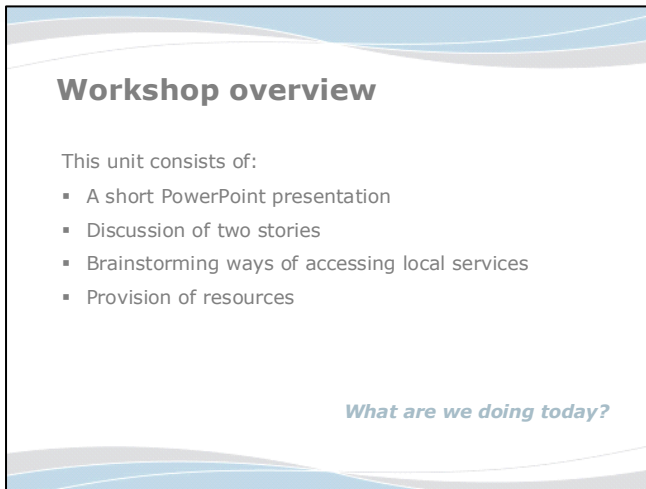
- Local partnerships and interagency collaboration is fostered.
- Professional networking is enhanced.
- Families and carers are included and their needs are understood.
- Shared care arrangements are understood and strengthened.
- Knowledge about local services is improved.
- Referral protocols and processes are identified.

- Care plans are streamlined.
- Stigma regarding working with the families and carers of people with mental health and substance use comorbidities is reduced.

This families and carers training unit provides the opportunity to:

- Discuss how best to provide support for families and carers.
  - Acknowledge the challenges that face family members/carers.
  - Place emphasis on understanding the broad picture of issues affecting families and carers.
  - Gain a better understanding of available local and national services.
-

## Slide 5: Workshop overview



The screenshot shows a PowerPoint slide with a white background and a blue and grey wavy header. The title 'Workshop overview' is in bold black text. Below the title, it says 'This unit consists of:' followed by a bulleted list of four items: 'A short PowerPoint presentation', 'Discussion of two stories', 'Brainstorming ways of accessing local services', and 'Provision of resources'. At the bottom right of the slide, the text 'What are we doing today?' is written in a smaller, italicized blue font.

This slide provides an overview of format of this 'Can Do' for Families and Carers workshop. It is intended as an overview of the main issues when working with carers and families of these population groups; however it is important to note that this is an extensive and complex area.

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### **Key points**

This unit consists of:

- A brief PowerPoint presentation to highlight key issues and ideas.
  - Discussion of two family/carer stories to provide an opportunity to share knowledge, skills and practical advice on working with these groups.
  - Brainstorming ways of accessing local services – service providers will be given an opportunity to introduce their service in the service mapping exercise.
  - A number of handouts and resources will be provided.
-

## Slide 6: A typology of families and carers

**A typology of families and carers**

- Nuclear family
- Partners
- Extended family members
- Young carers
- Blended families
- Single parent families
- Non-parental primary carers
- Friends

*Anyone who cares...*

This slide provides an introduction to families and carers. Who are families and carers? The definition of a family member or a carer is anyone who cares for and chooses to remain connected with a person with co-existing substance dependence and mental health issues. It is important to identify and accept that 'those who care' in the 21st century go far beyond the traditional concept of a nuclear family.

### Key points

- Traditional concept of a nuclear family: a family group consisting of a married father and mother, and their children; the children have dual roles as sons and daughter, and as brothers and sister – in a family with a child becoming a young mother, the parents may become involved in the care of a child/grandchild.
- Partners: including both heterosexual and same-sex couples.
- Extended family: a family group consisting of not only the nuclear family but also including the grandparents, aunts, uncles, cousins, and sometimes more distant relatives or in-laws – this may be particularly relevant to CALD individuals who become carers.
- Young carers may take on the role because of family breakdown or loss of family members; examples are children/adolescents supporting a parent, or supporting a sibling due to a breakdown in communication with parents; in this group the effects of taking on roles beyond their developmental years is important, and the potential imbalance of parent/child relationship or older/younger sibling.
- Blended or step-family: a coupled family containing two or more children; children may include the biological children of the couple as well as children from previous relationships.
- Single parent families: where either the father or mother is the primary carer.
- Non-parental primary carers: when the biological parents are unable to care for their children, others step into the role of primary carer; these may include grandparents, foster parents, god-parents, adoptive parents, other family members and more.
- Mentors and friends: those who do not fit into the above categories but still choose to remain connected – to care for, support and love; note that when a person with mental health and substance use issues does not have or is disconnected from their family, friends, mentors and carers may be their only source of support.

## **Additional information**

### **Blended family and stepfamily**

Terms are often used interchangeably. The National Family Resource Centre (US) notes that members of a stepfamily are sometimes expected to blend into an entirely new family unit, which may cause them to lose their individuality and attachment to other outside family members.

### **Grandparents**

There are increasing numbers of grandparents with children with mental health and substances use issues who subsequently become the primary carers for their grandchildren. Grandparents may be coping with:

- the loss of 'normality' as a grandparent
- loss of time with their peers
- having to be a parent again to a younger generation
- stress and physical exhaustion in caring for a young child again
- mourning the loss of retirement – a time to enjoy the fruits of their lives
- custody issues
- financial burden
- relationship issues with their adult child/partner.

In some instances this may be compounded by mental health and substance use issues emerging in the grandchild. These issues impact on the health of the grandparent and on relationships between grandmother/grandfather and other family members/carers and friends.

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## Slide 7: Importance of families and carers

**Importance of families and carers**

- Families and carers are the most important resource
  - Able to grow, change and adapt
  - Experts with wisdom, strength and experience
- They play an important role in treatment
  - People who remain connected to families or carers do better in treatment for mental health and substance use.
- Families and carers are experts in knowing the individual

*Connection leads to better outcomes*

This slide addresses the importance of families and carers.

Support from family and friends has been important for those who wish to moderate their drug use without seeking professional help (Shearer et al 1999; Dietze et al 2003), and in the treatment seeking process (Hartnoll 1992; Treloar 2005). Stanton (1997) noted that whether or not drug-dependent people actually live with their parents, evidence suggests that most are closely tied to their families at many points, with communication often routed through siblings, relatives and spouses. They tend to use a given household as a constant reference point in their lives.

### Key points

- Families and carers are an essential resource - consider the importance of:
  - a mother of a young woman with children,
  - the wife of a rural man with depression,
  - friends of a CALD individual with limited English who is experiencing a mental health and substance use problem
  - the wife of an older man who is dependent on her care
  - the families and children of returned veterans or peace keepers.
- Growth, change, and adaptation – change, either positive or negative, is inevitable within the family context; the same holds true for the influence families and carers have on a person's mental and drug health; the move towards potential change and positive outcomes is enhanced by providing support, education to families and carers and encouraging self-care.
- Families and carers are an excellent source of knowledge, strength, practical assistance and support.
- Families play an important role in identifying the need for treatment, facilitating entry into treatment and providing support during treatment processes (Mitchell et al 2001); people who remain connected to families or carers do better in treatment for mental health and substance use.
- Families and carers are the experts when it comes to knowing the individual, and it is important to acknowledge that families and carers are ideally placed to support a person who may be experiencing mental health and substance use problems.

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### Additional information

- Research shows that family involvement in treatment has a positive impact in treatment retention. However, family involvement may be difficult to achieve and is even less likely if it is not actively sought. Approaches employing active engagement of the family have been trialled with positive effect, although they might need some modification depending on the cultural group (Spooner et al 1996).
- Families and carers need to be supported and nurtured themselves. Health professionals and community services, including general practice, alcohol and drug and mental health services, community pharmacy, youth services, family support groups and more can be a source of strength for families and carers.
- Involvement of all family members is preferable – however, this is not always realistic. Effective change is achievable with one or more supportive and committed family members/carers.
- Unbundling the behaviour from the person – families and carers are able to remain connected when they can separate the person from the behaviours associated with drug use and mental health issues.

As one person put it, *'I would have been dead ages ago if it wasn't for my family. The fact they remained connected despite my behaviour was what kept me going.'*

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## Slide 8: Who are families and carers supporting?

### Who are families and carers supporting?

Family members or friends of any age who may be:

- At different developmental stages of their life
- Living at home or away from home
- In the early stages mental health and/or substance use issues
- Experiencing years of problematic mental health and substance use
- Out of contact
- In trouble with the law
- Alienated from mainstream society
- Aggressive and abusive towards families and carers

This slide addresses, generally, who families and carers are supporting.

It is important to take into consideration the age, gender, developmental stage, location (urban or rural) and culture of the person that the family or carer is supporting. People who have mental health problems or use drugs are real people and individuals. Avoid labels like 'dual diagnosis', 'addict' or 'junkie'. People with mental health and substance use issues are someone's son, daughter, father, mother, partner or friend. The use of labels is not helpful and increases stigma and social isolation.

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### Key points

Families and carers are supporting family members or friends of any age who may be:

- at different developmental stages of their life, such as the adolescent or young adult who is seeking identity and independence,
  - a new mother unfamiliar with parenting,
  - a relatively recent immigrant, a CALD individual who is traumatised,
  - an older person with loss of physical mobility and independence,
  - a veteran of long ago or very recent conflict,
  - living at home, possibly with partners or siblings,
  - living away from home, homeless or moving frequently from one place of residence to another, presenting at home only occasionally,
  - in the early stage of mental health and/or substance use issues,
  - experiencing years of problematic mental health and substance use requires repeated long-term hospitalization/institutionalization or regularly taken to casualty departments,
  - in financial difficulties due to the drought,
  - has disappeared from home and with whom they wish to restore contact,
  - in trouble with the law, such as facing break and entry charges or charges for dealing in drugs, or in detention,
  - alienated from mainstream society,
  - aggressive and abusive towards families and carers.
-

### **Additional information**

Where people have experienced long periods of problematic mental health and substance use during adolescence, it is quite common for them to have missed out on many of the usual learnings that are experienced at this time. This can mean they are less aware, less able to rationalise and have poorly developed coping skills. Adult carers may 'expect' that they will behave and cope in the same way as other people in their age group. This mismatch between adult expectation and the abilities of the individual can exacerbate conflict and reduce the self esteem and resilience of both the person and the family or carer.

