COPMIA PROJECT EVALUATION

Report for SF Taranaki

Diane Doehring and Lynne Holdem

3D Evaluation, PO Box 8238, New Plymouth, 4342

Summary.

Recent years have seen an increased awareness of the risks that children of parents with mental illness or addiction (COPMIA) face. While there are a range of services that support children and parents in Taranaki, none of them are specifically focused on the challenges that COPMIA face.

SF Taranaki has undertaken this project to identify a sustainable means of meeting this need. Following a period of community consultation and research into existing programmes (both New Zealand based and international) it was established that interventions need to focus on fostering resilience, reducing self-blame and stigma for the children and resourcing their parents to improve or maintain attachment, social engagement and learn skills for dealing with stress, anxiety and problem-solving.

It was decided to pilot a structured group programme. The programme was run twice, with evaluation and adjustments made after the first programme.

Five children attended each programme. Three families attended the first programme and five attended the second. Two of the teenagers who attended the second programme had been part of the first group of children too. One young person attended without parental participation.

Children and parents were seen in separate groups, once a week. The adult programme was facilitated by a psychotherapist and a student mental health worker; the children's group was facilitated by an arts therapist and an adult who had experience of growing up in a family with mental illness.

The evaluation focused primarily on process (rather than outcome) with data being gathered from the facilitators after each session and a group evaluation at the end of the pilot. Feedback from the families was gathered from the parent group midway through the first programme and at interviews with each of families after the finish of the programme.

The following conclusions were reached

- Six weeks is too short for families to develop trust and make the changes they are seeking. 10-12 weeks would be a better model.
- Families with older children, with disorganized attachment or where the children have their own significant mental health challenges, need a more intensive intervention than the group model we used. Perhaps a mixture of family sessions and group sessions would meet this need.
- Families with significant mental health challenges do not want to attend generic "parenting classes" provided by agencies to NZ families. The challenges they face as parents need special consideration by people who understand their mental health challenges.
- Many of these families are weary of, and defended against well-meaning social services trying to "fix" them. Some families need time to build trust.

When asked about the outcomes of programme particpation, the consensus was that both adults and children found the social connection and sharing of a common experience, in a safe space, to be the aspect of the programme that they valued the most. All the of the children said that they would like to continue meeting and most of the adults felt this way too.

Most families reported instances of gains in insight and were able to make small changes in interpersonal relating and individual behavior.

The evaluation confirmed some of the existing knowledge about the stressors experienced by the COPMIA families. These include: poverty, confusing and conflicting involvement of multiple agencies, generic services that do not meet individual needs, stigma and bullying, disruption of parenting capacity and social isolation.

The need for improvement in interagency and service co-ordination and collaboration was highlighted.

For some children, a caseworker who can provide support and advocacy, in particular during periods of crisis, is indicated.

Introduction

Problem Statement

Recent years have seen a growing awareness of and focus on meeting the needs of children who live in a family with a parent who has a mental illness and/or addiction (COPMIA).

There is no well documented data on the number of children in New Zealand affected by parental mental illness or addiction but the prevalence, risks and outcomes for COPMIA in Australia are summarized thus:

> - *Up to one in five children live in families with a parent who has a mental illness.*
> - *There are various genetic, individual, family and environmental risk factors for children living in these families.*
> - *Outcomes for children vary according to factors related to a parent's mental illness as well as certain environmental protective and risk factors, related to the family, social support and community.*
> - *Healthcare workers need to acknowledge their patients' parenting roles and responsibilities and the needs of other family members, especially children.*
>
> Ruepert, Maybery & Kowalenko, (2012), p.7[1]

Starting with a stock take of services in 2012,the New Zealand Ministry of Health has been involved the development of a National Strategic Plan to meet the needs of COPMIA. This plan is aimed at developing sector wide capacity.

One element of this support, includes specialized programmes for the families with the greatest vulnerability. There are no programmes that meet this need in Taranaki.

The Project

Following the SFNZ conference in 2012, where presentations on Children Of Parents with a Mental Illness or Addiction (COPMIA) were included in the programme, Lynne Holdem of Supporting Families in Mental Illness Taranaki (SF Taranaki) started talking to colleagues and funders about the ways in which the needs of COPMIA could be met.

