CHILDREN OF PARENTS WITH A MENTAL ILLNESS: SYSTEMS CHANGE IN AUSTRALIA REPORT

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This report was commissioned by the Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA) regarding Children of Parents with a Mental Illness. The report is based on consultations with a wide range of organisations and individuals in the Australian states and territories and nationally between June and September 2008. Grateful thanks are expressed to all contributors for sharing their time, experiences and ideas. Inputs from the National Children of Parents with a Mental Illness (COPMI) Reference Group are also acknowledged. The views expressed in the report are those of the author and not necessarily of AICAFMHA or any other individual or organisation.

CONTENTS

EXECUTIVE SUMMARY

The 1993 Australian report, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin, Guilfoyle & Hall, 1993) highlighted the impact of mental illness on Australian families and children.

Historically, various services for children of parents with a mental illness or 'copmi' were provided by government and non-government and consumer/carer organisations and groups in the Australian states and territories. From the 1990s, data about the extent of mental illness and impact on adults and dependent children was increasingly gathered within services (Maybery, Rupert & Goodyear, 2006; Jenkins, 2004; Farrell et al., 1999) With concern growing about the numbers of dependent 'copmi', early intervention, prevention and promotion policies and programs were established, usually with non-recurrent funding.

On a national level, the Australian Infant Child Adolescent Family Mental Health Association (AICAFMHA) was established in 2000, with a commitment to representation and sharing; principles and data regarding best practice; advocacy; and collaboration with other relevant bodies in Australia and overseas (Fudge & Robinson, 2008). Australian government funding for national COPMI was provided in 2002, with the overall aim of promoting 'better mental health outcomes for children (0 - 18 years) of parents with a mental health problem or disorder' (COPMI). Several phases of funding have occurred since that time. Current funding supports the development of a flexible training package and focus on evaluation, including in regard to the efficacy of approaches for supporting 'copmi'.

Current Study

This current commissioned research study undertakes a critical analysis of 'copmi' systems change within government, non-government and consumer/carer organisations. The study involves research in various Australian states and territory jurisdictions and nationally, with the report providing details of the historical developments within various locations and also supplying comparative analysis information about different approaches utilised.

Literature searches, semi-structured interviews and focus group consultations with a wide range of stakeholders have been used, with questions asked relevant to enablers, barriers and future directions. Following taping and note taking, transcription and collating of information from focus groups, key themes in relation to enablers and barriers and systems change and sustainability and future directions were analysed.

Systems change models based on organisations using strategic and intentional change approaches or more evolutionary approaches occurring day-to-day within organisations or through interaction with others, are key aspects of the study.

Findings

After collating the data, five key themes emerged in the findings in relation to enablers, barriers and future directions. These are:

- Big Picture Context and Leadership
- Policy and Strategy
- People Culture and Management
- Structures, Systems and Processes
- Resources

The study highlights the importance of strategic approaches in building sustainability of 'copmi' services and also of fostering a positive culture which nurtures evolutionary aspects.

The first key theme regarding 'copmi' systems change as identified by various stakeholder groups across the states, territories and nationally was multi-organisational, big picture context and leadership. Specific aspects highlighted in this report regarding **Big Picture Context and Leadership** enablers, as well as barriers for change and future directions, may be summarised as follows:

Big Picture Context & Leadership: Enablers, Barriers & Future Directions

Enablers	Barriers	Future Directions
• Legal and policy interconnected contexts • Critical incidents • High level influential champions and national contexts • Historical/social issues and timing.	• Poor high level government commitment across agencies • Changing political agenda, crisis not prevention driven • Changing senior managers & little interest & support • Insufficient national/state links	• Increased international/ national and jurisdictional consistency • Systemic interconnected approaches • Centre for Excellence for research

This study shows that considering the overall context beyond a single organisation and having high level influential champions involved are very important enablers for 'copmi' change. Poor high-level cross-sector and national/state interconnections and changing political agenda or constantly-changing or disinterested managers are barriers. However, many respondents noted that there are signs of more systemic and interconnected approaches. Greater international/national/state and territory consistency related to recovery models and family-sensitive practices are present indicators for future directions.

Policy and strategy was another broad area which received widespread comments from various focus group participants and relevant enablers, barriers and future directions sub-themes are shown as follows:

Policy & Strategy: Enablers, Barriers & Future Directions

Enablers	Barriers	Future Directions
• Having high level cross-agency governance and policy or formal signatory documentation such as Memoranda of Understanding (MOU) • Developing strategic implementation plans at the state and territory level • National and jurisdictional and regionally aligned policies • Ensuring there is a clearly articulated mission/vision.	• Few cross sector policies & protocols MOU • Policy but no implementation plan & resources • State-regional links needing some local flexibility	• Cross agency protocols agreements • Early intervention, prevention, promotion policy re-badging

In terms of Policy and Strategy enablers, the importance of establishing statewide high-level cross-sector committees and jointly developed protocols or Memoranda of Agreement to support 'copmi' change is emphasised. Additionally, organisational leaders at all levels within government, non-government and consumer/carer bodies who influence the development of or are responsible for formulating a clear mission and vision aligned to centralised and regional directions, are key aspects. This is supported by the development of implementation plans with detailed strategies and clear outcomes, and with key performance indicators, funding and timelines. Similarly, policy

without organisational implementation plans or cross-sector protocols or those which were considered overly-centralised and which did not allow for local flexibility to meet specific needs were cited as barriers.

In terms of the future in regard to Policy and Strategy, many jurisdictions are beginning to establish or to re-establish high level cross-sector committees in relation to 'copmi', with clear leadership directions and terms of reference and various subcommittees

People, Culture and Management is another broad category which captures responses in relation to enablers, barriers and future directions, with sub-themes for each category indicated as follows:

People, Culture & Management: Enablers, Barriers & Future Directions

Enablers	Barriers	Future Directions
• Champions at all levels including consumers; building formal/informal alliances • Bottom-up and top-down influencing • Formal & informal alliances • Leadership commitment and reculturing • Professional learning including joint conferences, mentors and team meetings.	• Government agency 'solos; & lack of sharing • Lack of training in parenting assessment/recovery model • Frequent personnel changes & intermittent services • Over-reliance on NGOs/advocates for continuity	• Cross-agency partnerships and networks • Increased family-sensitive cross-sector and GP training • Jurisdictional and area staff networks and formalised reporting • Training of undergraduate/ postgraduate health-related workforce groups

Champions at all levels building the successful establishment of 'copmi' organisations represents a key message regarding enablers which was consistently reinforced by all stakeholder groups and across various organisations and jurisdictions. This report also highlights leaders who know how to enthuse workers and influence high level people and have the capacity to build formal and informal alliances as key drivers. This may involve senior level leaders in committees who are able to use their roles and skills to reculture and support others and to bring conflicting points of view together. Conferences and training sessions are an important part of the people capacity focus and as an enabler for 'copmi' and the involvement of consumers was noted as vitally important in many jurisdictions and across various stakeholder groups. Beyond more formalised courses as change enablers are ongoing professional learning processes for people capacity-building. Some respondents commented that this is using team meetings and other day-to-day opportunities to build the skills and knowledge of each worker.

Lack of sharing within government services and across agencies, frequent personnel changes and over-reliance of non-government and consumer/carers during resource shortages and lack of training for workers in terms of the recovery model and parenting assessment were noted as barriers.

However for the future, many respondents highlighted that they were seeing the beginnings of cross-agency partnerships and networks and greater linkages between central and area staff within jurisdictions and cross-sector training. Some involvement of general practitioners in programs and training for relevant students within their undergraduate and postgraduate courses were noted as processes in the early stages of occurrence.

Another key broad area in 'copmi' change is the establishment of relevant **Structures, Systems and Processes** focused on achieving the outcomes and key performance indicators, with enablers, barriers and future directions summarised below:

Structures, Systems & Processes: Enablers, Barriers & Future Directions

Enablers	Barriers	Future Directions
• National/state/area/team network alignment and local flexibility • Protocols within and across agencies and systematic data • Documented minutes and dissemination • Clear role statement and responsibilities • Evaluation processes.	• Few structures/policies for continuity in agency • Disconnect of Mental health with GP services • MH intake data not mandated & poor follow-up • Confidentiality rules & concerns re data sharing	• Shared positions and joined up services • Mandated intake data • Sophisticated evaluation tools use

Regarding enablers, this report indicates that many focus group participants highlighted alignment including state/territory policies and implementation plans and establishing structures such as statewide cross-sector advisory committees, with support provided by a funded statewide coordinator. Some states have also provided funds for area-based 'copmi' staff and increasingly there are considerations about dual roles involving combinations such as 'copmi' and drug and alcohol or 'copmi' and parenting. Area leaders have generally established their own area based cross-sector committees which are focused on the state planning directions but also on local area initiatives, with some funding resources available for these activities. Clear role statements, protocols for working across services in relation to adult mental health intake data and identifying dependent children and their needs and processes for documenting and disseminating minutes, were specific enablers noted. Evaluation and data collection were recognised by some respondents as key enablers.

However, the disconnection between mental health services and general practitioners was also recognised as a barrier, as well as lack of structures, policies and mandated mental health intake data collection. Confidentiality rules preventing data sharing across agencies was another barrier noted by various stakeholders in their responses.

In terms of future directions and structures, systems and processes, a range of services such as child protection, education, drug and alcohol, perinatal, nursing, police, disabilities, housing, general practitioners are increasingly identified by various stakeholders across jurisdictions as being involved in 'copmi'. There is some ongoing coordination and interconnected resourcing being provided.

Resources is the final category emerging from the interview and focus group consultations in terms of enablers, barriers and future directions, with the study report indicating the following aspects:

Resources: Enablers, Barriers & Future Directions

Enablers	Barriers	Future Directions
• State, area level and specialist services coordinator positions • Recurrent funding and longevity of key personnel • Funding for activities/materials.	• Child Mental Health funding focus • No funding for expenses • No funding for evaluation • Short term position funds	• Ongoing state coordinator/some regional staff position • Cross-agency interconnected resourcing

This report indicates the importance of funded positions for coordinators of 'copmi' work at the state, area-based levels and within specialist services as key enablers. State level coordinators are particularly important and some jurisdictions have now achieved this although not always as a recurrent position. Where a statewide position has not been forthcoming, there have been appointments made in some jurisdictions for area level persons or for specialist services.

Concerning barriers, most states in the past decade and currently have been providing some funding for 'copmi' state, area-based or training roles and project activities but essentially on a non-recurrent basis and some projects had little financial support for activities expenses or for evaluation.

In terms of future directions and resourcing, several jurisdictions have now secured some recurrent funding particularly for a centralised coordinator. In addition, area-based funding is increasingly provided on the basis of increased linking and formalised reporting between area and centralised 'copmi' personnel.

In this report, these themes and the associated sub-themes are linked to systems change literature concerning strategic change approaches and evolutionary approaches which are all relevant within the context of sustainability. A key message is that evolutionary and ongoing processes for change which occur through individual efforts at all levels, team and as individual organisations on a daily basis and within interactions with other organisations and groups, are an important part of change happening over time.

These evolutionary approaches can be highly influential as individual people and teams experiment on a daily basis within their work, sharing new ideas with others and influencing networks and organisations, including those in leadership roles. Over time within the big picture context and with organisational leaders shaping particular directions, new ideas can be built into strategic change management approaches for organisations. Policies and frameworks are developed and strategic planning and processes are devised, with funding and resources for key positions provided and accountability occurring, also including the training and motivating of people to carry out new directions.

In addition to describing these future directions as highlighted by those consulted, arising from the study, the report produces one view of a 'copmi' change management and sustainability matrix. The matrix highlights the Big Picture Context and Policies, Strategies, Resources, and People aspects. Various phases of organisational change and sustainability are outlined in terms of Immature, Early Maturity, Defined, Managed and Integrated/Sustainable. The matrix is particularly relevant because it provides a mechanism for individual states and territories and organisations to identify their own progress across the various change management elements and to identify pathways forward towards ensuring 'copmi' services are sustainable in the future.

A key recommendation arising from the study is that: **The national COPMI initiative provides opportunities through collaborative workshops for documentation of 'copmi' systems change case studies reflecting differing phases within a sustainability matrix to provide support towards more ongoing and sustainable interconnections for the future within a national context.**

1. INTRODUCTION

1.1 Background to 'copmi' study

The Council of Australian Government (COAG) *National Action Plan on Mental Health 2006-2011* has been released and this includes a $1.9 billion investment in mental health reform, with funding provided across a range of different government departments (Parham, 2007). This includes funding for Children of Parents with a Mental Illness through the national body, Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA).

The recent initiatives build on policies and initiatives which have been occurring over the past two decades. Since the early 1990s, there has been an increasing awareness and concern about mental illness within Australian society, with the impact on families and particularly children increasingly highlighted. In 1993, a key report regarding mental illness, the *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin, Guilfoyle & Hall, 1993) emphasised the importance of support for families and children of mentally-ill adults. Around this time, the *National Mental Health Strategy* (1992) and *First National Mental Health Plan* (1993) were released, with a national evaluation in 1997 indicating insufficient progress in addressing the issues (Australian Government, 1997). The *Second National Mental Health Plan* (1998-2003) and *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* (2000) and associated monographs focused on the importance of promotion and early intervention, and children of parents with a mental illness were included (Fudge & Robinson, 2008a).

Throughout this time, data was released which indicated increasing concern for children with mentally-ill parents and the potential impact on their own mental health. Nationally in Australia, the estimates showed one in five adults experiencing a mental health problem in their lifetime, with around 29%-35% having dependent children (Cowling, 1999; Farrell et al., 1999). Mental health services clients with dependent children are likely to be females in their mid-thirties, with young children less than six years old, 70% of whom are living with them (Farrell et al., 1999). Over 20% of children and adolescents are living in households where at least one parent has a mental illness (Farrell et al., 1999; Victorian Government Department of Human Services, 2007).