Changing relationship dynamics from 'parent to child' to 'adult to adult' – the journey with a drug dependent and/or mental health comorbidity can span years, decades, to a lifetime. Drug dependence and/or mental health issues may have been present from an early age when the relationship was on a 'parent to child' basis. Through the passage of time, the child has become an adult; however, families (especially parents) may still be stuck in the child-to-parent mode and unable to treat the person on an adult-to-adult level.

Delay in developmental cycles – although the person may have matured physically to an adult, his or her stage of development may be delayed. For example, the person may be 30 years old but behave like a teenager or younger adult. This is a major challenge in rehabilitating someone who has had a long-term history of drug and/or mental health issues.

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## Slide 9: Who are families and carers supporting?

**Who are families and carers supporting?**

- **Young women/young mothers** facing many challenges, and those with the onset of mental health and substance use problems in adolescence and adulthood
- **Rural men** with poor health status and who are coping with environmental uncertainty
- **CALD individuals** with risk factors for mental health and substance use
- **Older people** who are becoming increasingly frail, experiencing the onset of dementia or who have experienced bereavement
- **Veterans** whose mental health and substance use may have been unstable since return from active service or peacekeeping duties

This slide addresses who families and carers are supporting in relation to the population groups covered in the other units.

### Key points

- Young women/young mothers face many challenges. The key issues for young adolescent women include identity formation and independence-seeking, peer relationships, becoming sexually active and experimentation. Young women may use drugs for a variety of reasons, but they generally use them for their recreational, stimulant and/or sedative effects (Boys, Marsden & Strang, 2001). Young women may also use drugs in an attempt to manage social and mental health problems. There is an increasing range and prevalence of risky drug-related behaviours associated with young women, notably in their use of alcohol and marijuana (Carr-Gregg et al., 2003)
- During adolescence and early adulthood the onset of depression, anxiety and substance use disorders is common (Andrews & Wilkinson, 2002), and the highest prevalence of depression in women is during child bearing years. Ten to fifteen percent of mothers develop post-natal depression within 6-8 weeks of giving birth, with psychological disorders potentially developing as a response to stress, particularly if the young woman is not able to deal adaptively with the stressor (Geldard & Geldard, 2005). Given that mental health problems are commonly experienced by young women and substance use is common in young women, it is not surprising that co-morbidity frequently occurs
- Rural men may have poor health status and be coping with environmental uncertainty. Health status in general is poorer for men in rural areas, and deteriorates with increasing remoteness. Rural and remote males experience 15% higher mortality rates compared to men in metropolitan areas. For the 25-64 year age group, males have a 252% greater rate of suicide and a 170% greater rate of motor vehicle traffic accidents than females in rural and remote areas (Huggins, 1997). Also, appropriate assessment and service provision in rural areas may be problematic (Fragar et al., in press). The impact of environmental uncertainty on the wellbeing of rural men cannot be underestimated. Alcohol abuse is a common problem for men in rural areas, and it is known that alcohol abuse commonly co-occurs with depression
- CALD individuals may present with risk factors for mental health and substance use. Statistics indicate that CALD communities have lower rates of alcohol and drug use than the general population (Australian Institute of Health and Welfare, 2003). However, risk factors for drug

use include family problems, social isolation and lack of community connection, low socio-economic status, difficulties at school, loss and grief issues, adjustment issues, lack of information about drugs, and a desire to gain acceptance. One of the robust findings in trans-cultural psychiatry is the close association between trauma exposure and risk of psychiatric disturbance in refugees. Hence, involuntary immigrants are at greater risk of common mental disorders such as depression and post-traumatic stress disorder. Immigrant children are particularly at risk of mental health problems: even years after resettlement, they have higher rates of mental health problems

- **Older People:** An older person may be a carer for another family relative or for a neighbour or friend. In many instances it is the women who become long time carers for frail older men. Issues to consider are the health of the older person who is a carer, what happens when the carer her/himself can no longer continue the caring role and what support services are available to support the carer. Issues that create particular distress among older people include the onset of dementia in a family member, increased dependence on family support, alienation from family and social isolation.
- **Veterans:** As for refugees (see CALD above) there is a close association between trauma exposure and risk of poor mental health status. Veterans are at particular risk of depression and post traumatic stress disorder and their children have a higher incidence of mental health problems than the general population. In many instances poor mental health is a long term feature of veteran health and in turn the families and carers of the veteran spend a lifetime supporting the veteran through treatment and management of mental health problems.

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## Slide 10: The perspective of families and carers

### The perspective of families and carers

- Carers' roles made more difficult by lack of community awareness (about depression)
- Carers experience a sense of isolation
- Family members/carers are often excluded when key decisions are made
- Community support organisations provided a sense of inclusion and common purpose
- More services and supported accommodation needed
- Carers feel undervalued

This slide outlines the experiences of carers and families.

### Key points

In a study of 37 carers or family members/carers caring for an individual with depression (Highet, 2004), the key findings were:

- carer's role was made more difficult by the lack of community awareness about depression,
- carers experience a sense of isolation,
- family members/carers are often excluded when key decisions are made, and
- community support organisations provided a sense of inclusion and common purpose.

### Additional information

Carers' perspectives on caring: qualitative analysis of open-ended responses to the Carer and Wellbeing Index Survey (2007). Carers:

- believe that the carers' allowance is not enough,
- believe that more respite services are desperately needed
- are frustrated about waiting lists and being unable to plan for respite,
- are concerned about the lack of supported accommodation available for a loved one when they can no longer accommodate their needs,
- feel undervalued,
- feel the government is out of touch with their needs and the realities of their lives,
- are financially insecure because of the sacrifices they make to be a carer and the additional expenses incurred,
- are time poor because of their 24 hour role,
- are highly anxious about the future of the person they care for and themselves,
- put the needs of the person they care for ahead of themselves, often to the detriment of their own health and well-being,
- want it to be recognised that caring is a full-time job for many carers.

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## Slide 11: Making first contact

**Making first contact**

- GPs are often the first point of contact
- Families and carers may be accompanying a person with mental health and substance use issues or as a patient themselves
- Families often present in crisis
- Families and carers are often in need of some support for themselves

*Who can they turn to?*

This slide provides information about families and carers making first contact with the health care system.

### Key points

- GPs are often the first point of contact with the health care system – they may have a long term trusting relationship with a GP.
- Families and carers may be accompanying a person with mental health and substance use issues, or present as a patient themselves – it is important to distinguish between the person's needs and the family's or carer's needs.
- Families often present in crisis or when a major event has occurred e.g. a drug overdose, trouble with the law.
- Families and carers are often in need of support for themselves, but may not directly ask for assistance.
- Arrange for time for thorough assessments to take place, either through your service or by appropriate referral.
- Encourage the person and/or the family member/carer to come back so care plans can be worked out and support strategies can be discussed.

It is important to consider both the role the family or carer can play in supporting the individual with mental health and substance use issues AND the health and wellbeing of the family members or carers. Point out the fact that there are two issues here – the health and wellbeing of the person and the health and wellbeing of the family member or carer, and that at times these will need to be considered separately.

### Additional information

The person with mental health and substance use issues is usually the primary patient/ client. It is helpful to outline the way in which your service works with the person and their families, and to gain as clear a picture as you can about the current relationships between the person and the family. As for any other person, it is important to obtain a thorough history, undertake a comprehensive assessment of their physical and mental health (including substance use) and

social circumstances. Depending on the age of the person, this may best be undertaken without the family member or carer present so that confidentiality is maintained.

Including family members and carers in care planning is a useful way to verify the persons experiences. They should also be offered time for discussion of their own circumstances and current health and wellbeing.

Families and carers may be presenting to a health or community service as a 'last resort', having tried to cope with the person's mental health and substance use by themselves for some time. Frequently, families and carers contact a health service at the time of a crisis or just after a crisis has occurred for the person.

The family member or carer may present with a myriad of symptoms. It is not uncommon to find the following:

- uncontrolled crying
- eating disorders
- relationship problems
- alcohol misuse
- prescription drug misuse
- sexual dysfunction
- suicidal thoughts
- uncontrolled anger
- insomnia.

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## Slide 12: Engaging with families and carers

**Engaging with families and carers**

- Establish relationship and build rapport
- Be non-judgmental
- Be aware of cultural/language issues
- Establish confidentiality and boundaries
- Use open questions, be mindful of language
- Empathy and listening are important
- Utilise an interpreter if needed

*Sending out consistent messages*

This slide addresses the communication strategies essential to engaging with family members and carers.

### Key points

Key communication strategies are:

- establish relationship and build rapport and trust
- be non-judgmental and supportive
- establish confidentiality and professional boundaries - take into account confidentiality/consent issues of the client
- use open questions and reflective listening, be mindful of language and not using jargon

- be aware of cultural/language issues – an example of a cultural issue might be shame related to a mental health issue, or disapproval of substance use
- empathy and listening important
- setting realistic goals
- differentiating the person's needs from the family's or carer's needs
- validating the role of family and carers
- building on family and carer strengths
- use an interpreter if required and appropriate
- providing practical advice, information and support strategies
- referring to other services where appropriate
- reviewing frequently.

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### **Additional information**

Establishing trust: shame/stigma, emotions and past experiences have a negative and cumulative effect on families and carers. They also become hyper-vigilant towards people judging them, feeling unsafe, and of not being able to trust. Being let down has often become the norm.

Identifying strengths: focus on drawing out the strengths and what has worked for families and carers in the past rather than dwelling on problems and barriers. Keep solution-focused!

There are no 'right or wrong' ways for families and carers. Each family has its own unique set of circumstances and people involved. Generally, families do the best they can with the skills and experience they have and according to the circumstances at the time.

Defining professional roles and boundaries: these are critical areas to establish. It is important to start the engagement process by explaining and establishing what your service can do and what it cannot or will not do.