In 2014 S F Taranaki decided to explore how the needs of COPMIA might be met. First, it was established what was already running in other SF regions. This mainly seemed to be a support and activities groups for children. Although this is improvement on no services it was felt that offering children a group without engaging the parents in a programme of change was less likely to make a difference. Lynne Holdem undertook some research of services available in UK, Finland and US and identified some strengths in a tiered approach that recognises that different families have different needs. They have been described as follows: level one - need education and tips on how to talk to their kids about mental illness and addictions; level 2- need relationship with other whanau/families and more complex psycho-education approach

---

[1] Ruepert, A., Maybery, D., Kowalenko, N. (2012) Children whose parents have mental illness: prevalence, need and treatment. *Medical Journal of Australia* (1 Suppl 1), 7-9.

deliverable in a group setting; level3-complex needs families with disorganized attachment, behaviour problems etc need a longer term intensive therapeutic approach.

Lynne concluded that a programme that gives young people a chance to hear and discuss COPMIA issues in a small group setting along with a support group that includes therapeutic moments with their parents or caregivers could be a cost effective approach that could also be effective at improving parental understanding of their children's needs and children's ability to understand and work with their parents' difficulties, strengths and weaknesses. This would also provide an opportunity to help parents plan for times when they are mentally unwell, to focus on their strengths as parents, to connect them with wider family and other parents in similar situations to provide ongoing mutual support.

Community Consultation

Alongside researching existing models, steps were then taken consult with service users mental health providers, referral agencies and the community.

This involved:

Focus Group

In May 2014 Lynne invited a group of parents and professionals, mental health, teachers, Plunket nurses, family advisors and alcohol and drug advisors to the research room at the library where she collected responses to the plan she had been making. Feedback from this group informed the initial designs. This group felt that a non-clinical peer support community programme would have better uptake and be welcomed mental health and addiction service users.

Advisory group

A group consisting of a mental health support worker, a creative arts therapist, a community representative, an early childhood teacher, the evaluator met with Lynne. They looked at and adapted materials from existing COPMI services, other resources and designed promotional materials and service application and assessment forms.

Service Provider Workshop

A one-day workshop, facilitated by Brontë Jeffries (an honours student at Victoria University) was hosted by Tu Tama Wahine and was attended by 15 workers from family and child wellbeing and safety services. The opening discussion highlighted the fact that there are no specific services for COPMIA in Taranaki and the children and their needs remain largely invisible. Despite this, families are sometimes identified when using other services related to their needs (e.g. perinatal services, programmes aimed at children who experience family violence and poverty and the SWIS workers). It was agreed that “persistent advocacy” is required to get the recognition and support services needed by COPMIA from health, social and educational providers.

> “*They face significant disadvantages through both direct effects of illness and through associated structural violences to mental illness such as invisibility, discrimination and social exclusion. Their vulnerability is extended because they do*

not receive any support from social and mental health services."[2]

Public meetings and networking

Brontë spoke about COPMIA, her research project and the SF Taranaki pilot at a well-attended meeting held at New Waves Hall on August 20, 2014. Many people spoke personally of their attempts to support parents with a mental illness and their children and their experiences as children, both good and bad, of growing up with a parent with a mental illness. Brontë's visit also received interest from radio and print journalists.

In addition, Brontë spoke with SF Taranaki Committee members and some volunteers that had been drawn to the project.

Lynne continued to speak with people likely to refer families in mental health, education and community settings and started to explore with Mel Loft from the South Taranaki Social Sector trial (SWEET) about offering a similar service in Opunake. Lynne made some trips to speak with teachers and students Opunake High School, a Social Worker in Schools for Opunake and interested members of the community.

The Pilot

The pilot was funded by NPDC community partnership; COGS North; Lotteries Community Sector Research. Two programmes were run, one in October 2014 and one in May 2015. An interim report, prepared after the first programme, informed changes made in the second programme.

Based on international research and examples from existing programmes (see appendix) and the feedback from community consultation, the following approach was formulated.

- Details of the planned programme was provided to New Plymouth DHB, NGO schools and community services by emailing referral forms, brochures and letters for parents and also dropping of copies in order to get referrals.

- Information Brochure, "UP", was distributed to schools, community organisations, DHB services and NGOs.

- Referred families were interviewed by Lynne Holdem, psychotherapist or Tambray Tucker, mental health worker.

- Each programme ran for 6 weeks with parents in one room and children/young people in the other. Sessions lasted 1 hour approximately.