Over one million children are affected, with about half having a significant risk of developing a mental illness themselves, which represents about three times the rate for children without a home background involving mental illness (Maybery et al., 2006; Commonwealth Department of Health and Aged Care, 2001). Post-natal depression affects between 10-15% of new mothers and insecure attachment, language delay, emotional and behavioural problems and cognitive deficits are issues for the children of these mothers (Kowalenko et al., 2000). In terms of parents with a severe mental illness, research indicates parenting skills are sometimes significantly affected and this results in increased risk of losing custody of children (Oyserman et al., 2000).

Drawing on relevant data from child welfare services in the United Kingdom, Jenkins (ed.), 2004) makes estimates of between 50-70% of notifications of at-risk children having a parent with a mental illness. Parenting centres report half of referrals are of mothers with depression and family support non-government organisations report a high proportion of referrals involving complex needs such as mental illness combined with drug and alcohol issues (Jenkins (ed.), 2004). Refugees and Aboriginal and Torres Strait Islanders (ATSI) have high rates of mental illness such as post-traumatic stress disorder/anxiety for the former group, (with little systematic data for ATSI but high anecdotal information) and this is likely to be exacerbated by economic and social disadvantage (Jenkins (ed.), 2004).

Long-term outcomes for children who come from families with mental health conditions may be high levels of depressive symptoms, conflict at home, social isolation and stigma and socio-economic issues. Emotional and behavioural difficulties, high suspension rates and low connectedness and engagement at school, substance abuse, suicide, involvement in crime, high risk of homelessness and joblessness and inconsistent contact with mentally-ill parents are other concerns (Raphael, 2000; Commonwealth Department of Health & Aged Care, 2001).

Various reports have indicated effective interventions for reducing risk and improving outcomes for 'copmi'. These include cross-agency approaches, staff training, supporting parents by further developing parenting skills and building resiliency in children and adolescents and increasing their knowledge base (Cuff & Pietsch, 1997; Cowling, 1999; Falkov, 1998).

This current study involves undertaking a critical analysis of 'copmi' systems change implemented within government and non-government organisations in Australia. A significant aspect of the research has been conducting focus groups and interviews with national and state and territory organization representatives about their responses to the challenges of providing support for children of parents with a mental illness within their organisational context, including the enablers and barriers. The report is commissioned by AICAFMHA as the national body, with details of the national scene provided in the next section of this chapter. State and territory documents and historical change aspects and national reports are then outlined in the following chapter.

1.2 The national scene

AICAFMHA and COPMI

At the national level, the Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA) was established in 2000 in response to various conferences which included participants from various backgrounds and organisations from around Australia. Conferences which reflect the progress towards the establishment of AICAFMHA include the Inaugural Child and Adolescent Mental Health Conference in Adelaide in 1995, followed by the second national conference in Melbourne in 1996 which resulted in the formation of a national steering committee. Further confirmation of directions occurred during the Plenary session and feedback at the Third National Conference held in Sydney in mid 1998, with this Plenary session being a critical milestone for the Association. Organising conferences, distributing newsletters, developing a membership base, involving consumers, establishing a website and completing nationally funded projects were key activities in developing the national association (AICAFMHA).

As a national body, in the initial phase AICAFMHA worked in partnership with other relevant groups to develop its guiding principles. A commitment to representation and sharing; principles and data regarding best practice; advocacy; and collaboration with other relevant bodies in Australia and overseas has been the focus (Fudge & Robinson, 2008).

The overall aim of the Association has been to actively promote the mental health and well being of infants, children, adolescents and their families or carers (AICAFMHA).

While there were various strategies and organisations providing support for 'copmi' around Australia, a key concern which led to the establishment of the national body was that responses were often motivated solely by individuals or groups with a passion for the area. Isolated programs and services emerged that were generally poorly funded often of a small scale, generally poorly evaluated and were rarely embedded within the broader policy or organisational framework of their host agencies (Fudge, 2002).

In 2001, the *Children of Parents Affected by a Mental Illness Scoping Project* was commissioned by the Australian Government from AICAFMHA for the purpose of systematically bringing together theoretical information, as well as identifying existing Australian programs for prevention, promotion and early intervention within the states and territories and nationally, also making recommendations for future action.

AICAFMHA was subsequently successful in obtaining funding from the Australian Government Department of Health and Ageing for the Children of Parents with a Mental Illness (COPMI) initiative in 2002. This initiative was supported by various national consumer, academic and practitioner networks including COMIC (Children of Mentally Ill Consumers), AUSIENET (Australian Network for Promotion, Prevention and Early Intervention for Mental Health) and the University of Queensland (Fudge & Robinson, 2008).

The overall aim of COPMI was 'to promote better mental health outcomes for children (0 - 18 years) of parents with a mental health problem or disorder' (COPMI).

The national COPMI initiative was established with the following objectives (Fudge & Robinson, 2008):

- Development and uptake of good practice principles and guidelines for services and people working with these children;
- Availability of appropriate resource materials for children and families and support workers; and
- Provision of high quality information to the Commonwealth Department of Health and Ageing to enhance future policy development.

Based on wide-ranging consultations and feedback, the COPMI National Consultation Group and COPMI Reference Group were established, with the *Principles and Action for Services and People Working With Children of Parents with a Mental Illness* being released in 2004. In this document, there is a focus on both systems and individual workers identifying their potential involvement in the provision of quality services. Key themes are promoting well-being and reducing risk; support for families and children; addressing grief and loss; access to information, education and decision-making; care and protection of children; partnerships and cross-agency processes; workforce development and service reorientation; and research and evaluation. Booklets, website development, and networking, (including through the COPMI e-discussion list) were other outcomes of this establishment phase (Fudge & Robinson, 2008).

In 2004, AICAFMHA received additional funding to increase awareness and uptake of the COPMI good practice principles and to support education and training, and access to the resource material. Specifically, workforce development programs, continued promotion and dissemination of outcomes and resources, and increased engagement with the media have been the focus (Fudge & Robinson, 2008).

Further funding was provided by the Australian Government from 2008 to enable national COPMI work to be continued and expanded until mid 2010. Desired outcomes for this phase are the increased availability of information for families and workers about factors and resources to enhance children's resilience and to reduce risk factors for children, also increased access to quality workforce development resources for those working with children and families. Increasing access by 'copmi' program planners and facilitators to relevant literature and evaluation methods, models and techniques and information regarding the efficacy of programs, services and approaches are other focus areas (Fudge & Robinson, in press; Fudge & Robinson, 2008).

Work being undertaken includes developing information to support, develop care plans for and explain mental illness to children in the 2-5 and 6-8 year age groups. In addition, there is a focus on developing materials in conjunction with other actions funded under the COAG *New Early Intervention Services for Parents, Children and Young People* in relation to early childhood workers, primary and high school teachers and support staff, principals and governing councils. Development of a flexible learning package to enhance workforce development, information to support program facilitators and increased accessibility to information regarding efficacy of programs and services are key areas. Another area of work in the current funding phase for 'copmi' program planners and facilitators relates to evaluation methods, models and techniques and efficacy of approaches (Fudge & Robinson, 2008; COPMI).

Consumers and Carers

Consumer and Carer inputs have been a significant aspect of Australian national mental health plans and the work of AICAFMHA, within a range of voluntary and paid positions: '*The COPMI initiative and its parent body AICAFMHA seeks to be informed through a diverse group of consumers, carers and young people that will be able to advise and inform the COPMI team on a range of issues as needed*' (COPMI).

The role of consumers and carers is stated in the *Consumer and Carer Participation Policy* (National Consumer and Carer Forum, 2004: 8) as follows:

> *This includes individual treatment plans which affect the lives of consumers and carers, through sharing of information and opinions, policy development, education and training of mental health workers, formal and informal planning, delivery, implementation and evaluation of all activities associated with the mental health sector, as well as in all processes that invest consumers and carers with legitimate decision making power.*

The Children of Mentally Ill Consumers (COMIC) network is a national organisation with international links which was established in Australia in Adelaide in 2000. COMIC and other organisations worked in partnership with AICAFMHA in securing the national COPMI initiative and funding in 2001.

The purpose of COMIC is to provide support for children of parents with a mental illness through resources provision, committee membership, supporting organisation of children's camps, policy advice, newsletters, training support, promotional activities and conference facilitation. In its advocacy role COMIC has been a contributor to mental health legislative reviews throughout many of the states and territories in Australia, with children now included in the relevant frameworks. COMIC is essentially supported by volunteers, with some grant funding and with the Mental Illness Fellowship of South Australia as their auspicing body. There are over 700 people on the contact list. The website has received over 30000 hits in its five years of existence. Building on the website, funding for virtual office technology has been granted to support the increasing demand for information, with teachers, drug and alcohol workers, social workers, nurses, justice, and health workers and organisations at the national and international level seeking help. The 'Supporting our Family' kit is available free on the net and other similar kits have been developed throughout Australia and overseas with relevant acknowledgements.

COMIC has recently become the COMIC Australia Foundation, with COMIC WA being established within the Mental Illness Fellowship of WA, thereby reflecting change processes which will now be introduced.

1.3 Systems change models

Government and non-government organisations and consumer/carer and other interest groups focused on a particular aspect of society are part of a system. Systems change cannot be precisely defined but it is about loosely connected organisations and groups, both formal and informal. The health and human services area is:

> *…composed of many interconnected systems and subsystems such as hospitals, social workers, home care providers, community service organisations and even individual families. These groups are not always directly connected to one another. For example, families and other informal caregivers are often the backbone of any care system yet many families remain remote and disengaged from the formal service systems. When we refer to the systems involved in 'systems change', we are talking about all these system levels, both formal and informal* (Kendrick, Jones, Bezanson & Petty, 2006: 3).

Systems change can be about minor or major systems components focused on policies, protocols, initiatives or workforce aspects. Change may start with individuals and interest groups, sometimes within formal organisations, then involve other groups and organisations and become more comprehensive over time. Both systematic and non-rational elements are involved. There are vested interests, attitudes and habits, so change is complex and not always entirely predictable or easy to implement (Kendrick et al., 2006).

Systems change theory highlights a range of processes which support and influence the evolution and direction setting of organisations and groups over time and these differ from one situation to another. Some models highlight the use of structured change processes while others are more evolutionary in nature.

Table 1 outlines a model comparing four change theories and their similarities and differences.

Table 1: Change theories: similarities and differences

	Systems Theory *Goals*	**Organisational Development** *People*	**Complexity** *Evolution*	**Social Worlds** *Conflict*
Broad change approach	Change is infrequent, intentional or strategic		Change is constant, evolving and cumulative	
Analytical framework	Change takes place at the level of a single organisation or group		Change occurs through interaction with other organisations or the environment	
Trigger for change	Clear goals, measurement & feedback	Overlap between individual and organisation goals	Multiple approaches and letting directions arise gradually over time	Difference of opinion
Change process	Change as goal achievement	Change as people focused process	Change as ongoing and without end	Change as conflict & synthesis into new order
Role of leader	Measurement and feedback	Participation encouragement	Interpreting emerging change	Taking strategic view of multiple agendas

(Adapted from Rydderch et al., 2004)

Table 1 shows Systems Theory and Organisational Development approaches as planned change models which are focused within the organisation or group concerned. In these models, processes include building teamwork and shared vision. Systems Theory highlights triggers for change including goal setting, feedback, and measuring the degree to which outcomes have been achieved. Organisational Development models reflect the people aspects, with building a link between personal and organisational goal directions, participatory decision-making and teamwork being significant focii (Senge, 1994; DFID, 2003).

As indicated in Table 1, Complexity Theory and Social Worlds approaches go beyond the particular organisation and focus on interactions with other groups. Change is highlighted as constant, evolutionary and to some extent, unpredictable. Multiple directions are important in Complexity Theory and conflict between ideas and directions is a key trigger for Social Worlds approaches. In these models, informal review processes and structures help those involved to make sense of what works well and areas for improvement (Rhydderch et al., 2004).

In considering change in relation to children of parents with a mental illness in Australia, current structures and operational directions reflect various influences and events. These include passionate people and alliances, state and territory funding sources, locally-based political events, the patronage of key individuals and national and local research reports.

1.4 Study aims

The aim of the study has been to undertake critical analysis of systems changes implemented within relevant organisations, jurisdictions and nationally across Australia to enhance the mental health and wellbeing outcomes of children of parents with a mental illness and their families. The research involves critical analysis of current Australian and international research regarding systems change and sustainability of 'copmi' service programs, as well as publication and promotion of comparative analysis information gained about different approaches.

1.5 Study methodology

The project was supported by the national COPMI Reference Group including representatives from academics, state-based coordinators, young carers, government department, area health services, and non-government organisations.

Reference Group committee members are listed in Appendix A.

Study methodologies included literature searches, interviews and focus group consultations with key stakeholders. Following a preliminary review of literature, a background paper was prepared including some conceptual frameworks regarding systems change, identification of national reports and some guiding questions, with feedback obtained from some members of the Reference Group. The background paper is included as Appendix B. Telephone and email communication was made with key 'copmi' contacts nationally and within each state and territory including government representatives at the central and area/regional level, non-government groups and consumer and carer organisations. A 'snowball' approach of contacting additional persons dependent on state and territory advice provided also occurred. The background paper was forwarded to research participants about three weeks prior to the agreed consultation date.