Realistic modes of engagement: the following are useful in relating with families and carers effectively:

- Recognise the stage that families and carers are at: Remember that what may seem simple to you (e.g. 'go and talk to this service') may be too great a hurdle for someone who is emotionally and physically exhausted.
- Avoid 'fixing the problem': this is what the family or carer has been trying to do for some time. Families and carers have had their fair share of others trying to solve the problem for them.
- Empathy and listening: most family members and carers would have tried most things. Some might have received and acted upon advice that have had negative results. Others might have taken advice that they were not comfortable with, but have nonetheless acted upon. Ask about their experiences.
- Acknowledging the need for on-going support: recognise that this is often a long journey.
- Validating their role: acknowledging and strengthening the importance of their supportive role and their choice to remain connected.
- Respecting their expertise: that they are the experts when it comes to their family and loved ones. No one knows them better.
- Acknowledging their strengths, wisdom, and experience: that despite the difficulties, families and carers have survived this far. This takes an enormous amount of strength and wisdom.

**Veteran issues:** It is easy to 'miss' the fact that the family member may be the partner or child of a veteran. A simple way to find this out is to always ask the question: "Have you or any

member of your family ever been a member of the defence force or a peacekeeper and served overseas?"

**Interpreter issues:**

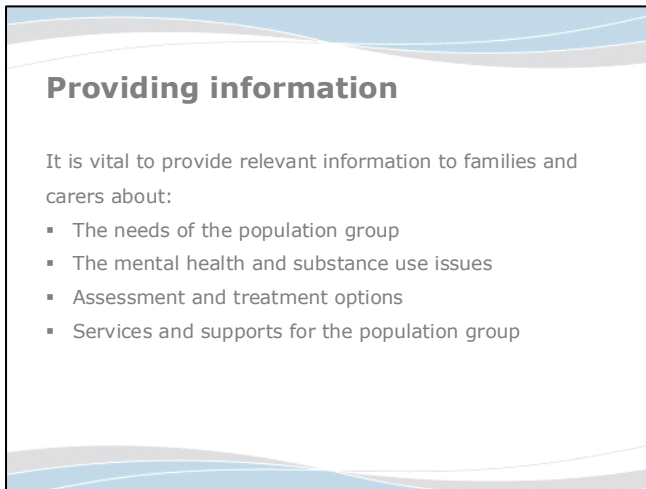
- Use of professional interpreters is encouraged.
- Be concise in your questions and language.
- There may be privacy issues: finding interpreters who are unknown to the CALD individual may be difficult in small CALD communities.
- Take care about using relatives as interpreters; sometimes people are not comfortable in discussing mental health or drug and/or alcohol related issues in front of loved ones.
- Using young relatives to interpret can put undue pressure and excessive responsibility on these young people, and expose them to issues beyond years.

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## Slide 13: Providing information



**Providing information**

It is vital to provide relevant information to families and carers about:

- The needs of the population group
- The mental health and substance use issues
- Assessment and treatment options
- Services and supports for the population group

This slide addresses the need to provide relevant information to families and carers.

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### Key points

It is vital to provide relevant information to families and carers about:

- the needs of the population group
  - the relevant mental health and substance use issues
  - assessment and treatment options
  - services and supports for the population group.
- 

### Additional information

A checklist of questions for carers of individuals with mental health problems to ask health professionals available from [http://www.rcpsych.ac.uk/pdf/Checklist\\_for\\_carers\\_BW.pdf](http://www.rcpsych.ac.uk/pdf/Checklist_for_carers_BW.pdf)

Relevant information for families and carers about young mothers with substance use and mental health issues:

- Many drugs cross the placenta and can affect the young mother and the foetus. Examples of physical issues affecting young women who use substances during pregnancy are fatigue, accidental injury, morning sickness and dehydration.
- Substance abuse can exacerbate existing mental health problems such as anxiety, depression and eating disorders. A young woman's pregnancy may cause tension within her peer, partner and familial relationships.
- After delivery there may be risks of withdrawal (mother and baby), continued addiction or relapse of the mother, and failure to thrive or neglect problems (baby). Co-existing mental health issues may worsen eg. anxiety or depression. However, this time may be an opportunity for the young mother to consolidate treatment and improve wellbeing. Treatment may be best managed with a team care approach.

Relevant information about the rural family:

- Men in rural areas may not present for help with mental health & substance use issues – instead, another member of the family might present (e.g. wife or parents).
- Isolation may mean that even greater pressure is placed on the family and that safety concerns are greater in cases of domestic violence.

- Long-term unemployment may be a risk factor for family breakdown, due to loss of morale and increased social isolation.
- Making sure children have an opportunity to talk and helping them to discuss what is going on for them, can prevent them from feeling isolated/left out. Maintaining usual family routines, as much as possible, can also help children to feel safe and secure.
- Anger (e.g. towards the urban population or government) and domestic violence may become issues as a result of the stressors experienced by men in rural areas. The role of the practitioner is to express concern, listen, counsel, refer to appropriate agencies and consider safety.

Relevant information about CALD individuals with substance use and mental health issues should include:

- The risks that can be associated with drug and/or alcohol use: it is important that younger and older individuals (particularly parents of adolescents) are educated about drug and alcohol issues.
- Addressing some of the social determinants of drug and/or alcohol use: two significant risk factors are the lack of connectedness to the community and strained family relationships. Therefore, initiatives to improve people's sense of connectedness are important, as well as assisting with interpersonal relationships eg. strategies to improve the family dynamic as a whole, such as practical assistance with employment, housing, education and family therapy.
- Harm minimisation strategies are advised, although information may need to be provided as to its use, as some cultures may believe this is condoning behaviours.
- These strategies will also assist in preventing mental health problems.

Issues for CALD parents related to managing their children/adolescents in Australia:

- Some CALD parents struggle when their children behave in a manner that would have been inappropriate in their own home country, but which is acceptable and normal in Australia. Parents can find it difficult if their children expect greater freedom than they would have been allowed in their home country. They can be over-protective and anxious about their children's safety, or place unrealistic expectations on their children to succeed at school.
- Some parents get very overwhelmed about what is going on in their families. Many parents' high anxiety levels are related to their child/children's behaviour. If the CALD parent's children are spending a lot of time outside the home, parents may feel that they are losing control. Also, difficulties can arise if children start to become more outspoken at home. These issues can cause significant intergenerational and (cross-) cultural conflict.

Issues for older people

- The role of family members as carers.
- The carer's own health
- Grief and loss
- Supporting a family member through changes in living arrangements – eg transfer out of the family home ('downsizing' accommodation), transfer into a nursing home or retirement village, move either away from or back within the family.
- Isolation from friends and familiar circumstances
- Changes in autonomy and decision making in the older person.
- (See 'Can Do' for Older People for further information [www.agpncando.com](http://www.agpncando.com) )

Issues for veterans

- The role of the family as carers

- The long term support of mental health and substance use problems within the family setting
- The toll on family members
- Maintaining the family/carers own health and wellbeing
- Conflict within the family
- The increased incidence of mental health problems evident in children of veterans.

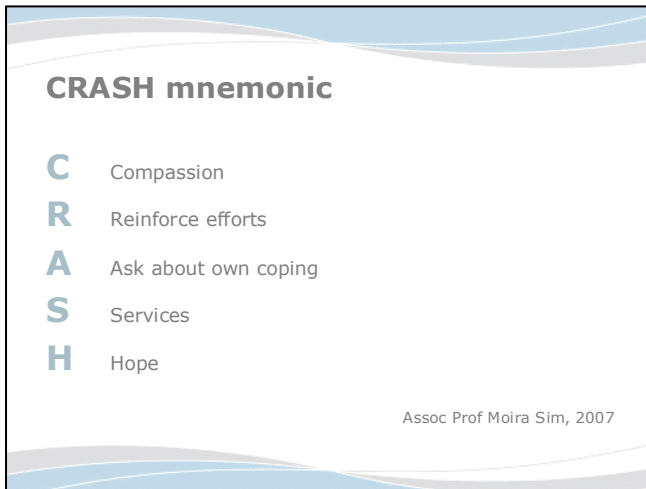
(For further detail see 'Can Do' for Veterans at [www.agpncando.com](http://www.agpncando.com))

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## Slide 14: CRASH mnemonic

A slide titled 'CRASH mnemonic' with a list of five items: C (Compassion), R (Reinforce efforts), A (Ask about own coping), S (Services), and H (Hope). The slide also includes a reference to 'Assoc Prof Moira Sim, 2007' at the bottom right.

**CRASH mnemonic**

- C** Compassion
- R** Reinforce efforts
- A** Ask about own coping
- S** Services
- H** Hope

Assoc Prof Moira Sim, 2007

The above mnemonic can be used when working with a family member or carer of a person with mental health and substance use issues.

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### Key points

- C** **Compassion:** acknowledge the difficulties the family has experienced.
- R** **Reinforce efforts:** there is not right way, whatever they have tried is part of a learning curve and worth trying.
- A** **Ask about own coping:** how is the family member or carer surviving the journey so far?
- S** **Services:** give the family a list of services and resources that they can get assistance from.
- H** **Hope:** reinforce the message that most drug users do eventually stop, hard as it is to feel like one can do nothing.

More about these points and how to implement them will be discussed in the next slides.

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### Reference:

Assoc Prof Moira Sim, Edith Cowan University, 2007

## Slide 15: CRASH- Compassion

### CRASH - Compassion

Acknowledge the difficulties experienced:

- The challenge of mental health and substance use
- Impact of caring for people with mental health and substance use issues
- Burden of caring
- A confusing world
- Shame, stigma, guilt and blame

These will be discussed in the next 5 slides

Many families and carers just want to know that they are not the only ones going through this experience and that their difficulties are understood. Many of these difficulties can be minimised by appropriate support and referral from health professionals.

Each of the difficulties listed here will be discussed in more detail on the next slides.