- Facilitators of the programme included: a creative art therapist, Stacy Waterson, and community representative, Tracy Flood with the children. Lynne Holdem and mental health worker with the parents. Drivers were provided to pick up and take families home.

---

[2] Jeffries, B. (2014). *Invisible Lives.* (Unpublished Research Project).

Details of the programmes:

Families were contacted and the operation of the two groups was explained. Confidentiality agreements and ethics of the evaluation process were explained. Families signed a service application form. Both parents and children were assessed for suitability for the group, an ORS rating scale was administered and goals and outcomes planned for by parents and their children. Family strengths and risks were identified and this helped inform content of the six sessions.

Families without transport had transport arranged.

In the first programme: Of the five families contacted and interviewed, one dropped out before we started, one teen had parents who lived out of town and could not attend, the other three families participated in both children and parents groups. There were six children and three mothers who participated.

In the second programme: Six families were invited into the programme. Five accepted places but only three of the parents came to the parents' group. One family declined because the mother thought her daughter's own mental health issues would make a group service too difficult for her. Two of the five families had participated in the previous programme.

Approach

The children were welcomed into a room with food and water, and beanbags to sit on. The facilitators used a talking wand to contain and focus the talk. They were warm, friendly and accommodating of the different needs of the older and young group members. The children were shown short video clips and followed this with related activities or discussions. The group usually ended with unstructured fun of some kind.

Then children were lead into the parents' room and were taken home. The approach of the arts' therapist was to allow expression of feelings and thoughts and responses to stimulus from video content but not to push for responses. The co-facilitator modeled talking and drawing about her own experience of growing up as a child of a parent with a mental illness in an age appropriate manner. Brontë's recommendation that we present materials in a speculative way was followed ("this is how some kids find this, is this right?"), rather than presenting any kind of expertise to the group.

The parents' group included some related videos and written materials such as "How to talk to your child about mental illness", handouts on empathy, circle of security information on attachment and parenting tips. The group started with a check in and evolved into peer support group that included mindfulness, parenting education and therapeutic moments dropped in appropriately. Care was taken not to judge or shame parents for their difficulties but to focus on existing strengths, small goals, practicing skills, problem solving and support seeking.

Content

Resources for the programme came from Copmi Family Focus dvd (copmi.net.au website), and from TED, YouTube, Circle of Security, headspace.org.nz and other youth, alcohol and drug, and mental health related websites.

These were interspersed in the children's programme with mindfulness exercises, games and art activities related to themes. This content was carefully assessed for suitability prior to group meetings by Lynne Holdem and was captured in Session Plans, UP group 1-6.[3]

The second programme

Based on the evaluation of the first programme, the following changes were made in the second programme:

- The programme focused on teens, with a narrower age band of 14-16 years, in order to tailor the service.
- The parents' group was smaller and more easily focused on expressed needs of families.
- The parents' group had no volunteer assistance. Staff for the teens' group remained the same.
- Similar but new content was used as two members were from the first programme and had already seen that material.
- The teens did not join the parents' group at beginning and end. The parents group was held at a different time in another space so it could happen during the day as some parents had other children that were not attending the group and needed to care for them.
- The parents' group was extended at the request of participants to 1.5 hours and there was no combined parent-child session as in the first group. Parents were emailed links to resources that were looked at or talked of in the programme whether they attended or not.
- Some teens found their own way to the group but all of them were dropped off afterwards.

Activities outside the programme – advocacy

The family/whanau worker employed by SF Taranaki, liaised with one of the mothers who did not attend the group so some integration occurred.

One mother became unwell and required intensive mental health support during the programme. Her daughter rang the programme facilitator, Lynne, for assistance. Lynne found the daughter and supplied her with a phone, went to the house to arrange for her and her younger brother to be taken to another family member's house. She also visited the mother to liaise and attended a Family Group Conference (FGC) to advocate for the daughter to stay in New Plymouth to complete her studies and for the younger son to go to live with his father in the South Island. This was a good outcome for both the son and the mother and sister.

---

[3] Copies of the session plans can be obtained through the office of SF Taranaki: manager@SFTaranaki.org.nz

The Evaluation Context and Purpose.

The project was set up by SF Taranaki to inform the design and implementation of a programme /intervention strategy for COPMIA.