Interviews and focus group consultations in the states and territories and nationally occurred between late June and September 2008 in capital cities and in some outer metropolitan and regional locations. Most sessions were face-to-face, although this was supplemented by telephone contacts where there were availability issues. Most sessions were specially-convened, involving single agency or, where relevant, cross-agency groups. Some individual interviews were conducted but generally the research involved focus groups with three to ten people. A total of

sixty-nine people were involved in the thirty-two sessions conducted, including eleven consumers/carers; four researchers/academics; five non-government organization representatives and forty-nine government sector representatives including from central and area-based services.

Government department senior personnel with responsibility for health, adult and child mental health and child protection were interviewed; government statewide and area-based coordinators; non-government organisation leaders and training coordinators; consumer and carers. Cross-sector committee representatives from government and non-government services including police, education, perinatal, children's camps and clubs, parenting, and disabilities representatives also participated in focus groups.

A semi-structured interview approach was utilised, with a conversational approach used and with the order of questions being varied according to the situation but with all question areas covered within the interview process. Permission was sought at the commencement of the face-to-face interviews and focus groups for tape recording of the session, with written notes also documenting the information provider.

Data from each consultation session was tabulated and relevant material transcribed for each state/territory/nationally, including identification of the stakeholder group, with confidentiality assured. Additional materials provided by research participants such as training and information kits, policy documents and planning frameworks were also examined. Mapping and manual analysis of the findings by the researcher was used to determine the key themes in relation to historical events, enablers, barriers and future directions, with key themes linked to other systems change literature.

The written report presents an overview of relevant literature and the consultation findings, with a focus on highlighting participant voices from various stakeholder perspectives through the use of quotations, but with de-identification occurring to support anonymity.

Limitations of the methodology

The study occurred within limitations of time, using a preliminary literature review, interviews and focus groups and then involving further consultation with the reference group and to a stakeholder conference. While investigative processes can become expansive, this was curtailed to complete the work within the available timeline. Some government department contacts were unable to be followed through due to changes in personnel.

1.6 Report structure

There are ten chapters in the report. Chapters 1 to 2 introduce the background to the research and provide information about the national and jurisdictional contexts and to the various organisations and stakeholders involved.

In chapter 3, some models in relation to systems change are outlined and the key themes arising from the interviews and focus group consultations in this study are introduced.

The five key themes related to the consultation identification of 'copmi' systems change enablers and barriers are then outlined in detail in Chapters 4 to 8. Chapter 4 concentrates on the first theme of Big Picture Context and Leadership and introduces a series of related sub-themes. Chapter 5 is about Policy and Strategy and Chapter 6 focuses on People, Culture and Management. Structures, Systems and Processes and related sub-themes are detailed in Chapter 7 and Resources in Chapter 8.

Chapter 9 examines key themes identified in the consultations in terms of future directions for

‘copmi’ systems change. A ‘copmi’ systems change and sustainability mature matrix is outlined.

The concluding chapter links the key study themes for ‘copmi’ systems change to the wider organisational change context.

2. COPMI: NATIONAL, STATE AND TERRITORY DEVELOPMENTS

This chapter presents information from selected key national reports and policies regarding children of parents with a mental illness, as well as state and territory reports and historical and policy developments. The information is essentially based on published literature and other materials provided by the jurisdictions, with some additional details arising from participant anecdotes expressed within the consultations.

Materials in relation to national policies and states and territories include:

- policies, frameworks, publications, implementation plans and training programs produced by various government health, mental health and other departments at the state and area levels;
- non-government organisation templates, training materials and publications; and
- consumer and carer training materials and publications

2.1 National 'copmi'

The key background document relevant to children of parents with a mental illness is the *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin, Guilfoyle and Hall, 1993), which broadly highlighted mental illness and raised the issues related to its impact on young people living in households where a parent was affected. This includes asserting that: 'Australia has basically failed to provide adequate services to meet the needs of children with parents affected by mental illness' (p. 500).

In the past decade, a range of other federal government policies and plans have been produced, as well as surveys and reports by other researchers and these will now be briefly outlined.

National policies and plans (1998-current)

Some key selected national responses to issues and strategies in relation to children with parents affected by mental illness are framed within various government key policies and action plans. These include:

- *Second National Mental Health Plan: 1998-2003* (Australian Health Ministers, Canberra, 1999) focusing on the importance of promotion and early intervention including for children of parents with a mental illness
    - *Mental Health Promotion and Prevention National Action Plan* (Commonwealth Department of Health and Aged Care, 1999) focused on priority groups across lifespan and carers (including children of parents with a mental illness and priority population groups: adverse life events, rural/remote, ATSI and various cultural groups). Intended outcomes for children of mentally ill parent(s) were improved support and mental health and fewer mental health problems; better knowledge and understanding of parental illness; and improved parenting.
    - *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (Commonwealth Dept of Health and Aged Care, 2000) which highlights consumers and carers and national action and the importance of supporting children of parents with a mental disorder through implementing programs for promotion, prevention and early intervention.
    - The *National Mental Health Plan 2003-2008* adopts a population health framework, recognising the importance of mental health issues across lifespan and across diverse groups within the population. It focuses on four priority themes and 34 associated outcomes: promoting mental health and preventing mental health problems and mental illness; increasing service responsiveness; strengthening quality; fostering research, innovation and sustainability.

National surveys and reports

Apart from government policies and action plans, other selected key national reports are as follows:

- *National Survey of Mental Health and Wellbeing* (Sawyer et al., 2000) describes services used by children and young people with mental health problems, with only one in four from this group actually accessing services and with a considerable proportion of them having a parent with a mental illness. Within the various age groups where children themselves have a mental illness, the importance of family doctors/paediatricians for 4-12 year olds and school counsellors having information about the roles of various services is underlined.
- *Promoting the Mental Health of Children and Young People* (Raphael, 2000) highlights children and young peoples' mental health and variations across age groups and with particular groups, with a focus on early intervention. The discussion paper also recognises critical risk factors including identifying parents who have serious health problems such as mental illness and providing early support as a preventative measure.
- *Children of Parents Affected by a Mental Illness Scoping Project* (AICAFMHA, 2001) provides information about various support programs then operating nationally and across states and territories and focuses on the need for interagency collaboration for services to meet specific requirements and for identifying and flexibly responding to the needs of 'copmi'.

Reports regarding enablers and barriers

The AICAFMHA (2001) report summarized various recommendation areas from other Australian reports (Cuff & Pietsch, 1997; Burdekin, Guilfoyle & Hall, 1993; Cowling, 1999; Kowalenko et al., 1999, Kalucy & Thomas, 1999). The AICAFMHA (2001) report highlights interventions needed at the national, state/territory and area levels which are focused around the child, their parents and family and policy and service aspects.

Documentation regarding support for the child includes better care services including during parental hospitalisation; support from peers, school, caring adult; education about mental illness including heredity, course of the illness and stigma; developing resilience and coping skills; increased community and school based education to build tolerance about mental illness and counselling. Support programs for parents and family include planned care and respite services; validation and support with the parenting role; supportive communities to reduce social isolation and community education; family-focused mental health services; assistance and coordinated help with housing, health and vocational training; specialist services such as specialist mother-baby in-patient and day services and knowledge about mental illness. At the policy and service level area, identification of dependent children including their needs and risk levels; reorientation of services to include prevention and professional development and supervisory support for mental health workers; changing culture and attitudes of workers; coordinated and collaborative interagency service provision; involving consumers in policy development, service planning and staff training and services practices including resource allocation, were identified areas of need.

Suggested strategies identified by the AICAFMHA (2001) report included a multi-agency focus at all levels of government involving federal, state/territory and regional; project officer employment regarding local needs investigation, strategies and resources; improved resourcing to undertake health promotion and prevention activities and coordinators for service development responsibilities.

This report noted that the suggested strategies were consistent with Cowling's (1999: 44) view:

> *It was apparent that the problems arising in attempting to effectively support parents and their children are too complex and the solutions too comprehensive for any one agency or organization to address on its own. Interagency partnership and collaboration with parents and among services appeared to be one effective way to try and ensure that all children and parents feel that they are fully members of their community.*

Barriers which were cited from various literature in regard to interagency collaboration and implementation of strategies included parents wishing to self manage and fear of parenting scrutiny and loss of child custody; lack of ownership and leadership by organisations within multi-agency situations; workers' lack of experience and familiarity with such service delivery, including confusion regarding roles and responsibilities (AICAFMHA, 2001).

2.2 State and territory 'copmi' background

The information in this section is essentially based on published literature and other materials provided by the jurisdictions, with some additional details arising from the consultations.

Materials within states and territories include:

- policies, frameworks, publications, implementation plans and training programs produced by various government health, mental health and other departments at the state and area levels;
- non-government organisation templates, training materials and publications; and
- consumer and carer training materials and publications

New South Wales

New South Wales is currently collecting parental status data as part of standardised Mental Health Clinical documentation and extraction of the relevant information is planned for the future. Some currently available area-based data regarding copmi is available as part of the Critical Incident Review (2004), with Central Coast figures indicating that 78% of clients were females and 27% of them had children under the age of 5 (Howe, 2004). A recent audit of adult mental health services active clients on the Northern Sydney Central Coast showed 28% being parents of dependent children (NSW Health: Northern Sydney Central Coast, 2008).

Since the late 1980s in NSW, there have been a range of prevention, promotion and early intervention programs for children and multiple family groups to meet the needs of adult mental health consumers. From the late 1990s to 2005, NSW Health introduced many discussion papers and frameworks in relation to mental health with an orientation towards prevention, promotion and early intervention and highlighting the importance of partnerships with services and organisations for program implementation. Documentation includes: *Caring for Mental Health: A Framework for Mental Health Care in NSW*, 1998; *Framework for Child and Adolescent Mental Health Services in NSW*, 1999; *Getting in Early: A Framework for Progressing Early Intervention and Prevention in Mental Health for Young People in New South Wales; Draft Discussion Paper*, 1999; *NSW Strategy: Making Mental Health Better for Children and Adolescents,* 1999; *Young People's Health, Our Future*, 1998; *Prevention Initiatives for Child and Adolescent Mental Health: NSW Resource Document,* 1999. Some significant champions in the NSW Health Department were involved in policy development and advisory committees. They highlighted the importance of population health models and linking to international directions, with various task forces being established within a consultative and dynamic environment. Early detection of parenting problems and building parent skills and preventing abuse, neglect and negative mental health outcomes of infants and children were key areas of focus.

The establishment of MHDAO under a single Director in 2006 integrated three previously separate entities including the Centre for Mental Health, the Centre for Drug and Alcohol and the Office of Drug and Alcohol Policy. The NSW 'copmi' program was transitioned from the Prevention Unit in MHDAO to MH-Kids in 2007. Key initiatives include a resource kit for working with children and families; a publication for practitioners regarding current issues entitled the *Clinician*; and training and education of mental health and related staff to enhance their understanding of collaborative partnership approaches and issues for dependent children of parents with a mental illness and also ensuring the safety of all children. The new structure comprises Government Policy, Drug and Alcohol Clinical Program, Mental Health Clinical Program and Programs Development and Coordination.

Examining the current situation, New South Wales children from families affected by mental health are supported within the broader organisation of MH-Kids, an Area-based Unit of the Mental Health and Drug & Alcohol Office (MHDAO). MHDAO is responsible for developing, managing and coordinating NSW Health Department policy in relation to mental health services and to the prevention and management of alcohol and drug-related harm. This includes developing, implementing and monitoring strategies for transition to the mental health service development agreed within the *National Mental Health Strategy* and Australian Health Care Agreements, as well as maintaining the regulatory framework for services under the *Mental Health Act 2007* (NSW Health, 2008b).

Various documents are guiding the NSW directions. *Mental Health – Clinical Care and Prevention Model (MH-CPP Version 1.11; NSW Interagency Action Plan for Better Mental Health; NSW: A New Direction for Mental Health; NSW Community Mental Health Strategy 2007-2012: from Prevention and Early Intervention to Recovery; NSW Family and Carer Mental Health Framework; Families NSW Supporting Families Early Package; NSW Aboriginal Mental Health and Wellbeing Policy 2006-2010; NSW Health Multicultural Mental Health Plan (draft).* Specific to 'copmi' is a draft document currently undergoing finalisation after wide consultation, the *NSW Mental Health Strategic Framework for Children of Parents with a Mental Illness.* This is a statewide planning and service development framework for improving the mental health and wellbeing of children whose parents have a mental illness, their parents and families which sets out the strategic priorities and directions for the continuing development of mental health services for 'copmi' and their families. The *Framework* aims to assist Area Health Services in the continuing development of collaborative approaches, with other human services agencies involved in the process of working with the children and their families.

There has been a shift towards Area-based self-sufficiency and a merger of seventeen Area Health Services in 2005, with the establishment of eight geographical areas plus the Children's Hospital at Westmead and Justice Health and with recurrent funding which has been provided to aRea Health Services since 1996-97 continuing to provide 'copmi' positions. Area health services with local protocols are a significant part of the NSW situation, with some of them developing strategic plans associated with child protection and other aspects which are relevant to 'copmi' (CCMHS, 2006). Project officers within area health services and area child and adolescent mental health coordinators have sometimes been the unofficial 'copmi' project officers, implementing different strategies according to the priorities of the area health service. Strategies across various area health services include establishing crisis response plans during parent hospitalisation; screening children to identify environmental /genetic factors; resource kits for information about mental health issues; establishing camps and childrens' support groups and playgroups (AICAFMHA, 2001).

A collaborative network of area-based 'copmi' related people has been operational but maintaining the 'copmi' focus to provide comprehensive New South Wales services has been challenging. Issues include area-based positions not being filled, people working in isolation and without coordination within the bigger state context, and considerable variability occurring between regions of the state in regard to 'copmi' work.

Victoria

Australian Bureau of Statistics data regarding Victorian families estimates that 34, 666 children live in 18,502 families where there is assistance provided by specialist mental health services for a parent with a severe mental illness. There are 21.7% to 23.5 % of children or approximately 250,000 dependent children living in households where a parent has some form of mental illness (Maybery et al., 2005).