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### Key points

- Co-existing mental health and substance use issues are complex and challenging: acknowledge the difficulties experienced, eg. in relation to diagnosis, finding appropriate care and treatment, times of crisis and instability
- Acknowledge the impact and burden of caring for the person: fear, loss of trust, alienation, broken relationships, financial losses, grief and loss, conflict and violence, declining health and wellbeing
- Acknowledge the confusion: mixed messages from everywhere, segregated services, array of treatment options, shortage of support services for families and carers
- Address shame, stigma, guilt and blame: resulting from societal stigma surrounding mental health and substance use

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## Slide 16: CRASH- Compassion - Challenges of mental health and substance use in the family

**CRASH - Compassion**

*The challenge of mental health and substance use*

- Substance use or mental illness are complex enough on their own
- Co-existing mental health and substance use brings greater complexity:
  - Increased stigma
  - Difficulties with diagnosis
  - Difficulties in finding coordinated care
  - Medication interactions
  - A higher level of care
  - Less stability
  - Psychotic episodes

*It is so complex and chaotic*

This slide describes some of the challenges of supporting a person with mental health and substance use issues.

### Key points

- Supporting a person with substance use or with mental health is complex enough
- Coexisting mental health and substance use increases the complexity, including:
  - Increased stigma and alienation in the community
  - Difficulties with diagnosis
  - Difficulties in finding coordinated care
  - Access and retention of the person with health and community services
  - Medication interactions, non-compliance
  - A higher level of care being required
  - Less stability, difficult or antisocial behaviour
  - Psychotic episodes (potentially)

### Additional information

- Mental health and substance use are chronic relapsing conditions.
- People with mental health and substance use comorbidities present with a wide range of characteristics and symptoms.
- Life can become chaotic for both the person and for their families and carers, with high demands on the level, type and consistency of care provided by families and carers.
- Families may expect a quick fix for the person and take time to adjust to the fact that this is a long term process.
- Families frequently find themselves going from one service to another.

All or some of these common characteristics of a person with unstable mental health and substance use may impact at various times on family and community values and lifestyles:

- chaotic life
- may not cooperate with their health care providers or families
- may be non-compliant or erratic with medication
- emotionally labile

- may have disturbed sleep patterns
- may have psychotic episodes including aggressive or violent behaviour
- may be homeless, or else moving frequently from one place of residence to another
- likely to relapse (drug use)
- repeated long-term hospitalised/ institutionalised or taken to casualty departments
- nicotine dependency
- poor physical health
- broken relationships
- debt
- in trouble with the law.

Seeking treatment and support:

- Families initially seek a 'quick' fix for the person with mental health and substance use issues. It takes time to adjust to the fact that these issues are usually long-term and that improvements come in small steps, often with retrograde as well as progressive steps.
- Families can find themselves going from one service to another as the person is passed between mental health, drug and alcohol and other services.
- People with mental health comorbidity respond well to an integrated approach towards mental health and substance use. Services that take this approach are limited, although recent policy initiatives at Federal and State levels have encouraged improvements in the integration of services.

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## Slide 17: CRASH- Compassion - Impact of caring for people with mental illness and substance use issues



**CRASH - Compassion**

*Impact of caring for people with mental illness and substance use issues*

A SANE Australia (2007) study on the effects of caring for someone with a mental illness found that:

- 56% stated their physical and mental health was worse
- 72% received no rehabilitation or community support
- 70% received no training or education
- 54% had no access to carer support services

*Most do not feel supported...*

This slide outlines the results of a research on the effects of caring for someone with mental illness.

People who have a caring consistent 'other' supporting them do better in treatment and experience better health outcomes in the long term. In 2007, SANE Australia identified the challenges faced by the families and carers of those with mental illness or substance use issues. The statistics above indicate some of the burden that falls on families and carers.

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### **Keys points made by families and carers**

Results of a study by SANE Australia (2007): points made by families and carers

#### *State of physical and mental health*

56% of respondents identified:

- frustration and anger due to lack of consultation from professionals
- being disregarded and excluded from treatment planning
- feeling alienated in their community.

#### *Rehabilitation or community support*

- 72% did not receive any
- 50% have trouble finding accommodation for those with mental illness
- 50% have experienced verbal aggression
- 25% have experienced physical aggression.

#### *Training or education about mental health/substance use*

- 70% never received any.

#### *Accessing support services*

- 54% did not access any support
- 32% used the internet to find information
- 5% used telephone support.

#### *Summary of findings*

- Families and carers report a range of health, financial and other problems when caring for the mentally ill.
- Families remain unsupported and isolated.

- There is an expectation from mental health professionals for families to provide the day-to-day care without being provided with support or the information to carry out this role.
- Majority of families struggle alone without help or support.
- Almost 75% receive no education or training on how to care for someone affected by mental illness.
- Families and carers urgently need practical day-to-day support.
- Families and carers want respect from mental health professionals and inclusion in treatment planning and programs.

### **Additional information**

An Australian study (Treloar et al 2005) reviewed more than 100 written accounts of personal experiences, mainly drawn from Family Drug Support (FDS) and the Australian and Illicit Drug Users League (AIVL) and printed in the records of national conferences and newsletters. The focus was on people who use illicit drugs, many of whom also had mental health issues. These stories were coded into broad categories and analysed according to main themes.

#### ***Main themes from an examination of available family and user written stories***

**Demographics:** The experiences show that dependent drug use can happen to anyone, irrespective of education, economic status, employment or locality.

**Family Types:** The families of drug users in these stories could be grouped into three broad categories: those who did not want to know, those who helped and those who wanted to help but did not know how.

**Hitting Rock Bottom:** Families had a strong aversion to agencies waiting until a substance user reaches rock bottom before offering treatment. 'She hit rock bottom alright, but now she's dead and what can you do once you're dead?'

**Treatment Episodes:** After the initial hope and search for a quick fix, families become resigned to view treatment as a 'long and bumpy journey' but encourage others 'not give up on your kids'.

**Family Support:** Families would go to considerable lengths to help, even to the extent of providing funds or even procuring drugs for their child.

**Treatment works:** Families had mixed views on whether 'treatment works'. This however, could reflect their earlier search for a 'quick fix'.

**Inclusion in Treatment:** On the whole families felt excluded from treatment, although individual service providers and counsellors were found to be useful.

**Substance user contact with family members:** Whether or not users with problematic drug use were actually living with their parents, those included in this sample were closely tied with their families. Users regularly or periodically made contact with a family member.

**Eligibility:** There were many examples of users and their families experiencing knock backs when seeking treatment. For example, users were turned away because they were too young, didn't look like an addict, their dole cheque was too low to cover costs or because they also had mental health problems.

**Treatment staff and treatment philosophies:** In general there were two types – those who sought to empower and those who sought to straighten and punish the user.

**Inappropriate treatments:** There were many examples (e.g. an 18 year old girl placed in a detoxification service with middle aged male dependent drinkers).

**Social stigma:** Widely encountered (e.g. 'we live in a country town so everyone knows her and her addiction. We have to put up with the glares, gossips, police, courts and the embarrassment to us all in our family')

**A plea for normalisation:** As a society, we need to look closely at our values regarding those who need our help and try not to judge them'.

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## Slide 18: CRASH- Compassion - The burden of caring

**CRASH - Compassion**

*The burden of caring*

- Fear
- Loss of trust
- Alienation
- Broken relationships
- Financial losses
- Grief and loss
- Conflict and violence
- Declining health and wellbeing

*Will this journey ever end?*

Families and carers are often left on their own to carry many burdens. There is a general lack of understanding, much less empathy, from others in society. Contrast the differences in acceptance, services and support infrastructure between families and carers of someone with a chronic disease (cancer, diabetes, asthma) versus those with substance use and/or mental health issues.

### Key points

The level of stress experienced by families/carers is high. Stressors include:

- **Fear:** the family/carer fears for the safety of the person and sometimes for their own safety.
- **Loss of trust:** trust with the family member/carer may never be fully re-established. Other aspects of trust are also affected.
  - Trust of self: 'am I able to make the right decision or do the right thing?'
  - Am I trustworthy: 'am I manipulative, do I spy on the user, do I collude with other family members/carers and so on?'
- **Alienation:** left unsupported, families and carers feel as though they are the only one travelling this journey. They feel that no one can possibly understand, and shame and stigma play a big part in enforcing this isolation and helplessness. Normal greeting rituals among family and friends and the exchange of news about family members/carers become something to avoid.
- **Relationships:** relationships between family members/carers may be strained because of the person's behaviour. Differences of opinion between partners about the best way to manage situations are common.
- **Financial losses:** from a monetary perspective, families and carers carry most of the burden that would otherwise have fallen on government and services. In extreme cases, they have exhausted all their resources and are in danger of relying on welfare for their existence.
- **Grief and loss:** families and carers grieve for the loss of the person they knew before the onset of mental health and substance use problems. Society, through a lack of understanding and driven by negative stereotypes, often condemns those who have mental health and substance use problems. Negative statements such as the following are hurtful but not uncommon, compounding family grief:
  - 'Let him go, he's not worth worrying about!'
  - 'Why are you destroying yourself trying to save her?'
  - 'Aren't they better off dead?'

- 'She's old. Too late to do anything. It's not worth bothering about it.'
  - Conflict and violence: conflict, physical abuse and ongoing emotional abuse are realities when dealing with people with mental health and substance use issues. For many families and carers, these are not isolated instances but are part of an ongoing cycle of abuse.
  - Declining well-being: self-esteem/worth erodes away. The lack of self-care also begins to take its toll spiritually, emotionally and physically as exhaustion increases.
- 

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## Slide 19: CRASH- Compassion - A confusing world

**CRASH - Compassion**

*A confusing world*

- Restrictive policies
- Mixed messages
- Segregated services
- Lack of services for mental health and substance use comorbidities
- Bewildering array of treatment options
- Significant shortage of support services for families and carers

*What is myth and what is real?*

There is a bewildering and conflicting array of messages about mental health and substance use. Finding the right services to support the person being cared for is yet another area ripe for confusion.

### Key points

Barriers include:

- restrictive service policies and protocols about access to treatment
- mixed messages from everywhere - about suitability of treatment options
- segregated services - lack of integration of services is frustrating and inefficient; for example, the person and their family or carer often have to tell their 'story' many times over
- lack of services for mental health and substance use comorbidities
- bewildering array of treatment options
- significant shortage of support services for families and carers.