The fact that project was a pilot of a new programme, with a limited number of participants and resources, meant that the most value could be gained from using a participatory, process evaluation of the programme design and implementation.

This informed the purpose of the evaluation and therefore the formulation of the following questions: (adapted from Davidson, 2005)[4]

1. How well designed and implemented was the programme?
2. What are the outcomes for the parents and children?
3. How worthwhile was it overall? Which parts generated the most valuable outcomes for time money and effort invested?
4. Was the programme needed and how well does it address the most important issues? Is it the right solution?

The Evaluation Methods

In keeping with this focus, most of the data was collected from facilitators. This included:

- Session Plans
- Session Reviews: after each session a brief written evaluation of the session was completed by facilitators
- Group review with facilitators after session 1. It was determined that this was too time consuming and sufficient information was gained form the written session reviews so this was not continued.
- A Group Focused Evaluation Discussion with facilitators after programme 1, using mini-rubics to facilitate group discussion.[5]

Information gathered from the facilitators was used to modify the programme between sessions as well as between programmes. An interim report was prepared for this purpose.

It was agreed from the outset that the evaluation process should be designed in such a way that it would impact lightly on the families. Data collection from participants was therefore restricted to:

- Notes taken during parent session 4 of programme 1(evaluator attended the session where participants were invited to reflect on the value of the programme thus far)
- Individual unstructured interviews with parents and children separately, conducted after programme completion. Interviews were conducted in a location of the participants' choice.

---

[4] Davidson, E. J. (2005). *Evaluation Methodology Basics. The nuts and bolts of sound evaluation.* Thousand Oaks,CA:Sage.

[5] Davidson, J. (2014) 'Mini-rubrics'- 7 hot tips for using this cool tool to focus evaluation conversations. http://genuineevaluation.com/minirubrics/

Data was gathered from the sources described above and stored on Evernote. A thematic analysis using Evernote tagging was performed. These were shared with the facilitators and they were invited to comment or add to the insights gained.

A draft of the final report was circulated amongst the facilitators for comment before being finalized.

Results

How well designed and implemented was the programme?

a. Composition of group

The families that attended the first programme had children in a diverse age range (6 to 14 years) and represented a group with a high level of support needs.

The facilitation of the children’s group was made more challenging by the diversity of the age range and support needs of the children involved. For example, the older boys showed a preference for some activities (rap over drawing) and chose not to participate at some points. The youngest child in the group had some difficulty with literacy so that he required support with some session material and also required extra support to stay focused and not distract the others in the group.

The composition of the group for the second programme was more homogeneous. This group appeared to form tighter social connections and reported at their post programme interview that they had continued to remain in contact through social media and visits to each other’s homes.

Learning:

The group with teenaged participants that were closer in aged was able to form and sustain support and connection outside the group, independent of the programme.

This did not occur with the younger more diverse group.

The need for consideration of the individual needs of participants was highlighted by the difficulty experienced by one member of the first group.

It is possible that some parent-child dyads require some other support/intervention before participating in a group of this sort.

b. Time: Length and timing of groups

The groups ran for 6 sessions, of one hour each.

In the first programme where the children were younger, parent and children’s groups were held at the same time, but in adjacent rooms with one instance when the two groups joined to share information on what the children had been discussing about mental illness.

The parent group expressed the need for longer sessions, while the children's group tended to end a little before the hour was up (when attention was lost). While some mothers were in favour of the groups being held at separate times (so that their session could be longer and uninterrupted), one mother stated that it was an example of an activity that she felt able to share with her son (in a supported way).

During one session, the parent and children's groups were combined and each child was invited to share their experience. It was determined that this exercise would have been more useful if the parents had been prepared more for their child's messages and supported in their response to what their child brought. It was also agreed that this exercise requires sensitivity and privacy so that families do not feel exposed and would be better facilitated outside the group context.

In the second programme the parents and teenagers met on different days.

Attendance for the parent group was more inconsistent than the first group as two mothers were dealing with significant mental unwellness themselves, and the third mother has two adult sons with severe mental illness and could not always attend. The parent and teen groups were on the same day but parents group was held at midday and teen group at 5pm.

The suggestion that participation by parents be made compulsory was considered but rejected.

All of the parents and teenagers in the second programme indicated that they would have liked longer sessions. They felt that it took a while to reconnect with each other and then felt that they ran out of time for everyone to be heard.