Historically, the Mental Health Branch of the Victorian Department of Human Services has published various documents relating to children of parents with a mental illness. This includes the guidelines document identifying relevant standards in each regional service system: *Victoria's Mental Health Services: the Framework for Service Delivery, Child and Adolescent Services* (Victorian Government Department of Health & Community Services, 1996), and subsequent papers and strategies in regard to women and people from non-English speaking background. *Victoria's Mental Health Service: The Framework for Service Delivery – Better Outcomes through Area Mental Health Services (1998*) and *Mental Health Promotion Plan 1999-2002* have also been important documents in framing directions.

In the mid 1990s there were two key projects funded by the Victorian Health Promotion Foundation, *Children of Parents Experiencing Major Mental Illness* (1993-1996) and *Building Partnerships-Interagency Collaboration to Effectively Meet the Needs of Families with Dependent Children where Parents Have a Mental Illness* (Cowling, 1997). The first was a research project (Cowling, 1996) and the *Building Partnerships* project then focused on building networks at the local level within the Southern Metropolitan region of Melbourne. These projects influenced other states (for example in Tasmania; see Farrell et al., 1999), also providing links between agencies across different localities in Victoria. The *Children And their Mentally ill ParentS* (CHAMPS) project, 1995-1997 and *Working Together* project (providing a framework for interventions and collaboration as well as peer support intervention programs for children) have been acknowledged as forming a basis for other programs and activities (Pietsch & Short, 1996). *Children of Parents with Mental Illness* (Cowling (ed.), 1999) includes contributions from various stakeholders, programs and experiences, many of whom are from Victoria.

Within the context of national policies and frameworks regarding depression and young people, in the late 1990s, the Victorian Health Promotion Foundation in collaboration with the Mental Health Branch (Department of Human Services) and Beyond Blue, funded VicChamps and PATS programs, with the former being for 5-12 year olds and the latter catering for 12-18 year olds (Paying Attention to Self: PATS). Supported by two project officers and a management committee which met each quarter, the projects were based in metropolitan east and rural north east Victoria across five regions, with Memorandum of Understanding involved and a focus on positive relationships.

Vic CHAMPS and Paying Attention to Self (PATS) programs (2002-2006 and 2003-2006 respectively) provided programs for over 1000 children and young adolescents within peer holiday camps and after school programs based on meeting local needs (Victorian Government Department of Human Services, 2007). Building knowledge about mental illness, and allowing opportunities to share issues and concerns with peers were key focii, as well as building the skills and knowledge of the mental health workforce. Data and evaluation were also important aspects of the projects. Improving self-esteem and resilience, reducing risk of homelessness, better educational achievements and less depressive symptoms were noted. Improved social connections and decreasing perceived stigma for children, as well as professional development of 2000 workers and strengthening partnerships between services and community organisations were other positive outcomes (Victorian Government Department of Human Services, 2007; Maybery, Reupert & Goodyear, 2006).

While the evaluation outcomes provided evidence of success for the various funded projects, more coordinated approaches were beginning. An interagency committee, the Parental Best Bets Committee was initiated, comprising preschool, school nursing, primary care, housing, child protection, drug and alcohol representatives, department of human services and mental health. In 2005, the Office of Children within the Victorian Department of Human Services was established. There is a Statewide Advisory Group, bringing together early years, child and family support services, child protection, juvenile justice and youth services with a focus on coordinated approaches, protocols and cross-sector joint training (Department of Human Services, 2007). Legislative support was provided by the new *Children, Youth and Families Act 2005* and *Child Wellbeing and Safety Act 2005* (Victorian Government, 2007).

The 2008-09 State Budget (through the Division of Mental Health, Drug & Mental Health Branch), has allocated additional funding to seed mental health reforms in Victoria to rebalance towards earlier intervention and support recovery within an integrated community based system. This includes a program of enhanced family support in the *Families where a Parent has a Mental Illness Strategy* (Victorian Government Department of Human Services, 2007) to include parents with drug and alcohol problems and delivery of support in partnership with Child FIRST (Child and Family Information, Referral and Support Teams) agencies. Within the *Child Wellbeing and Safety Act 2005* and *Child Youth and Families Act 2005*, the Every Child Every Chance philosophy addresses cumulative harm for children related to neglect and the importance of information sharing (State Government of Victoria, 2007).

The current focus is about early intervention and systemic approaches across the state, both bottom up and top down, working with senior managers and key stakeholders and those who have authority and leadership. There is a full-time state Families where a Parent has a Mental Illness (FaPMI) coordinator and also regionally-based FaPMI coordinators who are funded approximately half-time by the state government, with their role in seven of the twenty–two regions (at this stage) being to liaise with clinicians, identify best practice and upskill workers. They are operating within the consultation paper for mental health reform in Victoria, *Because Mental Health Matters* (2008), which is based on early intervention (early in life, early in illness, early in episode), also highlighting interconnections between mental health and drugs, child protection, criminal justice and homelessness. The approach is focused on making mental health services family focused; developing network partners through a Statewide Advisory Group (involving drug and alcohol services, education, indigenous health, General Practitioners, family and community services and mental health, child protection); also workforce capacity building with those who are involved with these families. At a system level, policies and protocols are about identifying that there are dependent children involved when parents enter the mental health system (plus ages and assessing parenting aspects). This all links to the FaPMI strategy and identifying families affected earlier and essentially changing how mental health services operate, building capacity and changing how other services operate, also strengthening networks and support. Essentially FaPMI is focused on stronger interagency networks and creative approaches to education and training including team-based, cross-sector, peer support and developing core competency modules.

FaPMI works cooperatively and complements Child First with co-location occurring, with collaboration and partnerships building sustainability. Area coordinators are meeting together and with the statewide coordinator, developing training programs which need to be implemented and sharing ideas. Each of the seven regional leaders has a local FaPMI network including government and non-government, consumers and carers. Terms of reference vary but they are about protocols, sharing ideas, and training. Top down and bottom up, there is statewide coordination and local solutions used to build sustainability.

Future directions involve formal agreements among key agencies; delivering core competency training and advanced skills training for senior clinicians and group supervisors; and consistent use of audit tools. Evaluation will involve workforce development surveys, feedback from training

programs, statewide mapping and using outcomes measures and key performance indicators.

Western Australia

Systematically-collected data regarding children of parents with a mental illness in Western Australian is not available but various specific sources provide some information. University of Western Australia data from 1980-1992 regarding the number of dependent children of mothers with schizophrenia and affective psychoses indicate 1831 adults, with 3174 children affected. Other data from previous studies shows that one third of adults with a psychotic illness had dependent or non-dependent children (Jablensky et al., 1999). A home visiting service in Midland and Albany indicated parental psychiatric illness in 31% of cases and depression in 47% of situations (South West Mental Health Services, 2002; cited in Department of Health, 2002). Care and protective order applications to the Department of Community Development showed 28.6% with a parental diagnosis involving psychiatric illness (Farate, 2001). A Western Australian Child Health Survey 2 indicated around 13% of principal caregivers and 4% of secondary caregivers being treated for mental health problems and 17% of all caregivers being hospitalized for mental health reasons (Farrell et al., 1999).

A local Western Australian survey conducted in the North Metropolitan Health Service among those diagnosed with schizophrenia indicated half of the respondents having children, with very considerable numbers of children affected when adults with depression are included in data, given that depression was seven times more prevalent (Ahern, 2000). In the Derby and Fitzroy areas, of 67 drug services clients where adult mental illness was diagnosed, over 83% had children, mostly aged between 0-10 years and with 87% of the children living with their parents (Van der Linden, 2002, cited in Department of Health, 2002). Extrapolations from ABS data suggest 18.1% of Australian adults having a mental illness and being treated through specialist services, thereby suggesting around 345,670 West Australians adults (ABS, 1997). However, this must be supplemented by data regarding patients using General Practitioner or private practitioner services for a range of mental health illnesses, with large numbers of Western Australian dependent children having a parent with a mental illness (ABS, 1997; Nicholson, 2002; Office of Mental Health WA, 2002).

Given the data about mental health prevalence and issues for children, initial concern about 'copmi' was raised during the late 1990s through informal regular meetings of interagency representatives. There were also consumer advocate networks and occasional full-day seminars involving state and interstate individuals and organisations with an interest in this area.

In 2001, funding was provided to non-government agencies through a state labor government election commitment. The Children of Parents with a Mental Illness ('copmi') project was established by the Mental Health Division of Western Australia, with an interagency group evaluating existing services, ensuring identification of vulnerable children and providing support, also improving intersectorial responses. This first committee in Phase One produced the *Pathways to Resilience* report (2002) providing a focus for action in Western Australia based on collaborative work, with the voices of families and using a strength-based approach. The overall systemic framework includes:

- Workforce development strategy for professionals involved with 'copmi' (generic training template; dissemination of best practice and facilitating and supporting district/regional integrated service delivery);
- Interagency protocols for working with 'copmi' across agencies and age groups from antenatal (including continuity of childcare/family support/respite/foster care; continuity of school placement; transition plan on parental discharge plan);
- Interagency protocol agreements for working with 'copmi' (delineating responsibilities for joint agency work; protocols with Homeswest and Centrelink to fast track family needs on admission or discharge from inpatient facilities);

- Improving data management systems statewide so 'copmi' can be identified across all age and specific population groups (recording and reviewing needs of children for each adult admission; implementing data management for primary health providers; protocol for transfer of information across agencies); and
- Identifying and supporting research (collaboration and support for research bodies for longitudinal research; formal evaluation of initiatives).

In the second phase, the 'copmi' Statewide Strategic Committee was established to build frameworks for collaborative work and develop strategies for greater responsiveness to the needs of 'copmi' around early identification and prevention.

During the third phase from early 2005, the 'copmi' Advisory Committee involved key government departments, agencies and consumers coming together regarding implementation focused on protocol frameworks for collaborative work. This committee was supported by a dedicated 'copmi' project worker through the Office of Mental Health. Other groups involve in the committee were Adult Mental Health Services, Association for Relatives and Friends of the Mentally Ill (ARAFMI), Child and Adolescent Mental Health Services, Child and Community Health, Commonwealth Department of Family and Childrens Services, Consumer Representative, Department of Community Development, Corrective Services, Education and Training, Housing and Works, Disability Services, Divisions of General Practice, Drug and Alcohol Office, Ruah Community Services and the State representative on the national COPMI Reference Group. A draft 'copmi' Interagency Protocol was developed particularly in regard to an adult mental health intake form and identification and support for dependent children, with cross sector signatories being sought to ensure identification of project processes for improved strategic cross-government and community and service links (Smith, 2006).

A 'Copmi' Executive group provided advice and was the key decision making group throughout the project, with negotiations also occurring for funding through the Commonwealth Stronger Families and Communities Program (Office of Mental Health, 2002).

During the 'copmi' work, three project areas were established in Albany, Armadale and Clarkson, each with a part-time funded coordination position and with locally-based interagency committees operation. Ruah received funding for a full-time position, the Community Capacity Building Project Worker who developed and implemented cross-sector training packages.

A 2006 evaluation report involving multiple data sources indicated increased agencies' responsiveness to early intervention, with cross-sector steering committee meetings generally attended regularly by signatory agencies and the protocol trialled. Three hundred and ninety five participants attended over twenty workforce development training sessions operating in the three pilot locations, with high satisfaction ratings; there was increased awareness of 'copmi' issues evident in a staff survey and greater knowledge regarding issues for 'copmi' and information access. The three interagency working groups supported by the 0.2 Project Worker trialled the protocol and there was some evidence of formal local agreements and informal collaborative processes occurring and of wider networks developing. Regarding increased joint agency assessment and referral to interventions for 'copmi', there was nominal evidence of formal local agreements and some case-specific and informal collaborative activity (Smith, 2006).

Despite some successes involving increased 'copmi' awareness and a more coordinated and systematic cross-agency approach, continued project funding for 'copmi' in Western Australia from 2006 was not forthcoming. New directions are now underway. Under the WA Mental Health Strategy, the Office of Mental Health is establishing a new interagency group. This involves clear Terms of Reference, a similar range of agencies to the previous cross-sector committee and a focus on implementation. A key task involves revisiting the protocols for interagency collaboration and obtaining relevant signatories and commitment. A 'copmi' project involving a resource centre with a statewide focus and operated through Ruah (in conjunction with W.A. COMIC) is providing

training. Materials within the Family to Family project involve production of five booklets related to children, carers and consumers, with six session workshops for whole families, also identifying gaps in service provision. Three cross sector training packages have been developed regarding talking to children about mental health issues, understanding impact of mental health on families and collaboration with 'copmi' families. Consumer/carer and non-government organisations such as ARAFMI in the north and Wanslea in the south are providing direct support services for families within particular regions.

In summary, collaboration and shared response related to day-to-day collaborative practice; flexible service delivery and innovation are key aspects of the future directions.

Queensland

Historically Queensland has had no consistent approach to data collection about the number of children whose parents have a mental illness. A Queensland Government publication (2006) provides some information about mental disorders in the state indicating 647,000 Queenslanders affected by a mental disorder in any one year, with 850,000 affected when alcohol and drug-related conditions are included. There are 98,000 Queenslanders who have severe disorders such as schizophrenia and bipolar, 549,000 have moderate and mild disorders such as depression and anxiety (Queensland Government, 2006). The *Queensland Plan for Mental Health 2007-2017* estimates that around 16.6% of the Queensland population is affected by mental health disorders (Queensland Government, 2007). This rises to 22% when alcohol and drug-related conditions are included, with anxiety and depressive disorders being the most prevalent and affecting about 7% and 6% of the population annually. Almost 2.5% of Queensland people experience severe mental disorder including psychotic disorders or major depression, severe anxiety or anorexia nervosa (Queensland Government, 2007:1). Hearne et al.'s (1999) survey of Queensland mental health services clients recorded that 35% were parents and of these about half had children under the age of 16, although less than 50% actually reside with their children.