### Additional information

**Service provision:** the quality and availability of services ranges from poor to excellent. Some locations/areas have very few options to choose from, while others have more. Rural areas generally have limited resources on offer, and services specifically for people with mental health and substance use comorbidities may be hard to find. In some places, services are simply non-existent.

**Integration of services:** until recently, drug and alcohol services and mental health units were separate entities (this is still the case in many areas). For families and carers dealing with mental health comorbidity with drug use, they were shunted from one to the other repeatedly. Many services are now moving to embrace multidisciplinary team approaches and integration of services – but this will take time.

Terms families will hear through media, government policy, treatment services, friends and others include:

1. Harm minimisation: harm minimisation/reduction has been National Drug Policy since its introduction in 1984. It encompasses supply reduction, demand reduction, and harm reduction. It includes abstinence as part of its many strategies. It is also associated with a

primary emphasis on maximum social, occupational and emotional functioning, rather than on an absence of substance use alone. Simply, it is about keeping people safe.

2. Tough love: a 'throw them out until they reach rock bottom' strategy. Unfortunately, for some, rock bottom can mean suicide or death from substance use. Tough love may fragment the family structure – it may not be possible to unite the family again or regain trust and connectedness with the person with mental health and substance use issues.
3. War on drugs: strategies focused on abstinence and getting rid of drugs in society. Those who use drugs or who support a person who is a drug user may be seen as 'the enemy'.
4. 'Just say no': popular as a preventive measure in school education, especially in the US. There is no evidence to show that using this strategy works. However, the primary message to should always be that it is better not to use drugs.
5. Pharmacotherapy: there are a number of different treatments available for treating substance use. Families and carers need to be aware of the realities of these treatment options, and the support that a person will need to access and remain in treatment. Some pharmacotherapies are offered through general practice and others are offered through specialist services.
6. Psychological strategies: brief intervention, motivational interviewing, counselling and cognitive behavioural treatment.
7. Self-help: 12 step programs, alcoholics anonymous (AA), narcotics anonymous (NA), websites etc.

Evidence-based treatment options that families and carers will hear about:

1. Detoxification: withdrawal from substance use. Options include medically or non-medically assisted, and with or without supervision. Detox can take place at home or through inpatient or outpatient services.
2. Rehabilitation: long- or short-term, inpatient or outpatient. Most rehabilitation services are abstinence based with many following the 12-step program.
3. Abstinence based: 12-step programs including Alcoholics Anonymous (AA) and narcotics anonymous (NA) models.
4. Pharmacotherapy: e.g. methadone/buprenorphine/suboxone treatment programs for illicit drug use.
5. Prescribed medication: prescribed by a GP or specialist to relieve symptoms or effects of mental health and substance use.
6. Psychiatry: management through a psychiatrist of mental health problems – usually includes medication.
7. Psychology services and counselling: counselling through a clinical psychologist, drug and alcohol counsellor or other mental health services.

Support for families and carers:

General practitioners, government and non-government agencies provide support. There are a handful of formal support services for families and carers of people with mental health and substance use – these include:

- Lifeline
- Inspire Foundation
- SANE
- Family Drug Support
- Carers Association.

For details, refer to the resource list.

Generally, greater family and carer support is offered through mental health services than through alcohol and drug services.

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## Slide 20: CRASH- Compassion - Shame, stigma, guilt and blame

**CRASH - Compassion**  
*Shame, stigma, guilt and blame*

- Families and carers are influenced at four levels:
  - Personal
  - Interpersonal
  - Organisational (institutional) and
  - Societal
- Shame, guilt and blame result from community and societal/cultural stigma surrounding mental health & substance use.

*It must be me... who can I trust?*

When mental health and substance use issues are present, families and carers are pulled in many negative directions.

<b>Shame</b>	How could this happen in my family?
<b>Stigma</b>	I feel judged by others for these problems
<b>Blame</b>	Others blame me and I blame others (police, government, their friends etc)
<b>Guilt</b>	Is it something I did or didn't do?

### Key points

Shame, stigma, blame and guilt can come from many sources. A number of values are associated with these and may be influenced at several levels (adapted from Winnett et al 1989):

- *Personal*: "it must be my fault" - Health and illness are primarily a result of personal lifestyle and actions.
- *Interpersonal*: "it must be the parents" - health and illness is influenced by family, friends, work colleagues and other social groups.
- *Organisational/institutional*: "young people's use of ice is causing violence in our neighbourhoods" - health and illness is influenced by organisational factors and by the environment.
- *Societal*: "we don't want people like her on our streets", "methadone clinics are full of dealers" - health and illness and access to treatment is influenced by community norms.

Some cultures view mental illness with stigma and shame.

Seeking help can also be fraught with negative attitudes:

- *Judgmental*: usually from people who don't understand or are fearful - that it is somehow contagious.
- *Confidentiality*: Can people be trusted?
- *Bias*: this is encountered everywhere. Even people who are highly educated and should know better can have surprisingly biased views when it comes to drug and mental health issues.

### Additional information

*Inappropriate advice and guilt* - People who are judgmental are prone to give inappropriate or untimely advice that can lead to negative consequences. In times of chaos and desperation,

families and carers may act on advice that they really did not want and ultimately cannot live with. In the end, families and carers can end up with more guilt as they attempt to live up to someone else's standards and expectations.

*Families and carers do the best they can* - They generally do the best they can, with the knowledge and experience they have at the time and according to their particular circumstance.

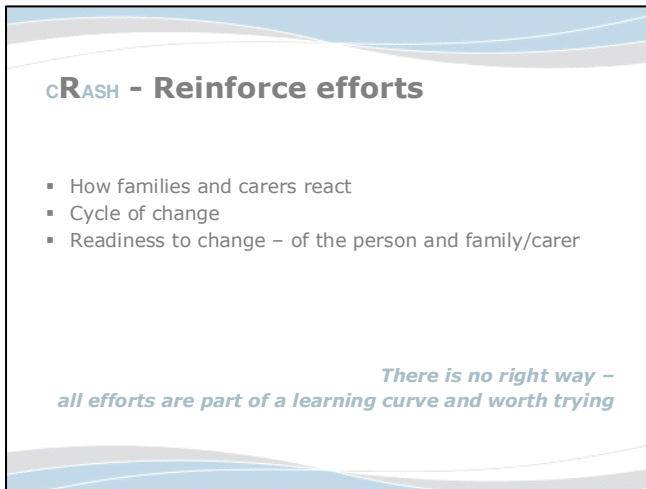
*Isolation and helplessness* - With negative attitudes coming from others felt by the carer, along with negative consequences of reaching out for help, families and carers may withdraw from seeking the very support they need.

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## Slide 21: cRASH - Reinforce efforts



This slide and subsequent slides address the issues related to reinforcing the efforts of families and carers.

In order to support and encourage families and carers it is important to reinforce that the efforts they have made so far were not useless and that how they have reacted to and changed because of the mental health and substance use issues of the user is normal.

These points will be discussed in detail in the next slides.

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### Key points

A positive, practical attitude can make all the difference to supporting someone with a mental illness or substance use, and also to help the carers look after themselves too.

It is important to inform carers that developing a positive attitude involves:

- Coming to terms with the fact that someone they care for has a mental illness.
- Developing a sense of balance in all aspects of being a carer.
- Preparing themselves to be a capable and well informed carer.

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### Additional information

Coming to terms means understanding and dealing with the psychological and emotional effects of caring for someone who has a mental illness and uses substances. It is essential to realize that neither the person with the illness, nor the carer, is to blame and that they are not alone.

Distress about the illness may have caused other emotional reactions such as grief, anger, guilt or shame in other family members/carers. Acknowledging these reactions is a first step to resolving them. It is important to understand too, that people affected by mental illness and substance use cannot deal with it simply by 'pulling themselves together' and that long-term treatment and support are often necessary. Distinguish between the person and the effects of the illness and/or substances. For example, someone with depression spending all day in bed is not lazy but probably affected by symptoms and in need of treatment and support to deal with this.

Developing a sense of balance: supporting someone who has a mental illness or uses substances is helped by balancing a realistic understanding of how the illness has affected the person, with a hopeful determination to help them achieve as great a level of recovery and independence as

possible. It is important to encourage carers to talk to the treating health professionals or staff at support organisations for advice on how to do this.

A balanced attitude means:

- *A balance of expectation:* sometimes we expect too much of someone, sometimes too little. Try to adjust expectations to the person's capabilities at the time.
- *A balance of help:* sometimes we try to do too much for someone, sometimes we do too little. Try to be involved at a level that is in the best interest of the person being cared for and that is fair to the carer and others around them.
- *A balance of emotion:* sometimes we are over-emotional, sometimes we withdraw emotionally. Try to show concern in a caring and matter-of-fact way, avoiding being over-emotional or unemotional.
- *A balance of time:* sometimes we may give someone too much time, sometimes we may have too little time for them. Try to share time between the person who has a mental illness or uses substances and other family and friends. Make sure the carer takes time specifically for themselves as well.
- *A balance of activity:* sometimes we may give the person too much to do, sometimes we leave them too little. Try to encourage a level of stimulating, healthy activity that is realistic, and at times that suit everyone.

Preparing themselves means understanding some of the basic principals of being a carer, as well as learning as much as possible to help themselves, especially about what support services are available for family and other carers.