Learning

Appropriate length and timing of sessions depends on a number of individual variables.

All the adults and teenagers wanted longer sessions to have time to explore topics in depth and have time to share their experiences (at least 1 ½ hour).

The amount and nature of content to be covered requires careful planning.

Some information (specific to individual parent-child dyads) is best shared outside the group context.

c. Session structure and group facilitation

For the parents, the facilitators intentionally provided a context and culture that was strength and solution focused, countering stigma and promoted empowerment rather than reliance on "services" or experts".

A flexible approach was adopted. Sessions were allowed to depart from the planned structure so that the content that the members brought and the interactions with the children that were observed, were used as "teachable moments" to cover some of the planned content and topics. It was felt that there was potential in the greater use of this strategy in making the content more relevant and meaningful to participants, meeting them "in the moment".

For the children's group, the structure of sessions was determined by the session plans developed by Lynne. Techniques for management of the group evolved as the facilitators made use of the experience of the previous sessions.

Learning

Adopting a flexible approach with the parent group enabled participants' immediate concerns and needs to be met. This requires a high level of skill in group facilitation and a thorough theoretical knowledge of the needs and issues of the group and how that might best be met.

The children's group worked best when following a structured plan with routines and strategies for behaviour management. The second facilitator was essential with this group.

d. Session content and focus

When asked what content they recalled or found useful, almost all the particpants found it difficult to name specific content without giving it some thought. They all talked about the benefit of the opportunity to share with others who have a common experience.

Parents:
The primary benefit for the adult group appeared to come from the opportunity to explore a shared experience and the mutual support that the group members were able to provide for each other.

Themes that emerged from the issues that the group members identified themselves:

- Limited resources – the struggle with limited material resources (poverty), perceived limited ability to cope, lack of connectedness with community and family
- Need for support with parenting – including a perceived lack of skill, difficulty with dealing specific situations or behaviours
- Stressful dealings with systems/agencies (e.g. Income Support, Health system) Feeling let down, abandoned or manipulated by social workers from other agencies and how to deal with CYFs.
- Barriers in accessing/inappropriateness of needed services or support (e.g. Respite)
- Bullying
- Stigma experienced by parents and how to dis-identify from it.
- Desire to have fathers/male role models in the lives of their children (all the participants were mothers)
- Difficulties experienced in shared custody.
- Anger of teens and how to manage it without emotionally escalating'

Children:
The children's group was able to cover most of the planned content. Topics that seemed to have the most impact were:

- Feelings
- Bullying – identified by all children and parents as an issue
- Mindfulness- able to be practiced and used in subsequent sessions.

While the group was attentive during the session on mental illness some members chose not share their experience or to participate in all the activities. Reasons for this were not clear. The facilitators felt that this topic could have been explored in more depth, given more time.

Teenagers:
The teenagers all recalled the session on the "teenage brain". Other areas that they reported that they found useful included:

- Information about substance abuse
- Knowing that other families "have issues" too : "we are all crazy".
- The feeling of "normality" they gained from sharing their experience.

Several of the particpants reported that they benefited from the individual conversations that they had with an adult during the car rides on the way home. This raises the potential for the use of adult mentors.

Learning

The opportunity to share a common experience was the most highly valued aspect of the groups for all participants.

There are some common themes/content that is of interest and use across participants.

Consideration needs to be given to what families bring as being important at that point in time.

Some issues/topics require more time to be explored in more depth.

What are the outcomes for the parents and children?

Outcome measurement was not a primary focus of this evaluation. However, participants were asked what, if any benefits/learnings had remained with them three months after the end of the programme.

They reported the following:

- One parent felt there were no changes. She felt the programme was not long enough for this to happen. Her expectation for the programme was that it would change the behaviour of her child in relation to her ("more helpful and understanding"). She did not remember any specific content of sessions but enjoyed the video clips and would have liked to be able to look them up on the Internet to look at them again. She did report that she felt "calmer" since attending the group but was not sure whether this was due to medication, individual therapy or the group.
- One parent said that she realized, "this isn't about me! ": She reported that she was learning to think about her children's experience/feelings and to try to ask how they are and to listen to them.
- One parent felt she did not benefit from the group as much as she might have, because she was unwell during that time. She felt that the main benefit has been for her child: it was a group context that he was well supported and accepted in; he enjoyed the sessions and looked forward to attending again. This mother recalled the video on depression and felt this helped her and her son to understand her "bad days". They had not talked about it but she felt he was able to recognize that "she is not happy today".
- While only one younger child remembered details relating to the content of the sessions (the activity on bullying), they all reported that they had enjoyed attending the group and meeting other children with similar experiences. One child said, "It's good for kids to feel they don't have to hide stuff anymore." The younger children had good recall for the activities, rather than the content.
- The teenagers most valued the social connection that was established and were able to maintain some of those connections after the group ended.