Children of parents with a mental illness history can be traced within the context of the Queensland Mental Health Strategy in 1996-2006, *Future Directions for Child and Youth Mental Health Services: Queensland Mental Health Policy Statement* which recognized issues of high risk for children in these situations although with little immediate action.

In 1999, the Child and Youth Mental Health Service of the Royal Children's Hospital and Health Services District developed the initial project to address the needs of 'copmi' in Queensland through The Koping Forum. A partnership with the Mater Child and Youth Mental Health Service to provide psycho-education and supportive programs to the 'copmi' population in Brisbane commenced in 2000. In 2000, service providers in South East Queensland within the Koping Forum developed a working agenda to promote awareness of the needs of 'copmi' through developing and providing information, resources, training and support to service providers and families. A State-wide Koping Training initiative was launched in 2002, offering services to areas such as Cairns, Charleville, Toowoomba, and health districts in the Central Queensland health area. SCKoping network supports 'Copmi' in the Sunshine coast region (Queensland Health, 2007). The interagency KOPING project involves networks, videos, library resources and kits, a consultation and liaison program, family safety plan to minimize disruption during adult hospitalization and an adolescent peer support program.

The *Queensland Mental Health Strategic Plan 2003-2008, Queensland Health Strategic Plan 2004 - 2010* and various plans in relation to people with disabilities and *Queensland Department of the Premier and Cabinet Strategic Plan 2002-2006* provide some current background documents in relation to mental health. The Statewide Mental Health Network delivers and oversees statewide mental health system reform involving Queensland Health, Mental Health, non government groups, disability, and community groups, with a senior level group meeting on a monthly basis. This group includes three area health network representatives, northern, southern, central and 20

districts who are responsible for the implementation and delivery of services, There also subgroups related to indigenous, aged, and early childhood (Statewide Mental Health Network Terms of Reference, 2006).

Sharing Responsibility for Recovery (Queensland Health, 2005) highlights the importance of collaborative approaches and a key current policy focus is on dual diagnosis, with more collaboration and sharing of positions in relation to these areas. District-based training is occurring in cross-sector groups involving non-government organization workers and government employees.

The *Mental Health Promotion, Mental Illness Prevention and Early Intervention subgroup for the Mental Health Services Plan Working Group 2006-2011* provides recommendations regarding prevention issues for children and young people. This includes a focus on integrated perinatal and infant care and children of parents with a mental illness and/or substance problem This report highlights the need for a systematic and integrated 'copmi' strategy linking government and non government organizations, including culturally appropriate approaches and building on Koping, Mater Kidz Club, Gold Coast 'copmi' and SCKOPING. The *Queensland Plan for Mental Health 2007-2017* which was informed by reports and advisory groups eventually provided $5.47 million of funding, with outcomes due in two stages: by 2011 and by 2017. The Plan focuses on establishing a broader base for mental health intervention, highlighting recovery-focused service delivery. Implementation of the plan will be overseen by the Mental Health Interdepartmental Committee. The Director of Mental Health is coordinating regular reporting as required in the Queensland Health's Agency Service Delivery Statement, the annual Queensland Health Performance Report and a report to Cabinet.

One key area focuses on Mental Health Promotion, Prevention and Early Intervention, with children of parents with a mental illness being specifically identified. Funding has been provided for a statewide coordinator position for two years, with regional health teams currently allocating their own funds for part–time positions for 'copmi'. One of the committee sub-groups relates to perinatal and infant mental health, with a 'copmi' subgroup planned for the future.

The State 'copmi' Coordinator will develop and implement a Queensland framework to address the needs of children of parents with a mental illness, entitled *Meeting the Protection Needs of Children for Whom a Person with a Mental Illness has Care Responsibilities* (Queensland Government, 2008). The purpose of the policy framework is to develop processes to ensure the immediate protection needs of children where the parent with a mental illness has care responsibilities; determine the impact of their mental illness on the care and protection needs of children and to support parents and carers with a mental illness to meet the needs of their dependent children (Queensland Government, 2008).

Given some critical incidents, in 2008 an intake and assessment process is now required for any consumer entering a mental health service in relation to their full-time or periodic care responsibilities for children. The intake and assessment process is a requirement at entry to mental health services, upon admission and discharge in relation to an inpatient unit, and when there is a change to consumer status such as giving birth, relationship changes or accommodation. Demographic details of children, immediate welfare needs and immediate reasonable suspicion of child abuse and neglect necessitating a Department of Child Safety report are requirements. Training of the 300 mental health and child protection workers is occurring, there are guidelines provided for clinicians and there is a follow-up policy requiring proper monitoring of involuntary patients on discharge from mental health services with face –to-face reviews conducted (Queensland Government, 2008).

South Australia

In South Australia, limited data exists which is relevant to 'copmi' but area-based information

suggests that around 24% of mental health services clients have children under the age of 18 years.

The *Strategic Plan for the Purchasing of Mental Health Services for Children and Young People* draft (1997) highlighted that services for children of parents with a mental illness were needed and various local initiatives began but there was no comprehensive approach until the *MHPP National Action Plan* (1998) focusing on specific population group needs. In 2000 the State Mental Health Unit, Department of Human Services conducted a conference forum for consumers, carers and bureaucrats to confirm current supports, identify service gaps and discuss needs, also informing department policy and strategy. The organisation called Children of Mentally Ill Consumers (COMIC) was formed as a result of this conference.

Given the national framework of the Second National Mental Health Plan (Australian health Ministers,1998), around this time in South Australia, a draft policy was developed including six key areas for short, medium and long term attention. These include developing a range of resources and information for the community and for 'copmi'; better cooperation between adult and mental health and child and adolescent mental health services; capacity building and staff development; partnerships including with consumer organisations; developing codes of practice and quality standards and establishing local support groups and initiatives (AICAFMHA, 2001).

In more recent times, the South Australian draft document *The South Australian State-wide Strategy for Children of Parents with a Mental Illness (2007-2010)* has provided an outline of a vision within the Social Inclusion Agenda, although the final version is not yet publicly available. The *Mental Health Bill 2008* which has been introduced into the South Australian Parliament after extensive consultation includes children as carers, with guiding principles including that: 'the rights, welfare and safety of the children and other dependents of patients should always be considered and protected as far as possible' (Ministerial letter).

While there has not been a statewide project in relation to 'copmi', over the past three years there has been an area-based project. The Mental Health Liaison Project: Outer Southern Region multidisciplinary team has been established, with a position funded through the Families SA (child protection agency) and with mental health also involved. This team brings together child protection, social workers, mental health and child and adolescent mental health personnel. Child protection early childhood, speech pathology, nursing, occupational therapy, child psychiatry, disabilities, and drug and alcohol services are also involved. Companion Agency Meetings are conducted and policies and protocols at the local level involving joined up therapeutic work are occurring. Case conferences are held. Reference committees, written reports and word of mouth are disseminating the project information and outcomes and there is discussion underway at executive levels within government adult mental health and child protection services about intake information and a role for non-government organisations. Evaluation through the Australian Centre for Child Protection has occurred. The approach is beginning to be replicated in other area-based services and there may be wider applicability in the future.

Tasmania

Tasmania has some specific data regarding 'copmi'. Data from a School of Nursing/University of Tasmania 1999 survey in a two week period indicated that around 29% of adult mental health clients had dependent children under 18 years, with 66% of these being women in their thirties with depression and the majority of children being less that 6 years old (Farrell et al., 1999). Regarding parents and carers with a mental illness, about 70% had one or two children and approximately 15% had three children (Handley et al., 2001). Almost 70% had post-natal depression shortly after birth. Thirteen percent of women have been diagnosed with mental health issues after six weeks and 11% of them have some issues after six months (Bennett, 2001).

The Tasmanian Department of Health and Human Services, *Mental Health Services in Tasmania:*

A Plan for Now and the Future – Strategic Plan for 1999-2002 (1999) was about promotion and prevention, also including some strategies relevant to children.

A review of services occurred including community consultations in various regions, establishment of a multi-agency/multi-disciplinary Steering Group and a workshop to bring together key stakeholders from government, non-government and consumer organizations, with agreement being reached about priorities and multi agency work during project implementation. Positives identified at that time were whole of government initiatives in interagency collaboration through formal committee structures, Tasmania Together standards, benchmarks, Our Kids Strategic Framework and Action Plan, partnership agreements between State and local government, strong community partnerships in some local government areas, Supportive School Communities and Health and Wellbeing Projects in schools.

However, essentially these were localized good practice models which were not broadly applied throughout the state, with practitioners trying to network but under pressure from workloads and with Commonwealth funding tied to specific time-limited projects build around the individualised department 'silo' mentality and with no shared resources (Jenkins, 2004). Concerns were raised about fragmentation of health and community services and little intersectoral work; weak links between government and non-government groups; demands on services exceeding resources; and insufficient resource allocation for early intervention and prevention especially in early childhood. Inadequate data collection, a need for professional development for diverse cultural groups, and need for practical and flexible home and community help for parents with mental illness, in addition to a widespread need for more parenting programs, and ongoing programs to support and mentor 'copmi', were aspects highlighted (Jenkins, 2004).

Given some high level political champions and personal experiences, the *Kids in Mind Project* was launched in 2003 through the Social Project Unit of the Policy Division of the Department of Premier and Cabinet with a focus on 'copmi', with the overall goal of improving outcomes for these children through intervention supports for 'copmi' chidren and families. Strategies include peer support for children and young people, time out and respite, information and individual case management and counselling. Support for parents and carers including assistance with parenting; early childhood community capacity building; service reform and improvement which includes interagency collaboration and staff professional development were involved (Jenkins, 2004).

The *Kids in Mind Project* has recently been reassigned from the Department of Premier and Cabinet (DPAC) to the Department of Health and Human Services (DHHS), with implementation plans for the next three years being developed. An evaluation report from the Department of Premier and Cabinet has been considered following a departmental review through statewide consultation including national planning days in 2007 which involved various stakeholders, including young people. Drivers for new directions are being considered especially Commonwealth policy frameworks under promotion, prevention, early intervention; the DHHS own agenda and statewide consultation directions and the DPAC evaluation report. Cross-agency collaboration is driving directions and there is consideration of the need for dependent children data to be systematically collected while overcoming legislative and privacy barriers to effective family-sensitive practice. Consumer/carer and young persons' involvement; dual diagnosis directions with mental health, alcohol and drugs and strong links to child protection, are key aspects. There will be an ongoing project management reference group for governance including executives, a departmental coordinator position and a *Kids in Mind* reference group which includes non-government representatives and young people. Funding, written-up policies and procedures, programs for children and data collection regarding children including follow-up when parents are hospitalized, are actions identified.

Australian Capital Territory

The Australian Capital Territory data estimates for adult mental disorders based on Australian

Bureau of Statistics Australia-wide information for schizophrenia, anxiety disorders, affective disorders and substance use disorder indicate around 51,705 mental health services clients, with 7% of the Australian Capital Territory adult population experiencing moderate to severe mental health problems. A further 10% are at risk of developing mental health problems or requiring early intervention (ACT Health, 2003: 18).

Until the late 1990s the Australian Capital Territory (ACT) had no formalized processes regarding 'copmi', although there were some informal networks operating which established 'kids clubs' and which began raising awareness, also organising seminars which included interstate 'copmi' leaders. Child and Adolescent Mental Health Services (CAMHS) became concerned that 'copmi' needed to be addressed in terms of promotion and early detection aspects. The ACT Health Action Plan launched in November 2002 set directions for health services in the ACT, incorporating the vision for health, the values and strategic areas of focus and identifying mental health as a key priority area. The *ACT Mental Health Strategy and Action Plan 2003-2008* was then developed in consultation with a range of consumers, carers, community organisations, health professions, other Government agencies and the general public. The Plan is aligned with the broader policy framework of the Canberra Plan and Canberra Social Plan (ACT Government, 2008a; ACT Government, 2004). This also links to the ACT Children's Plan setting out a whole of government approach to supporting the development of ACT children (Australian Government, 2008b).

Within various policy frameworks, in 2003 a project position was funded which eventually focused on 'copmi' with key functions being coordination; setting up networks; awareness raising and training, with the role essentially having a CAMHS orientation but also working across services. Being on a range of committees including at a national level; supporting a cross sector steering committee involving about fifteen government and non-government agency representatives; information sharing and information kits for workers and children of adult consumers; establishing long term plans for children in preparation for possible adult hospitalization and building understanding of the recovery approach, were key aspects of the role. Developing and delivering training programs for cross –sector groups is became increasingly important, with workforce development training for ACT Health already systematically occurring and becoming more specific and with child protection and other groups sometimes involved.

The *ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006-2008* identifies children as a priority group including perinatal and early childhood support. Key focus areas involved are broadening the availability of positive parenting programs, improving screening, assessment, referral pathways and care for children at risk of perinatal depression. The Plan specifically identifies children of parents affected by a mental illness and the need to 'continue to build on the work of the 'copmi' (Children of Parents affected by Mental Illness) project to meet the needs of children of parents affected by mental illness across services and sectors in the ACT'.

Therefore from 2008, 'copmi' has recurrent funding for a program coordinator within the adult mental health services, with data systems capturing parental status when adults enter mental health services and with referral to services. Training of all mental health staff clinicians occurs. Team leaders in adult mental health teams actively promote 'copmi' and training of all staff. There is a policy being developed for Mental Health, accompanied by a Memorandum of Understanding for other agencies. Education, Department of Youth, CAHMS, care and protection services are involved.