- *Realistic expectations:* it is essential to accept the person as they are now and to have sensible expectations of what can be achieved and how long it may take. They may also need encouragement to make realistic plans for work or study. Try setting modest, concrete goals at first to work toward this. These goals should be practical as well as positive, acknowledging the need to reduce stress and avoid taking on too much – for example, by working part-time or by taking study courses one at a time instead of all at once.
- *The need for stability:* often it is only when the symptoms – such as persistent feelings of hopelessness or delusional thinking, for example – are controlled, that the person can begin to focus on the everyday things in life. Once these acute symptoms are being managed as well as possible, the carer will then be able to offer effective support more easily. In other words, the person needs to be receiving and cooperating with the treatment they are prescribed.
- *Encouragement of responsibility:* mental illness can have a serious effect on how people feel about themselves – their sense of self-esteem and responsibility. Encourage the person to accept responsibility towards themselves and others as much as possible. Development of personal responsibility, with the dignity and respect this brings, is an important aim of being a carer.
- *Learning about mental illness and substance use, treatments and support:* learn as much as possible about mental illness and substance use. Find out, too, about treatments and what clinical and disability support services operate in the area. Understand and accept that symptoms may come and go, may vary in severity, and that different degrees of support may be needed at different times. Encourage people to contact a carer support organisation for information and advice as soon as they find themselves in a caring situation.
- *Deciding what can and can't be done:* decide what level of care and support carers are realistically able to provide. It is important to then explain this to the person being cared for and any other health professionals or support organisations involved. The support that the carer is unable to provide should then be arranged in collaboration with the case

manager, for example. Encourage the carer to talk to the person with the mental illness about the support and care arrangements and go over any decisions with them. Discuss options for the future with the carer and individual, as well as any other health professionals, family members and friends, to plan for situations when the carer may be unable to fulfil their role.

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## Slide 22: cRASH - Reinforce efforts: How do families and carers react?

**cRASH - Reinforce efforts**  
**How do families and carers react?**

**Families and carers generally fall into 3 categories:**

1. Active
  - do care
  - active in seeking help – highly motivated
2. Challenged
  - do care but don't know how
3. Uninvolved
  - don't care or don't need to
  - negative over involvement

*Some do,  
some want to,  
some don't care to*

Families and carers fall into three categories in terms of how they react to the person with mental health and substance use issues. They may be actively involved in supporting the person, challenged by the behaviours and unsure how to offer support, or uninvolved and distanced from the person. Within a family, individual members may differ in their choice and ability to offer support. It is important to acknowledge these differences and to accept that generally there are no 'right or wrong' approaches.

### Key points

- *Active:* families and carers are generally supportive and involved. They are highly likely to have good communication skills and actively seek to engage with the person and treatment and support services. There is a higher level of self-awareness, willingness to change, and they are generally well-educated and articulate.
- *Challenged:* families and carers do want to be supportive and involved but are up against barriers when seeking ways to support the individual with mental health and substance use issues. This may include language and cultural differences. Often, the level of exhaustion centred around coping with mental health and substance use problems in the family restricts motivation and ability to problem solve. Once these barriers can be overcome, they become 'active'.
- *Uninvolved:* families and carers, for a variety of reasons, do not engage with or are alienated from the individual. Some may be emotionally and/or physically disconnected from the person because of the mental health and substance use problems. Others do care but are negatively connected through enmeshment and over-involvement. They work to defined agendas and high expectations, and see no reason for needing external help. Control may lead to 'either/or' situations in which the person is excluded from support until they conform to parental or family requirements. This may drive the patient away from the family, either temporarily or permanently.

Families and carers in the first two categories are also more likely to be involved in seeking support for themselves and to accessing support services that may assist both the family member/carer and the user.

## Slide 23: cRASH - Reinforce efforts: Cycle of change for families and carers

**cRASH - Reinforce efforts**  
*Cycle of change*

Families and carers move through various emotional stages in the cycle of change

- Denial
- Reaction
- Control
- Chaos
- Acceptance

*Around and around we go...again*

Families and carers move through various emotional stages in the cycle of change, ranging from denial, reaction, control, chaos to acceptance. They will present at different stages of the cycle of change (which may also be different points from where the client is in the cycle of change).

The 'stages of change' model (Prochaska & DiClemente, 1986) is widely referred to when working with people with mental health and substance use. It is used to gauge a person's readiness for change of their drug use and identify where he or she is in the 'cycle of use'. This model is discussed in unit one of 'Can Do' for Young People, Families and Carers. See [www.agpncando.com](http://www.agpncando.com)

### Key points

There are five stages which families and carers go through when confronted with mental health and substance use issues in the family:

1. Denial
2. Reaction
3. Control
4. Chaos and confusion
5. Acceptance.

It is important to note that acceptance is not the same as approving or condoning. It is a matter of facing the reality of mental health and substance use but it doesn't mean families and carers have to like the situation. Families often get stuck in the first four stages of the cycle, becoming repeatedly more exhausted and reducing opportunities for positive support for the individual. Families need help themselves if they are to move into acceptance of the person's mental health and substance use issues, and health professionals and support groups play an important role in supporting families and carers to reach this stage.

### Additional information

The following information expand on the five stages of the cycle.

Stage 1: Denial

- Don't want to know or are not ready to face reality.

- Only hear what they want to hear (self-deluded), e.g. finding injecting equipment and accepting the person's explanation that it belonged to a diabetic friend.
- Little to no awareness and knowledge about mental health and substance use.
- Denial/minimisation can have both beneficial and negative effects:
  - Beneficial: gives positive expectations, avoids stigma and keeps the family/carer in the mainstream.
  - Negative: avoidance of treatment, cause the family to blame the person's "bad" behaviour, or leads to excessive demands being placed on the individual (e.g. to return to university).
- Families/carers in this stage are often beginning to isolate from society and other family members (disengagement).
- Families/carers can often re-enter denial. They might have had some initial success and feel their problems are over only to find them repeated.

#### Stage 2: Reaction

- Feeling shame and judged by others.
- Feeling emotionally 'all over the place' – a sense of being out of control and powerless.
- Feeling negative emotions range from guilt, uncontrolled anger, anxiety, fear, great sadness through to grief.
- Feeling stressed and torn in many directions.
- Looking to blame – government, police, dealers, their partner, their friends, etc.

#### Stage 3: Control

- Adopting a rigid black or white stance.
- Ordering, confronting, and issuing ultimatums.
- Becoming judgmental and hard-lined with unrealistic expectations and hidden agendas.
- Expecting others to re-build trust but unable to trust or work towards re-establishing trust.
- Controlling, rescuing, and generally being overly-involved.
- Blaming and constantly looking for scapegoats.

#### Stage 4: Chaos and confused

- Physical and emotional exhaustion – having been around this cycle many times.
- Confidence and self-esteem at an all time low – feeling incompetent and powerless.
- Poor communication.
- Relationships with other family members and other relationships falling apart.
- Failing to set boundaries and feeling compromised.
- Tired of keeping the peace, making sure everyone is happy and generally being the meat in the sandwich (particularly true of mothers).
- Unable to put up with the lies, manipulation, and sometimes abuse, and having to cover up and clean up.
- Feeling alone and unsupported.
- Feelings of panic and that everything is in a mess.

#### Stage 5: Acceptance

It is important to note that acceptance is not the same as approving or condoning. It is a matter of facing the reality of mental health and substance use, but it doesn't mean families and carers have to like the situation. With help, family members can come to accept and understand that:

- There is no 'quick fix'.
- Mental health and substance use are chronic relapsing conditions.
- Improvements in mental health and substance use require small steps at a time over a long time.
- Change occurs when the person is ready.
- Implementing change can be influenced by support from the family or carer.

- Professional support is available and affordable.
- There are strategies for coping and health professionals and support groups can help with these.
- It is important to look after themselves as well as the person.

Acceptance is difficult to achieve if the family or carer tries to 'go it alone'. Failure to reach this stage results in the families and carers repeating the first four stages of the cycle and becoming increasingly confused and exhausted. There is a direct effect of this on their own mental and physical health.

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## Slide 24: cRASH – Reinforce efforts: Readiness to change

**cRASH - Reinforce efforts**

*Readiness to change*

- Families and carers will present at different stages of the cycle of change
- Families and carers may be at different points of the cycle of change from the individual
- Assess the readiness to change of both the person and the family and carers
- Discuss ways to deal with these differences

*Ask: What have you already tried and how has it worked?*

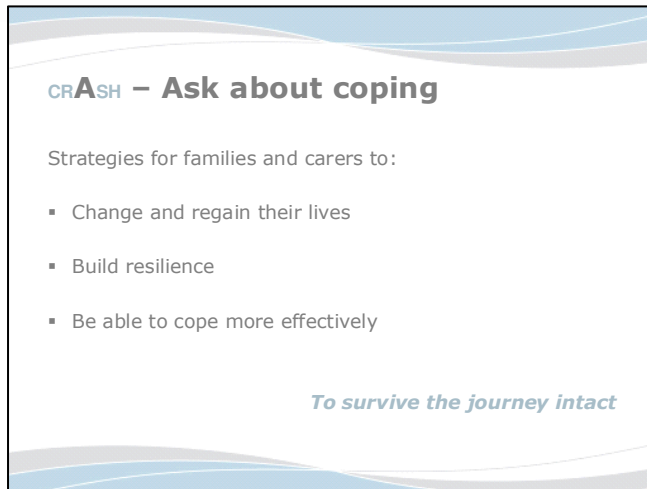
Families and carers can continue to go round and round in the cycle of denial, emotion, control and chaos. As they repeat these negative and draining stages, isolation and helplessness increases and exhaustion becomes a reality. Moving forward into acceptance of the current situation and finding ways to look after themselves is an important step and one that can be influenced by health and community service providers.

### Key points

- It is important to discover where in the cycle of change the family or carer is at, so that you can assess their readiness to change.
- Stages of change in the individual and in family members/carers may not be synchronised (e.g. a wife may be ready for action for the husband while the husband may be in a pre-contemplative stage).
- Families and carers commonly move through five stages in their cycle of change: denial, reaction, control, chaos/confusion and acceptance. Many families take years to reach the stage of acceptance and become stuck in a repetitive cycle of the first four stages – making both solutions for the person and moving forward with their own lives difficult.

Handout 4 provides some tips for how to communicate with a person who is using substances. It also includes a table which maps the different stages of both the person and the family or carer and the thoughts, feelings and actions that are associated with each stage.

## Slide 25: **CRASH** – Ask about coping



**CRASH** – Ask about coping

Strategies for families and carers to:

- Change and regain their lives
- Build resilience
- Be able to cope more effectively

*To survive the journey intact*

It is important for families and carers to have options that build on hope and towards success. Despair and defeat are not the only outcomes. However, it takes hard work between health professionals, families, carers and support services and a willingness to change towards the positive.