- Some parents noticed that their children “looked happier after the group”, were more tolerant and understanding of other family members or managed “their anger a bit better” for a while.

Learning

For all of the families, the primary benefit of the groups (adult and child) was about the experience of a place of safety, acceptance, non-judgement and the social connection for both adults and children.

Bullying and inclusion at school is an issue for all of the children.

A six-week programme is too short to see lasting change.

Families with older children with disorganized attachment or where the children have their own significant mental health challenges need a more intensive intervention than the group model used. Perhaps a mixture of family sessions and group sessions would be of benefit.

Families with significant mental health challenges do not want to attend generic "parenting classes" provided by agencies to NZ families. The challenges they face as parents need special consideration by people who understand mental health, their family's unique needs and not one size fits all models of intervention.

Many of families are weary of, and defended against well meaning social services trying to "fix" them. They need time to build trust.

How worthwhile was it overall? Which parts generated the most valuable outcomes for time money and effort invested?

Families were unable to recall much of the content of the programmes. A few families reported some small changes in insight or short-term changes.

Both participants and facilitators agreed that lasting changes would need a longer period of engagement. For some of the families it was thought that parenting coaching and therapy with individuals or families on their own would be worthwhile.

There was unanimous agreement that the most beneficial aspect of the programme was the mutual support participants got from meeting other COPMIA families. With this in mind, it was concluded that offering an ongoing COPMIA Support Group would meet this need.

If the group continues with a different focus the skill mix of facilitators could be changed. The parents’ group was facilitated by a psychotherapist and a volunteer, mental health student. The children and teen groups were facilitated by an arts therapist and volunteer (with lived experience as a child and parent with mental illness).

The use of highly paid therapists raises a question of sustainability for the groups. When considering the aspects of the groups that proved most valued by the participants it is suggested that the skill mix could be changed from skills in psychotherapy to the following:

- Adult group: skills in group facilitation with knowledge of mental health, attachment theory and parenting skills.

- Child/Teen group - skills in facilitating groups of children, teenagers and/or adults with the aid of psycho-educational programme such as the one that was used in this evaluation.
- The child /teen group benefited from having a skilled volunteer alongside the facilitator while the adult group did not need a second person.

This would retain the most valued component (support) and make the group more sustainable and accessible to others.

Was the programme needed and how well does it address the most important issues? Is it the right solution?

The families that participated in the pilot had a range of unmet needs. The content of the programme had the potential to be of use to all of the families.

However, for some of the families there were other related events or factors (such as individual mental health or un-wellness, school exclusion or CYF involvement) that effected attendance and reduced resilience and therefore ability to benefit.

The facilitator was able to step outside the programme and provide support and advocacy in some of these instances. This highlights the complexity of challenges faced by the most vulnerable families and the need for inter-agency co-ordination, collaboration as well as advocacy and support to access available services.

Given the complexity of the needs of COPMIA families, it was concluded that the programme has the potential to meet some of the needs of families while embedded in a broader menu of services.

Discussion

Information gathered from both groups confirmed some of the existing knowledge about the stressors experienced by the COPMIA families. These include: poverty, confusing and conflicting involvement of multiple agencies, generic services that do not meet individual needs, stigma and bullying, disruption of parenting capacity and isolation.

Families talked about their frustration with and experience of failure with existing programmes and services. It is evident that each family has unique strengths and needs. Where those needs are complex or longstanding it became clear that that family centered, individualized and joined-up interagency approaches are required to offer effective support and/or make meaningful, lasting changes.

There is a risk where an intervention or programme, does not meet the needs of the family, the family will be seen as deficient rather than the limitations of the programme being acknowledged.

Possiblities for meeting the needs of COPMIA families are beginning to emerge. This includes capacity building in mental health services to increase their ability to identify and respond to COPMIA families, exploration of ways of partnering and working with parents and children (seperately and together), investigating the most appropriate content and models of service delivery, including the possible value of partnering with other services that work the same families (such maternal mental health, schools, Work and Income and CYF).