There are a range of programmes operating in the Australian Capital Territory. A 'copmi' program established through a steering committee and networking group develops intervention strategies linked to national and territory health strategic plans and AICAFMHA Principles and Actions. The steering committee provides opportunity from cross-sector information exchange and influences numerous agencies; cross-sector commitment includes the IMPACT program for women in mental health and opiate; Marymead Horizons for children aged 0-8 years and Anglicare Litmus for young carers. A Mental Health Recovery plan includes children and young persons care plans. A

Resource Kit has been developed for 'copmi' families and workers and a website is being developed and promotion of a family focused approach to children is underway and more cross-sector training is occurring. One Australian Capital Territory program is the Canberra/Goulburn St Nick's young carers' holiday camp. Other programs are Horizons: Healthy Minds, Healthy Families Marymead home visiting family support and counseling services focused on the 0-8 age group, as well as the POPPY weekly playgroup in Canberra South. The Big Red Book provides strategy-based information and service profiles for a range of professionals having contact with young people ('copmi').

Northern Territory

The Mental Health Territory Services is aware of issues for children of parents with a mental illness and the importance of broadly supporting children and families with safety at home.

One key support program for all children is called *7 Steps to Safety* which aims to promote children's safety and wellbeing. This resource was developed through a consultation process involving Northern Territory parents, children and services providers based on Australian and overseas literature. The first three steps involve making the house and yard safe for the family; making rules to help children make safe and responsible decisions; and teaching children about feeling safe with people and dealing with uncomfortable situations. The last four steps are about working out family needs and planning for children's care and safety; teaching children what to do in emergencies; working out whether children are ready to spend time at home alone and making a care plan so children can feel confident they will be well cared for if something happens (Northern Territory Government).

TEAMhealth is a specially designed key program to support families, parents, children and young people aged 15-24 where there is a family member with a mental illness. Three types of support are provided including an education program, case management program and a social activities program. Funding is through a Family and Youth Service with a focus on prevention and early intervention and responding to the identified local need (Northern Territory Government: TEAMHealth).

3. SYSTEMS CHANGE MODELS and 'COPMI' CONSULTATION THEMES

Building on the Chapter 1 introduction to systems change theory and Chapter 2 national and jurisdictional information, this section of the report introduces the strategic goal and evolutionary change theoretical frameworks for systems change in more detail. In addition, key themes arising from the analysis of findings from the interviews and focus groups in the States/territories and nationally regarding systems change will be introduced, with further discussion relating to enablers and barriers for each of the themes being outlined in successive chapters.

3.1 Strategic change approaches

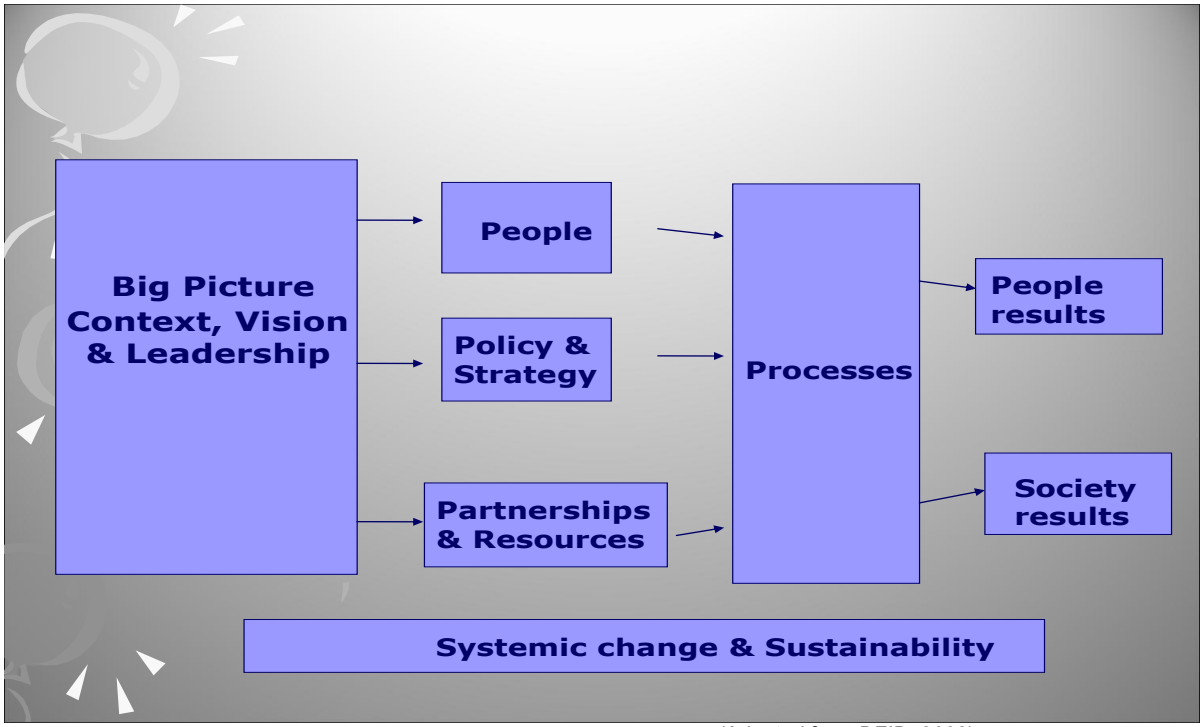
Strategic change approaches were introduced in Chapter 1 of this report, with models presented regarding Systems Theory and Organisational Development models. These models reflect change as intentional and strategic and sometimes infrequent, with change generally occurring within the single organisation or group. Clear goals, measurement and feedback are involved and linking individual people with the directions of the organisation. Change processes are about goal achievement and may be people-focused, including training and working alongside individuals and teams to get them involved. Measurement and feedback about goal achievement and encouraging participation are the roles of leaders in these change approaches.

Figure 1 shows further detail about some processes and aspects involved in establishing the strategic approach within a particular organisation, which in broad terms involves three layers: leaders having a vision and doing some strategic planning; establishing a project management team for implementing change and then operationalisation and involving all relevant teams and individuals. As shown, processes for achieving a strategic approach include initially examining the overall context both within and external to the organisation, identifying all the stakeholders and considering the various perspectives. A detailed organizational analysis examination of the particular organisation, its purpose and processes and achievements and the gaps is the next step. Designing a change including considering staffing needs, training, evaluation processes and involving others and getting their support and ideas is also involved, leading to implementation of the change. The final steps are about monitoring the change and collecting data about success and then building processes so that the change becomes sustainable.

(Adapted from DFID, 2003)

Figure 1: Strategic change aspects

Therefore, as shown in Figure 2, in establishing strategic change in a sustainable manner when health and other social improvement areas are the focus, there needs to be a big picture context, leadership and vision. The involvement of people, policies and strategies and partnerships and resources then occurs and processes to implement the change, followed by evaluation processes to look at the outcomes for people and society (DFID, 2003).



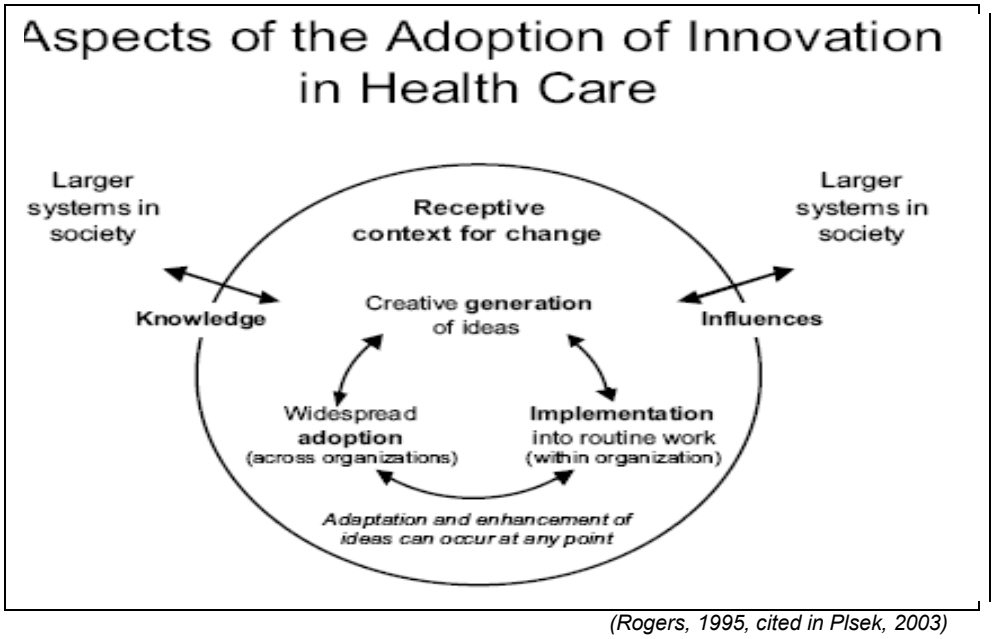
(Adapted from DFID, 2003)

Figure 2: Sustainable systems change enablers within a strategic change approach

3.2 Evolutionary change approaches

The evolutionary change approach was briefly outlined in Chapter 1 in regard to involving interaction across organisations and the environment and change being consistent and cumulative rather than intentional and infrequent as occurs within the strategic approach. Complexity Theory and Social Worlds or constructive conflict models were previously presented. In the evolutionary approach, multiple approaches and letting directions arise gradually over time or working through conflicting ideas and creating new directions are the change processes involved. The leader's role becomes one of working with others and interpreting the emerging change and taking a strategic view of all the different agendas underway.

Figure 3 provides a representation of the evolutionary change process within a health care context (Plsek, 2003). A key difference from the previously-outlined strategic approach is that the change is recognised as happening within a wider two-way context, with those other influences and knowledge having an impact. Secondly rather than being top down, the generation of new ideas can come from anyone and may simply evolve in the course of routine work for a few people and then become more widely adopted across the organisation and across other organisations.



(Rogers, 1995, cited in Plsek, 2003)

Figure 3: Evolutionary change in health care

In terms of 'copmi' change processes, both strategic and evolutionary approaches have some relevance and a purpose for this research is to learn more about the enablers and barriers for change and the degree to which strategic or evolutionary approaches are important.

Considering the strategic and evolutionary approaches as having some relevance to this research means focusing on:

- the importance of relationships and leadership
- need for relevant structures, processes and patterns
- changing 'how people think' (mental models), leading to adoption and other innovations
- considering what causes attraction to new ideas for different groups of people
- understanding that adaptation and change are constant
- the importance of encouraging experimentation, ongoing ideas and seeking evidence
- understanding that ongoing small-scale evolutionary and 'informal' change can have a strong impact long term
- recognising systems are embedded within other systems and co-evolve

(adapted from Plsek, 2003)

3.3 Change management and sustainability maturity models

Change management and sustainability maturity models are being developed in the corporate world and have some relevance to this work. Maturity models are useful in identifying the indicators for various levels of capability. One change management model linked to sustainability has various elements of Outcomes; Resourcing and Evaluation; Policy and Strategy; Capacity and Capability Management and Project and Programme Management. The characteristics for each of these elements can be described across various levels of development in terms of sustainability. While there are various labels which can be used, these can be outlined from Immature to Early Maturing, Defined, Managed and Integration/Optimisation (Cambridgeshire County Council, undated; CSR Quest, 2007).

As shown in Table 2, the model shows progressively more alignment between various parts of an

organization over various stages in terms of clarity of outcomes, consistency of policies and responsibilities to objectives, and resources and training, as well as evaluation:

Table 2: Change management maturity matrix

Immature	Early Maturing	Defined	Managed	Integration/ Optimisation
• Outcomes unclear • Low level of ownership • Ad hoc & incongruent goals • Low accountability for resources • No consistent approach to change management	• Some alignment of policies & responsibilities with objectives but mostly 'bottom up' • Strategies and practices documented but needing improved communication • No formal tracking or evaluation • Project management approach under development	• Large change management projects identifiable and show alignment to overall change agenda • Improved overall awareness of strategies and priorities • Some understanding of roles and responsibility • Identifying those with skills needs and internal groups beginning to share best practice • Resource plan available and needs identified within context of other projects	• Evaluation of programs and resources systematically occurring • Training program established and evaluated • Performance and resources assessed against organisational needs • Formal networks established • Processes, systems and services within organisation integrated	• Integrated resource utilisation and decision making • Strategic change management planning occurring in regard to other projects

(Adapted from Cambridgeshire County Council, undated; CSR Quest, 2007)

Health studies reviews examining sustainability across six domains showed enablers and barriers as follows (Sibthorpe et al., 2005):

- Political: including local, state/territory and national political contexts, with individual champions occurring locally and nationally and with good links established with regional health planning and with alignment to national policy directions;
- Institutional: between institutions and within institutions connections involving good relationships and structures (e.g. Linkage group, Memorandum of Understanding), with processes supporting this including flexibility in implementation to account for local conditions and good information (formal/informal and national/local, training tools);
- Financial: dependent on general funding and specific funding, with good general funding facilitating sustainability;
- Economic: time and workload issues with no specific incentives for incorporating into routine general practice;
- Client: issues about resilience of client base with sustainability enhanced if people sought care and there was acceptance of the provider role or service was embedded in patient community and there were few out of pocket costs for patients; and
- Workforce: staffing, skills and motivation aspects.

3.4 'Copmi' research systems change key enablers introduction

The key themes in terms of supporting systems change identified are:

- Big Picture Context and Leadership
- Policy and Strategy
- People, Culture and Management
- Structures, Systems and Processes
- Resources

As shown in Figure 4, each of these aspects incorporates various sub-themes. A coding system has been used to identify the frequency of responses. Some of these sub-themes were frequently raised by research participants, as indicated by the sign +++. Sub-themes which were sometimes raised have been indicated using ++. Sub-themes rarely raised are shown using +.