In the next few slides we will discuss some strategies to help families and carers cope effectively.

## Slide 26: CRASH – Ask about coping: strategies for families and carers



**CRASH – Ask about coping**  
*Strategies for families and carers*

Change and regain their lives by:

- Valuing self
- Nurturing interest and relationships
- Maintaining an outside life

Build resilience through:

- Regular support
- Building self-esteem
- Information

This slide addresses strategies for families and carers to change, care for themselves, build resilience and regain their lives.

### Key points

Encourage families and carers to change and regain their lives by:

- valuing themselves
- nurturing interests and relationships
- maintaining an outside life – activities and friends
- looking after themselves physically, emotionally, and spiritually
- allowing themselves to take time out and care for themselves
- having short, medium, and long-term goals that have nothing to do with the drug user and a commitment to work towards them
- treating themselves on a regular basis
- rekindling lost interests and discovering new ones
- reconnecting with family and friends who have fallen by the wayside.

All of the above are integral parts of valuing oneself. It affirms that families and carers are important and have personal value and means that whatever happens, they will survive with purpose and meaning in life.

By surrounding themselves with the following, families and carers can begin to work on strategies towards resilience and success:

- Education: becoming more knowledgeable on about mental health, drugs and drug issues – helps to reduce stigma and empower the families/carers.
- Support:
  - Reaching out and getting regular support (professionals, telephone and support groups).
  - Sharing collective wisdom and experience with others.
  - Seeking support through financial and practical schemes like Centrelink carer financial support schemes, local Carer Respite Service funds and Respite Services themselves.
- Developing self-awareness and self care: building self-esteem/worth by engaging with professionals/courses, etc.

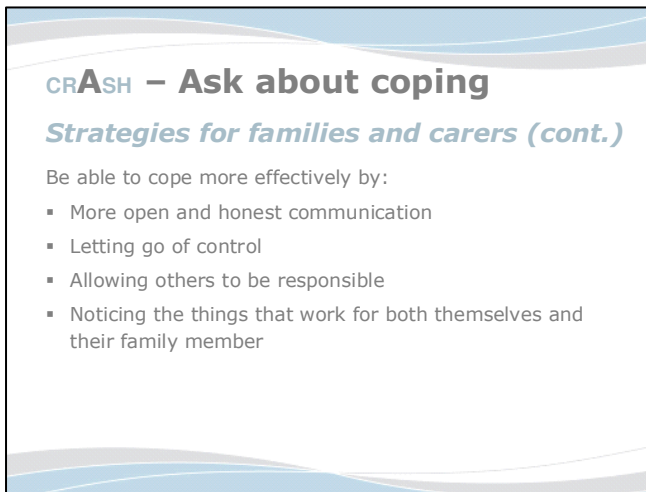
- Learning new tools: better communication and problem solving skills to communicate with other family members, health professionals, and the person with mental health and substance use issues.

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## Slide 27: CRASH – Ask about coping: Strategies for families and carers (cont.)



**CRASH – Ask about coping**  
*Strategies for families and carers (cont.)*

Be able to cope more effectively by:

- More open and honest communication
- Letting go of control
- Allowing others to be responsible
- Noticing the things that work for both themselves and their family member

This slide addresses other strategies for families and carers.

### Key points

Be better able to cope, by:

- accepting that change is inevitable and there is a choice of whether it is positive or negative
- recognising that change can only be achieved through hard work, perseverance and pain
- becoming more self-aware of own patterns of behaviour and reactions
- working towards more open and honest communication - not only the drug user
- loving and supporting more and needing to be controlling and directive less
- working on being less over-responsible and needing to 'fix' things less
- allowing others to be responsible for his or her own actions and choices
- allowing others to help and moving from working alone towards working with others
- learning to celebrates life's success no matter how trivial they may seem at the time
- dealing with anger and other negative emotions in healthier ways
- being able to have less but workable boundaries
- letting go of expectation and hidden agendas but not love and hope.
- engaging with professionals.

### Additional information

*Re-evaluating the definition of success:* universally, families and carers would like their loved ones to be drug-free and to have control over their own mental health issues. As the journey continues, this expectation causes immense frustration and pain – again, it is about letting go of expectations. It is being realistic about what is achievable as opposed to what is ideal.

Most families and carers come to realise that they can't make anyone change or stop using drugs. The drug user is capable of stopping when they decide to do so. It can be a very difficult and long process, and to expect too much and too soon can be unrealistic and painful.

As difficult as it is for families and carers, they may have to take a more objective view of where their family member is in their process and learn to accept it. For some groups of drug users,

families and carers have to settle for simple harm reduction strategies – clean needles, safer use, reduced use, less chaos, less crime and other negatives. It doesn't mean they have to like it. Redefining and realigning their definition of success with that of the drug user can provide much relief.

*Strengthening families and carers:* - The more families and carers strengthen themselves by adopting the above strategies, the more options they have for staying connected and being supportive of the person they are caring for. Although they can't directly make them stop, families and carers can provide the most positive environment for change when and if the drug user decides to do so.

Success for families and carers is about becoming more resilient, being better able to cope, and managing to survive the chaos and the journey intact.

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**Reference:**

- Chang, T. (2006). Handbook: a guide for family group support meeting facilitators. Unpublished.
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## Slide 28: CRA<sub>SH</sub> – Services and support

**CRA<sub>SH</sub> – Services and support**

- Self-help services
- Telephone support services
- Respite care
- Life skills programs
- Carer support programs
- Websites and information

*Making it meaningful and workable*

Mental health and substance use affects families and carers. This slide addresses the need of families and carers to have information and support.

There are a number of programs that support and assist carers. Mostly these are services specifically for carers of people with a mental illness, for carers of people with a disability and for carers of older people. There are few services for families and carers of people with substance use issues and even fewer that focus particularly on families who care for a person with both mental health and substance use issues. General practitioners and other service providers should be aware of the services for the specific population groups that are available locally, state wide and delivered through national programs.

### Key Points

Families and carers should be provided with information and support.

- Information about the needs of the population group.
- Information about self help services and telephone support services, as *self-help services provide contact and support*: talking to other families and carers about their experiences can be a good way to relieve stress and to feel connected to others; it's a way to share information about looking after themselves and about the person they care for; self-help groups also often offer education and information sessions.
- *Telephone support services provide instant and anonymous support*: a limited number of services provide 24-hour phone lines that offer general support for families and carers, counselling services and information about local mental health and substance use services.
- *Respite care gives carers a break*: planned respite gives carers a break and provides them with opportunities to pursue or pick up other activities and interests. Respite care can be provided in an emergency – for example, if the carer has to be away unexpectedly or goes to hospital. It can also be planned at regular intervals or provided in the home. Respite care is rarely sought by families and carers of people with mental health and substance use issues. 'Respite' tends to occur when a person enters detox or a residential rehabilitation program for substance use treatment or hospital for inpatient care for mental health stabilisation.
- *Life skills for people with mental illness*: psychiatric disability rehabilitation and support services, such as day programs and home based outreach assist people with mental illness to develop social and living skills. Life skills programs tend to be offered to those with severe

mental health disability where life skills are limited. Group therapy programs are offered through mental health services. Life skills and group therapy programs in this instance help to provide stability and independence. Carers get a break while the person attends these programs.

- *Carer Support Programs:* in some States, carers of clients in the public mental health system are eligible to apply for assistance through the Carer Support Program. The program provides flexible funding to enable highly individualised support.
- Web sites and other information.

Use the mapping exercise at the end of this workshop to map your local support services and circulate to participants.

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### **Additional information**

Relevant information about CALD individuals with substance use and mental health issues:

- Providing information about the risks that can be associated with drug and/or alcohol use: it is important that younger and older individuals (particularly parents of adolescents) are educated about drug and alcohol issues.
- Addressing some of the social determinants of drug and/or alcohol use: two significant risk factors are the lack of connectedness to the community and strained family relationships. Therefore, initiatives to improve people's sense of connectedness are important, as well as assisting with interpersonal relationships e.g. strategies to improve the family dynamic as whole such as practical assistance with employment, housing, education and family therapy.
- Harm minimisation strategies are advised, although information may need to be provided as to its use, as some cultures may believe this is condoning behaviours.
- These strategies will also assist in preventing mental health problems.

Issues for CALD parents related to managing their children/adolescents in Australia:

- Some CALD parents struggle when their children behave in a manner that would have been inappropriate in their own home country, but which is acceptable and normal in Australia. Parents can find it difficult if their children expect greater freedom than they would have been allowed in their home country. They can be over-protective and anxious about their children's safety, or place unrealistic expectations on their children to succeed at school.
- Some parents get very overwhelmed about what is going on in their families. Many parents' high anxiety levels are related to their child/children's behaviour. If the CALD parent's children are spending a lot of time outside the home parents may feel that they are losing control. Also, difficulties can arise if children start to become more outspoken at home. These issues can cause significant intergenerational conflict.

Relevant information about the rural family:

- Stress in rural areas affects family relationships. The impact of drought may mean that partners & children are required to become more involved in farming tasks.
- Men in rural areas may not present for help with mental health & substance use issues – instead, another member of the family might present (e.g. wife or parents).
- Isolation may mean that even greater pressure is placed on the family & that safety concerns are greater in cases of domestic violence.
- Long-term unemployment may be a risk factor for family breakdown, due to loss of morale & increased social isolation.
- Making sure children have an opportunity to talk, & helping them to discuss what is going on for them can prevent them from feeling isolated/left out. Maintaining usual family routines, as much as possible, can also help children to feel safe & secure.