The Ministry of Health's *Supporting Parents Health Children,* a guideline for the mental health sector makes the point that, "A whole-family, strengths-based approach that is informed by the service user and involves well-integrated services appears to be the most effective form of intervention." In addition it identifies the need for specialized evidenced based programmes.[6]

Based on the experience gained during this pilot, the existing research[7] and consideration of the Ministry of Health COPMIA guidelines, options that SF Taranaki might be able to faciliate the delivery of (alone or in collaboration with other services) :

- Hold a resource of material to assist parents to talk to their children about mental health and addition issues and age appropriate resources for children about mental health and addiction issues.
- A psycho-educational programme similar to the one evaluated in this project, deliverable over 10 to 12 weeks, in a group setting for both parents and children.
- For families with complex, high needs, a longer-term intensive therapeutic approach is needed. This could include:
  - Referral to an intervention that focused on attachment e.g. adaptation of Circle of Security assessment and treatment group.
  - Referral to intensive child focused programmes such as the Stand Family Therapy Service.
- Regular peer support groups for parents, children and teenagers, facilitated by a COPMIA worker.
- Intensive service facilitation and advocacy for families with complex needs or when in crisis, provided by a COPMIA worker

This raises the issue of affordability, cost effectiveness and sustainability of services. Not all of the options on the "service menu" listed above can be offered by SF Taranaki. However, it can play a role in assiting families to access appropriate existing services and also play a role in advoacting for the deveopment of new services.

By first identifying the potential and limitations of what is able to be offered, and at the same time acknowledging what is needed but not being offered, it is possible to enter a transparent and empowering partnership with families to approach funders and providers.

Conclusion

The needs of COPMIA are complex and meeting those needs requires cross sector, multi-level interventions.

In undertaking to develop a strategy to address those needs, SF Taranaki is well placed as a community based, consumer driven organisation to provide ongoing advocacy and innovation to identify sustainable and effective interventions.

---

[6] Ministry of Health. 2015. Supporting Parents, Healthy Children. Wellington: Ministry of Health. http://www.health.govt.nz/publication/supporting-parents-healthy-children

[7] Gladstone B., et al (2011) Children's experiences of parental mental illness: a literature review. Early Intervention in Psychiatry.5, 271 -289

At this point in the project, with the results of this evaluation, as SF Taranaki is faced with the challenge of considering how to create something that is both sustainable and useful to the children and their families, it is appropriate to ask: Is SF Taranaki best placed to establish a service for families and children, advocate for those services to be provided or try to build community amongst isolated families and individuals? Or should it be endeavouring to do all three?

Acknowledgments:

Thanks to:

The families, for their participation in this evaluation.

The group facilitators Lynne Holdem, Stacy Waterson, Tracy Flood and Tambray Tucker.

Bruce Woodhead and Ian Humphries, for the venue where the groups were held.

Shirley Vickery and Catherine Heaven from Supporting Families in Mental Illness as well as Lynne Holdem and Tracy Flood for providing transport for the families.

Appendix 1

Links to resources consulted in the development of the programme:

https://www.mja.com.au/journal/2013/199/3/intervention-programs-children-whose-parents-have-mental-illness-review

https://www.mja.com.au/journal/2013/199/3/family-matters-infants-toddlers-and-preschoolers-parents-affected-mental-illness

http://www.copmi.net.au/kids-teens-young-adults/teens/what-you-need-to-know-teens.html

http://fampod.org/file.php/1/collaborations/Finland_The_Effective_Child_and_Family_Programme.pdf

http://www.werrycentre.org.nz/site_resources/library/Training_and_Events/COPMIA/20121004_COPMIA_Forum_Presentation.pdf

http://www.strong-kids.eu/rpool/resources/restricted/KS_Module_1_Lets_Talk_about_Children_eng.pdf

http://tampub.uta.fi/bitstream/handle/10024/81786/gradu04456.pdf?sequence=1

http://www.gresham.ac.uk/lectures-and-events/the-impact-of-parental-mental-health-on-children

http://www.bouverie.org.au

http://www.midlandmentalhealthnetwork.co.nz/file/About-Us-page/Summits/debbi-tohill.pdf