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Figure 4: 'COPMI' research change enabler themes

3.5 'Copmi' research key barriers introduction

Barriers, as indicated in Figure 5 in relation to Big Picture Context and Leadership; Policy and Strategy; Structures, Systems, Processes; People, Culture and Management; and Resources will also be presented.

Detailed discussion of each of these themes including enablers and barriers will occur in chapter 4 to 8. Quotations are provided from various government and non-government representatives, also consumers and carers in states and territories and nationally, thereby capturing the voice of stakeholders, although without specific identification of individuals, organisations or jurisdictions.

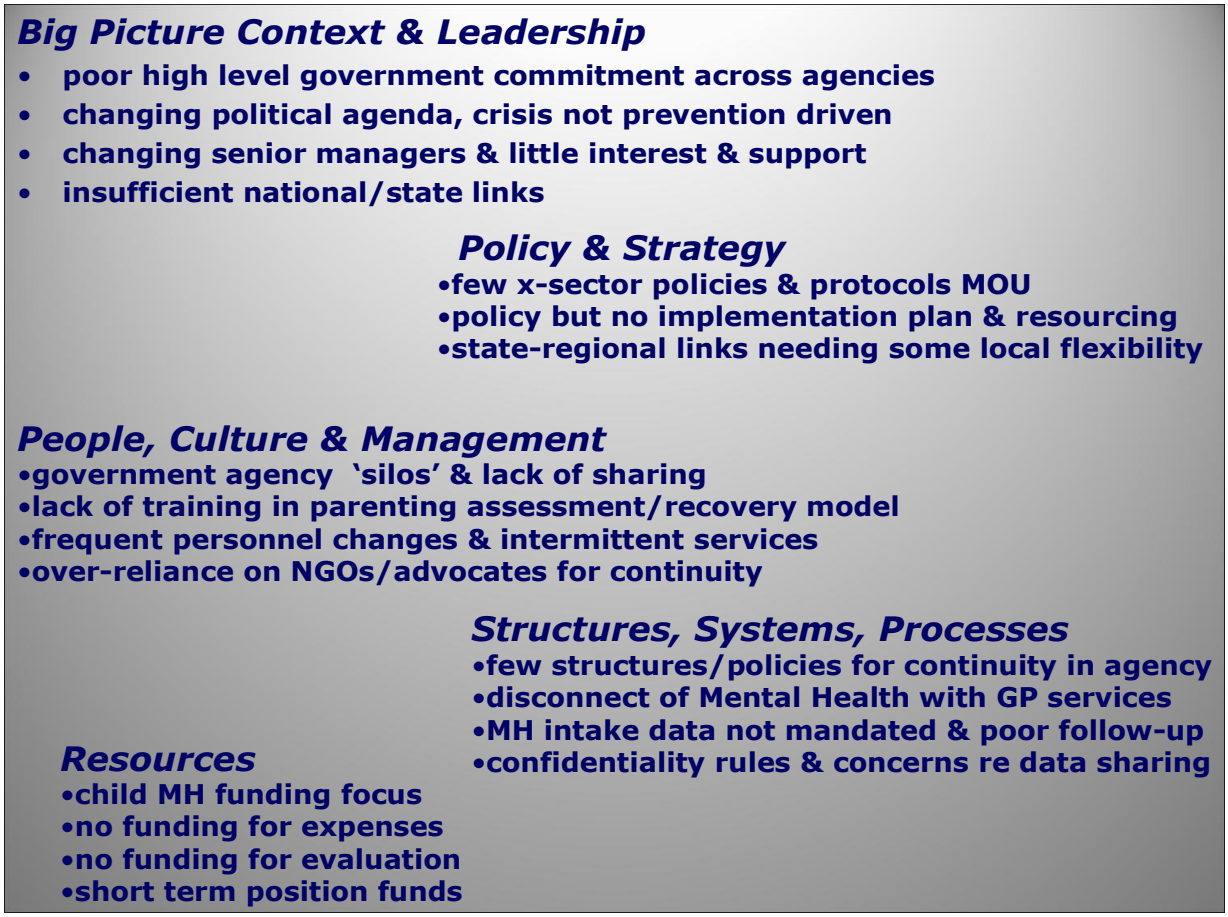

Figure 5: Barriers to sustainable change

4. BIG PICTURE CONTEXT AND LEADERSHIP

The first key theme regarding 'copmi' systems change as identified by various stakeholder groups across the states, territories and nationally was multi-organisational, big picture context and leadership. Specific aspects are:

- Legal and policy interconnected contexts;
- Critical incidents;
- High level influential champions and national contexts; and
- Historical/social issues and timing.

Enablers and barriers will be discussed. Relevant barriers, as outlined in chapter 3, include poor high level commitment across agencies; changing political agenda including crisis-driven rather than prevention-driven; changing senior managers and lack of support, also insufficient national and jurisdictional links.

4.1 Legal and policy interconnected contexts

Multi-organisational approaches and consideration of the overall context beyond a single organisation are increasingly identified as drivers for change in relation to 'copmi', with poor high-level cross-sector interconnections also being viewed as a traditional barrier. Beyond government or non-government services in areas such as child and adolescent mental health and perinatal, the policy directions of early intervention/prevention/promotion and family-focused approaches, as well as child protection legislation, have essentially been resulting in changes over time.

Given significant numbers of 'copmi' requiring mental health services for themselves, rather than child and adolescent services supporting the children at the point in which mental illness commences, under early intervention approaches, adult mental health are being given additional responsibilities. Increasingly, adult mental health services have a significant role beyond the medical model of individual support for mentally-ill adults. This includes adult mental health services intake information identifying whether there are dependent children involved, the existence of support structures among family and friends, assessment of the situation in terms of parenting (both strengths and weaknesses), as well as identifying other services and referrals needed by the children.

State and territory-based legal and policy frameworks, such as in relation to child protection are highlighting the wider range of child safety issues beyond the physical and sexual aspects of the traditional focus towards also including neglect. The links between adult mental health and drug and alcohol issues are increasingly recognised. Interconnected perinatal support is also occurring such as identifying, assessing and supporting mentally-ill expectant mothers, including in terms of parenting skills prior to and following the birth at various phases.

Child protection is a significant driver for greater interagency cooperation and this is captured in this response from a 'copmi' leader in a government health service:

> *..child protection enquiries were happening in most states...and that created awareness of the more serious end of the impact of mental health....so that led to more links between health, children services, child protection. And people were being asked and required to consider children within an adult service.*

4.2 Critical incidents

While many jurisdictions have been working progressively towards multi-organisational approaches and seeking to establish government and non-government cross-sector responses and responsibilities, the challenges of achieving this were widely acknowledged by stakeholders in the research. Financial aspects, cultural mismatches, structural impediments and individual personalities and egos were all raised as considerations.

However, several states identified critical incidents attracting the media spotlight and capturing public attention for an immediate political response as significant drivers for galvanizing cross-sector and multi-agency cooperation. For example in one state, response to a critical incident finally resulted in interagency collaboration and agreement on mental health intake paperwork regarding dependent children, as well as parenting assessment and follow-up of mentally-ill adults upon release from an institution. Wide-scale mental health worker training in child protection and increased dual diagnosis work were other outcomes, as well as increasing the range of allied health and other professions having responsibility for mandatory notification. A family support plan has been developed and confidentiality issues which have previously prevented information sharing within and between agencies, are being reconsidered in terms of child safety requirements.

There was some concern expressed however that the crisis-driven response could become counterproductive, with the potential for reactionary political response rather than well-researched and consultative directions being viewed as a barrier. Detracting from the essential consumer partnerships message of a positive framework of prevention/ promotion/early intervention was believed to be a considerable risk and the need for continued ongoing government funding for wider support services was highlighted as essential.

4.3 High level influential champions and national contexts

While leadership across various groups and organisational roles is recognised as a key driver, influential champions at the highest level and national contexts have provided a significant boost to the status and funding of the 'copmi' agenda. At the national level, this means organisational leaders meeting regularly with key political figures within a context of sometimes changing political parties and personnel, and regularly re-telling the 'copmi' story to ensure that issues are understood and ongoing funding is secured.

In some of the states and territories, these champions have been significant political leaders who have been influenced through life experiences of family members to take up the 'copmi' cause. In other cases, the high level champions at a state or national level have been academics or practitioners with significant links to overseas organisations or individuals working in the 'copmi' area. Their role has sometimes involved leadership of government committees and cross-sector practitioner networks or policy development groups. Championing of national mental health and related policy frameworks and state-initiated key conferences led by highly-regarded 'copmi' individuals attracting national and even international audiences, are other aspects in terms of enablers cited by interviewees. Focus group participants highlighted that even though national policies and conference resolutions are not binding in the state and territory context and this has been a barrier to 'copmi' change in the past, where national policies and frameworks are available, they do provide some leverage. This includes signaling key directions and this has the potential to influence jurisdictional decision-making and future action.

For example, some government-based 'copmi' staff highlighted the importance of the national mental health policies and reports for engaging senior bureaucrats in discussing the state situation and its directions and resources provision, particularly in relation to other states. In addition, the 1993 Commonwealth-funded report (Burdekin et al., 1993) received multiple

comments as being critically important in initially raising the issues of 'copmi' and this led to jurisdicational funding for 'copmi' training for family support workers and to some funding for peer support programs for children. National mental health frameworks including the AICAFMHA national directions provide opportunities to engage senior bureaucrats in considering state policies and future plans, with some opportunity to use rivalry between states to leverage and to be able to talk about relevant issues at the local level. In one state, Australian Government funding in previous years has supplemented the jurisdictional resourcing and enabled a more wide-scale response and in-depth research and planning of future directions. The National Mental Health Plans and the focus on early intervention, prevention and promotion, even without having associated implementation plans, have had a significant impact on the policies and frameworks developed by states and territories.

4.4 Historical/social issues and timing

Underpinning legal and policy frameworks, critical incidents and high level champions, research participants noted the context of historical and social considerations within the local situation and the importance of timing.

While historically mental health services have been focused on their own organisation and some specific mental health conditions, there is increasing social awareness of mental illness in the wider context of depression and anxiety including recognition of the range of backgrounds affected such as politicians at the highest level. The historical 'secretive' approach toward mental illness is being replaced. Recognition of the wider range of people supporting mentally-ill adults is increasing. General practitioners are a particular group of health professionals who are increasingly recognised for their role in working with adults and children with depression and anxiety and for their knowledge of family situations and skills in adopting family-focused approaches. Therefore, general practitioners are being included in cross-sector network committees at the state/territory and area levels and they are now being seen as a vital target group for training in 'copmi' issues and as part of the information network for specialist services such as psychiatry professional bodies.

So, while historical and social issues are key drivers, this is linked to the issue of timing as a critical enabler. In various states and territories and from various stakeholder groups, the issue of historical sequence and opportunism and various factors aligning at a particular point in time has been highlighted as captured in the following comment: '*I see the 'copmi' project being able to be sustained because there was funding…it was the right time. It's not one thing, it's timing, it's not just executive support'* (jurisdictional coordinator).

5. POLICY AND STRATEGY

Policy and Strategy was another key theme identified in terms of supporting 'copmi' change and building sustainability. Sub-themes include:

- Having high level cross-agency governance and policy or formal signatory documentation such as Memoranda of Understanding;
- Developing strategic implementation plans at the state and territory level;
- National and jurisdictional and regionally aligned policies; and,
- Ensuring there is a clearly articulated mission/vision.

Enablers and barriers are outlined, with barriers summarized in Figure 5 as few cross-sector policies; lack of implementation plans and resourcing attached to policies and state-area links needing some flexibility.

5.1 High level cross-sector agreements

Focus group participants from a range of government, non-government and consumer/carer perspectives within jurisdictions identified the establishment of a statewide high level cross-sector committee and jointly developing policies or Memorandum of Agreement as key enablers in supporting 'copmi' change. Similarly lack of cross-sector agreements was identified as a barrier in some states and territories.

In one state the high level cross-sector committee was established and it developed a framework for working together in relation to 'copmi', and this in indicated as follows:

> *…the framework and systematic analysis is critical….it appreciates the issues...we work together in collaboration. It's whole of government...all services, support and assist and skill up workers to appreciate that whoever walks in their door...and whatever the issues are…. that they're coming to the service.. (and it) will have implications for children, for their immediate relationships... and we need to be mindful of that.*

This included developing protocols such as in relation to mental health intake questions regarding dependent children and follow-up services. This is highlighted in the following statement by an area based coordinator in one state:

> *It needs to be really such a top down directive and it needs to be on forms that register because what we're finding is if it isn't on people's minds, if it is not in front of them we've lost them. Unless it's an interest people aren't going to want to know…most of the time even though you're supposed to ask that family stuff ….if it's an adult client…is there something more for the children in this family apart from just that they've got a safe place for the night because mum or dad are an inpatient? It's putting it in people's minds that there are children, that they need to work holistically as opposed to just seeing the individual...*

For some states, working across government departments and organisations was a significant shift in operational approach and it had raised the profile of 'copmi' amongst high level executives significantly as noted by a government mental health leader in this statement: '*A few years ago we'd never been able to roll out a strategy that impacted on other services... a few years ago if you went to cross-sector meetings very few bureaucrats would know about it ('copmi') ...it really has been quite a change'*.

5.2 Strategic implementation plans

Policies, frameworks and cross-sector agreements are increasingly being supported by implementation plans with detailed strategies and clear outcomes, key performance indicators, funding and timelines to ensure that action and change can be effectively supported, with policy without organizational implementation plans being cited as a barrier. In several states the policy framework focuses on the importance of delivery of effective mental health services involving collaborative approaches and having policies, committees and structures that:

> *..build systems that allow you to collaborate…between difference services....identify systems issues and have the responsibility and the power to actually put processes in place… that needs to come from the top down to give you the authority … and then be supported*…(government service leader).