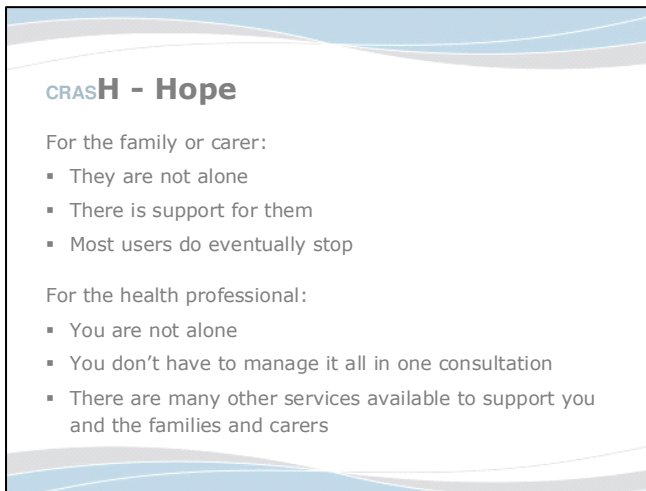
- Anger (e.g. towards the urban population or government) and domestic violence may become issues as a result of the stressors experienced by men in rural areas. The role of the practitioner is to express concern, listen, counsel, refer to appropriate agencies & consider safety.

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## Slide 29: CRAS<sup>H</sup> - Hope

A rectangular box with a light blue and grey wavy header and footer. The text inside is as follows:

**CRAS<sup>H</sup> - Hope**

For the family or carer:

- They are not alone
- There is support for them
- Most users do eventually stop

For the health professional:

- You are not alone
- You don't have to manage it all in one consultation
- There are many other services available to support you and the families and carers

This slide emphasises the importance of maintaining a sense of hope for both the family or carer, and the health professional. It is important for people to leave discussions on a positive note and with information on where they can go to help.

---

### Key points

For the family or carer:

- They are not alone.
- There is support for them.
- Most users do eventually stop.

For the health professional:

- You are not alone.
- You don't have to manage it all in one consultation.
- There are many other services available to support you and the families and carers.

The purpose of these workshops is to enable local services to network, share information and develop effective pathways of care between their services. This allows professionals to work better together for better outcomes for the person and their families and carers. You will now be given the opportunity to do this through the case discussion and service mapping.

---

## Slide 30: Story vignettes and case discussion – story A

**Story vignette A - Mary**

1. What do you think are the important issues here for Mary?
2. How do you think she is coping?
3. If Mary was telling you this story, how would you engage with her?
4. What role might the general practitioner play in supporting Mary?
5. What professionals, services might also be able to assist Mary?

*"Some days I just want to pack my bags and go. I'm so tired and worn out. I have two young kids, and they have both had terrible asthma. They've had lots of admissions to the local hospital, and they're on all sorts of puffers. My mother lives with us and she used to be able to help, but she is getting frail and doesn't remember things so well now.*

*Then there's my husband, Joe – he's been impossible. He had a job as a storeman, but lost it six months ago. The drought has had been really bad for the town, there aren't as many jobs any more. Then he went and got injured on the footy field - he hurt his neck and shoulder, so he couldn't work even if there was a job, and he always has pain.*

*He gets into these black moods, with the pain and everything. He uses weed for the pain and he's drinking.*

*I'm so tired and stressed - I can't look after him and the kids, and be expected to look for work. I worry about the money all the time. I went to Centrelink and that's keeping us going, but I don't know for how long. I want to do a budget, but Joe isn't interested. I told him we can't afford the dope or the grog any more. He just argues whenever I mention it. The other day he really scared me, he'd been drinking and said he thought we'd be better off if he just drove into a tree. I don't know what to do any more."*

---

### Points for Discussion

1. What do you think are the important issues here for Mary?
2. How do you think she is coping?
3. If Mary was telling you this story, how would you engage with her?
4. What role might the general practitioner play in supporting Mary?
5. What professionals, services might also be able to assist Mary?

---

### Story vignette - feedback session:

- The points for discussion are to trigger group discussion
- Use the whiteboard to write up main ideas
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.

- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone
- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic

**Facilitator's notes**

- Explore the issues that Mary raises including her health, her families' health and the substance use mentioned in the story.
- Encourage participants to unpack the many issues that are raised and to prioritise these into primary and secondary issues.
- Make sure that participants explore ways to engage with Mary and to obtain further information relevant to the issues raised.
- Explore ways in which clear information about mental health conditions and substance use can be provided to Mary.
- Explore the role that health and community services, especially general practitioners, can play in including Joe and potentially other family members in improving this family's health and wellbeing..
- Discuss how participants would assess Mary's own state of health and wellbeing.
- How can services improve communication and assistance for families like this? What opportunities are there to keep Mary in the loop?
- What support groups, help lines and resources are there that you could refer Mary to?

## Slide 31: Story vignettes and case discussion – story B

### Story vignette B - Lee

1. What are the key issues for Lee?
2. What does the story tell you about Lee and his family?
3. If Lee was telling you his story, how would you engage with him?
4. How might the stigma of mental illness affect Lee and his family?
5. What support and assistance might help Lee?
6. What services might become involved in assisting Lee and his family?

*"I am so grateful to be in Australia. When we first arrived from Cambodia we had to stay in a refugee camp for 2 years. That was very hard, as we were still dealing with the disappearance of my father. As the oldest son it was my responsibility to take care of my mother, brother and sisters. I have a job and a wife now.*

*My mother died two year ago. That was hard on all of us because we had been through such a lot. My younger brother, Sok, took it really hard, and he started getting into the wrong crowd. This was very bad. He is using too many drugs now and he has been in trouble with the law. He even stole from my sisters and me. It is so hard - I try and help him and he gets angry. But I have to keep trying – it is my duty.*

*I am very worried about him. He would get very angry and call me bad names when he was on the drugs, but now he is saying someone is giving him bad drugs and is spying on him. What if his head has been affected by the drugs? I don't know what to do."*

---

### Points for Discussion

1. What are the key issues for Lee?
2. What does the story tell you about Lee and his family?
3. If Lee was telling you his story, how would you engage with him?
4. How might the stigma of mental illness affect Lee and his family?
5. What support and assistance might help Lee?
6. What services might become involved in assisting Lee and his family?

---

### Story vignette - feedback session:

- The points for discussion are to trigger group discussion.
- Use the whiteboard to write up main ideas.
- The facilitator's notes below are to direct discussion and prompt further exploration of important issues.
- Ensure only one participant speaks at a time and is heard by the entire group. Be aware of who is speaking and who is not.
- Invite participation from everyone.

- Reflect, and if necessary, rephrase the participant's comment to link its relevance to the topic.

**Facilitator's notes**

- Ask participants to explore the family's immigrant status – and the difference this may make to care and support for Lee and his family.
- Discuss how participants would assess Lee's own state of health and wellbeing
- How can Lee move forward with his own life, while still remaining connected with his family?
- What advice would participants provide to Lee to assist him in supporting his brother with his mental health and drug use?
- How can services improve communication and assistance for families like this?
- Explore the supports that Lee can access – include his family, family support groups, telephone line options.

## Slide 32: Accessing local services

**Accessing local services**

- Names, location
- Service philosophy *Knowing what is available and what works*
- Service programs
- Inclusive of families and carers?
- Opening hours
- Inclusion/exclusion criteria
- Referral process
- Contact telephone numbers/emergency contact
- Cost
- Waiting lists

This slide is intended as a prompt for the networking/service mapping part of the unit.

- Refer to the dot points as a way of facilitating discussion on the resources and services available in the local area that may be useful to families and carers of the particular population groups addressed in this series of units.
- It is important to map key services on the white board or to scribe information. Be as precise as possible and include contact phone numbers and key information.
- Where possible, include other agencies and services such as non Government Organisations and community or Council programs.
- Ask participants for consent to circulate the information provided to all participants
- Following the workshop, ensure the coordinator circulates a copy of this information to all participants.

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### Key points

- What services are available in the local area?
    - names, locations
    - philosophies
    - programs, services provided
    - inclusive of families and carers?
    - opening hours
    - inclusion/exclusion criteria
    - referral process
    - contact details
    - cost
    - waiting lists.
  - What agencies have attendees worked with successfully?
  - Do attendees have any other tips to share about working with services for families and carers of these population groups?
-

### **Additional information**

Facilitators may revisit the two stories discussed and 'map' the services identified so that participants are aware of the service location, referral procedures, opening hours, contact numbers, and other relevant information.

#### Personal Helpers and Mentors (PHAM) Program

- Has been funded at \$284.8 million over 5 years, for approximately 900 full-time equivalent Personal Helpers and Mentors from May 2007.
- The role of the Personal Helper and Mentor can be broadly described under three main types of activities:
  1. Direct involvement: including needs assessments, developing Individual Recovery Plans and linking with clinical case management, advocacy, peer support, personal development, supporting family relationships, mediation and supporting people to manage their daily activities.
  2. Referrals to relevant services: including to housing support, employment and education assistance, drug and alcohol rehabilitation, independent living skills programs, clinical services and allied and other mental health services as required.
  3. Monitoring and reporting (non face to face): including monitoring participant referrals, monitoring progress against Individual Recovery Plans and reporting.

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Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. (2007). Personal Helpers and Mentors (PHAM). Retrieved 8 April, 2008 from [http://www.facsia.gov.au/internet/facsinternet.nsf/mentalhealth/phm\\_faq.htm](http://www.facsia.gov.au/internet/facsinternet.nsf/mentalhealth/phm_faq.htm)

## Slide 33: In summary

**In summary**

- Meeting the needs of the person and their families and carers
- Including families and carers
- Utilising other services
- Creating partnerships
- Identifying roles and responsibilities
- Encouraging professional collaboration
- Establishing workable procedures for realistic and sensible referral

*What will you do differently now?  
(Please take a minute to complete your evaluations)*

### In summary:

- Meeting the needs of carers and families of different population groups – including young mothers, rural men, CALD individuals, older people and veterans – with mental health and substance use problems.
- Families and carers are an important resource and needing assistance and support.
- Creating partnerships, encouraging collaboration and appropriate referral.

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### Key points

This slide provides an opportunity to ask the question, “What will you do differently?” (as a result of knowledge and information received at the training sessions), and to answer any questions arising from the information covered.

Also ask participants to complete unit evaluation forms, and hand out the information packs if not already done.

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