Implementation plans in one jurisdiction for its lead agency include resourcing which provides for a full-time central position to coordinate the work of the cross-sector committee and follow through on policy areas and implementation, also developing other networks at the area level. These area positions have funding for some key personnel for conducting workshops and building other collaborative approaches at the local level. As noted by one interviewee involved in network leadership:

> *…so that there is a central position … with .the role of promoting the mental health in these families involving collaboration…and getting people over time on the same page about these families…parenting, the effect on children…involving interagency collaboration…(and area positions) a conduit between all the various agencies in the area…Given that there's only one of them on their patch, joined up by workshops, and consultation is a key role of those positions…not doing work themselves….skilling up workers on the ground in family support…*

Some people currently in funded coordinator roles and operating as a leader in the past but without implementation plans commented on this as a barrier as reflected in the following: '*I was a bit like a lone ranger...I didn't have any mandate...no evidence but ...I knew in my heart it was making a difference and helping people but I went about it the wrong way... although people say if you hadn't done that… you have to start somewhere....it was a practical thing but it didn't have any legs'.*

Jurisdictional strategic plans providing a framework for area-based plans and networks, but with opportunity for local decision-making to meet the particular needs of that region and with some funding for locally-based projects was emphasized as important, with the lack of flexibility seen as a barrier: *'It's problematic if it becomes too structured. It doesn't meet the needs of the local area' (area-based coordinator).*

Other barriers commented on were related to an over-reliance on the non-government sector, with the strategic government framework and resources being essential for long-term sustainability, although with non-government organisations sometimes providing some level of services and visibility between government funding availability:

> *We've been reforming and enculturing our mental health workers with a family inclusive approach but now we're picking it up for the whole (X) community services ...through collaborating with others and having key bureaucrats ..we've managed to keep it on the state agenda.. The way the state is progressing it it's still not comprehensive enough to the plan that we all drew up...because clearly this work has to be across all government departments....There's a level of disappointment that it hasn't been picked up ....but still a spirit of optimism* (non-government organisation leader).

The efficiencies and long term sustainability of using a more strategic approach has been noted by

some experienced 'copmi' staff, as highlighted in the following statement by a jurisdicational coordinator: '*You have to be very strategic...this is what I'm doing now ..what's going to make sure it's ('copmi') still there in five years time.. And that's a question I try and ask myself every day now '.*

5.3 National, jurisdictional and regional alignment

The alignment of state and national policies and frameworks was another sub-theme receiving comment in terms of policy and strategy. Given the nature of federalism and state-based responsibility for many issues, many research participants recognized the issues for gaining alignment and joint action in terms of national and state policies. It was however recognized that national policies play a significant role in establishing a framework for state-based frameworks and implementation plans. Regular meetings between national body leaders related to 'copmi' and relevant state and territory government leaders are essential in updating knowledge about jurisdictional directions and national 'copmi' pathways.

Membership of national committees also provides opportunities for jurisdictional 'copmi' leaders to gather information regarding Australia-wide directions and to disseminate this and influence their jurisdictional senior executives with responsibility for this area. This is shown in the following jurisdictional leader response which indicates:

> *....the national COPMI project had established itself and they had invited me to be on the group and it gave me some power...and I could say this is what's happening nationally ....this is the national standard for the workforce and I could see what was happening at a national level*.

The lack of national and state alignment within and across services was noted as a significant barrier for some non-government organisations and within some jurisdictional contexts, as indicated by this non-government organisation leader:

> *It was very eye opening just how dysfunctional bureaucracies were...the Australian Commonwealth through its government instrument...have a long way to go in terms of integration...Some of them (jurisdictional officers) couldn't even communicate with their regional offices....We don't have a clear common enough way forward for children yet across government ...One of the things we confirmed quite strongly in the end...we knew it was important to expend some energy sort of empowering groups in the community sector because we knew they would keep it on the agenda.*

5.4 Clear vision and mission

Clear mission and vision and some practical skills for marketing ideas and bringing others on board was another sub-theme identified in relation to policy and strategy, as commented by an area-based jurisdictional leader:

> *And also it's about that whole of government approach that you actually need child protection and all those people at the table developing these pathways and their support because..if you've got a mother who is going into hospital for one night and is a good carer for the other 365 days..It's about partnerships. They need the partnerships to help parents to be the best possible parents in the 70-80-90 % when they are well and then for the 10-20% of the year that they're not, what services can support the relationship and the family unit.*

Cross sector committees and policies without commitment and clear vision and resourcing for long term

change was highlighted as a significant barrier and had significant implications in some jurisdictions, with discontinuity causing loss of trust and services:

> *For long term change it always has to fall back onto the commitment and vision of people above us….The clinical directors they have to have the long term support and commitment…It's not for the want of passion….It's heartbreaking in a way to see these people (consumers/carers in committees) sitting there and thinking well, where do we go…And it's taken a long time to build up those good relationships..*(jurisdictional leader).

Part of the issue of strategic approaches and mission and vision also involves marketing a relatively long-standing philosophy such as children of parents with a mental illness and the early intervention, promotion and prevention, and providing a fresh approach and a new context. Several very experienced 'copmi' government-background interviewees acknowledged this issue, as shown in this response from a government leader within one jurisdiction:

> *We were strategic about the families. We believed in that…we called it slightly different names, we rebadged it to sound like something new.*

6. PEOPLE, CULTURE AND MANAGEMENT

People, Culture and Management was the third key theme identified in terms of enablers for 'copmi'. This includes various sub-themes:

- Champions at all levels including consumers; building formal/informal alliances;
- Bottom-up and top-down influencing;
- Leadership commitment and reculturing; and,
- Professional learning including joint conferences, mentors and team meetings.

Similarly, People, culture and management barriers identified previously in Figure 5 were about agency 'silos' and lack of sharing between various government services; lack of training in parenting assessment and recovery-oriented approaches for workers; frequent changes to 'copmi' personnel and intervention services and over-reliance on non-government and advocates to provide services continuity.

6.1 Champions at all levels

Champions at all levels as a key driver for 'copmi' was the message consistently reinforced by all stakeholder groups and across various organisations and jurisdictions. While strategic approaches and policy frameworks developed by states and territories are relatively new directions and non-recurrent funding of key positions continues to be a concern, it is the consumers and practitioner champions within government and non-government organisations who often play a significant role in ensuring some degree of continuity of services: '*There have been a lot of champions along the way….who've been people who have stuck it out and lobbied, like line managers crazy for funding, for recurrent funding'* (State coordinator response).

While many champions were identified within specific agencies, a key enabler identified involved passionate individuals and organisations, bringing people together from across the system, building 'copmi' awareness and developing information about issues and services. In most situations this has initially occurred without any formal agreements, structures and protocols for such collaboration, with these informal networks eventually working together to gain funded positions. One jurisdictional network leader describes some of the processes involved in the championship role, also highlighting some of the challenges:

> *Leadership is a key factor....I was setting up meetings. ..saying what my vision was… a local area network about children and (then) arranging the next meeting…and over time it means that the inherent tension in that group was about getting others to feel like stakeholders....And from this it came back to commitment…key people keeping the group going and having regular meetings...not necessarily structurally supported....(and eventually) having it on somebody's job description…making those positions permanent or making the work part of a permanent position*.

Consumers and carers have also been a significant group, particularly in some states, playing a key role on various high level committees and sometimes involved in training programs and working with non-government organisations to continue small-scale projects including during times when government funding was not unavailable. For example in one state, during a period of government funding shortage, a non-government organisation and consumers worked together to undertake various tasks related to resource material production for training packages for child carers, consumers and families and also for workers. The need for a partnerships approach with consumers and providing a supportive environment is expressed by one leader of a non-government organisation as follows: *'We as an*

organisation were committed to working respectfully with consumers and we were also happy to be told we were doing it wrong'.

Various national and state-based consumer and carer groups have now been established, attracting some grant funding and producing web and hard copy support materials, templates related to the care of children when parents are hospitalized, as well as conducting cross-sector workshop programs. For example, in one state, a consumer group has developed a materials package for teenagers and templates for care of the child when parents are hospitalized and also workshops for government and non-government workers and for children and families.

On a political level consumers are extremely powerful as there is generally a high level of government concern about their responses to events occurring and a commitment to their involvement in relevant issues, with many 'copmi' organisations recognizing this: *'consumers having involvement in it is also helpful...there's considerable concern about consumer attitudes and views'* (organisation leader).

However, over-reliance on consumers and non-government services was also considered a barrier by some of the focus group respondents because a more ongoing government-sponsored commitment is considered to be essential, with policies and an implementation plan providing longer- term sustainability.

6.2 Formal and informal alliances

In many states, the beginnings of a more strategic approach to 'copmi' was initiated by champions using their formal and informal alliances to agitate for funds and build the momentum, sometimes also keeping 'copmi' on the agenda during periods of political change or funding scarcity.

For example, examining the beginnings of 'copmi' in the 1990s in one state, agencies focused on parent mental health and concerned about leaving young children alone when parents were hospitalised, established informal breakfast meetings. These informal events began to support regular interagency collaboration, and there was discussion and an opportunity to hear from consumers about their issues. Some initial data collection was undertaken in relation to the numbers of dependent children, cross-sector workshops eventuated and links were made to national AICAFMHA directions and researchers. A key government/non-government/consumer committee was eventually established:

> *We let it develop organically. Lots of people wanted lots of order and structure... the only purpose was the discussion.....The informal breakfasts got sufficient people from across services around the table, hearing the issues for a sufficient time so we could make the connection to other things happening* (non-government agency leader).

However, many jurisdictional and government and non-government area coordinators and leaders highlighted the difficulty of cross-agency work, including the barrier presented by frequent personnel changes or discontinuity of services during funding transition periods. Given short-term funding, usually for two or three years, as the funding finishing timeline approaches and funding continuity is unclear, those holding the position being to seek other roles. So even if funding is eventually secured, there is a loss of personnel and formal and informal alliances interconnections have to be formed yet again. The impact of discontinuous funding on people and projects and particularly cross-sector work is indicated in the following statement by a senior official of one government service: *' …wonderful creative ideas about what they could do… they were really passionate and there was a wonderful energy with professionals working with consumers and young people ….and all of a sudden they were left hanging'*.

A successful strategy outlined was that some agencies have used their own funding for small-scale

projects and to continue informal networking. This has occurred even when government funding has not been available, thereby keeping 'copmi' on the agenda and pressuring for additional resources. Reflecting on the importance of this role, one non-government organisation leader states:

> *…the other learning that we had is that if you have people that hang in long term ..and keep links to, you know in this case, the mental health division....with all that effort it stays on the agenda…..it's enough for us...What we will do no doubt is attract more grant money for projects like that ...Small capacity building projects generate a lot if you can hold a continuity around them.*

While many cross-sector alliances are formed through interested individuals, formal alliances also play a role in bringing together a range of people to represent their agencies and with varying levels of interest and motivation. Through information sharing and collaborative work, there is also the potential to shift attitudes and disseminate new ideas across a wide range of situations, with some degree of discomfort for certain groups sometimes being part of the process: *'…after a while shaming other organisations that we really should be doing that….it's not good enough that you're not doing it '* (government coordinating leader).

Learning how to work across agencies and government services and address territoriality was certainly raised as an issue and various examples were given in different jurisdictions of the difficulties. For example, within one jurisdiction, a video was made by one service but was not able to be shared because funding came from one particular service. Different cultures for government services cause problems, with adult and child mental health being cited in various jurisdictions as an example. This is reflected in this statement from an area-based coordinator: '*You've got to be careful with adult services about how you approach that because they get narky'*.

In cross-sector committees, different cultures and agendas need some careful management and one jurisdictional cross-sector committee leader highlights some of these aspects:

> *...different agendas were brought to the table....At the start they were quite vocal about what the project should be doing.... I think through discussion people really understood that there weren't the structural things in place...I think its naïve to think that all of the tensions were ironed out....The primary goal for the project was to get 'copmi' onto the agenda in as many places as possible* (jurisdictional cross-sector committee leader).

Given funding limitations and the lack of opportunity and formal governance infrastructure for government cross-agency work, alliances have also been used to raise the 'copmi' profile and disseminate material widely. One jurisdictional government leader outlined a strategy for distributing materials across relevant workforce groups through participation in conferences for education and nurses: *'seeking opportunities...so it's becoming more everyday language …(and) distributing materials widely'* (government leader).

6.3 Bottom-up and top-down influencing

Consumers, practitioners and leaders having the opportunity and skills to influence senior level people across a range of service areas, as well as to motivate workers was a sub-theme identified in the focus group research within the context of the People, culture and management theme.

In regard to the issue of influencing senior level people and also bringing workers onside through provision of effective training programs, some research participants indicated various processes they had utilized to achieve this. One government jurisdictional leader outlines these approaches:

....You need high level (support)...and convince them that it's worthwhile and then drive it up to the top. That's actually what makes it sustainable because people at the top change.. So within the health or community services area, you really do need some champions there who will drive it and that comes from relationships. You need to do quite a bit of lead up work ...and also that can be across departments. Education is a very obvious one… offer to come and talk to people. So spreading the word...getting funding ...in an ideal world I would get coordinators in every service... People criticize us for rolling it out on a shoestring budget but I still think it's been worthwhile...We've got change...it's hard to measure but you know there's a lot of activity going on. You know with the satisfaction in the training and the response from people that they're using 'copmi' resources, that the links are being made.

Relationship-building with a range of people from senior levels and with workers and building trust was also emphasised in another jurisdiction in relation to a coordinator and the processes used for the purposes of influencing future directions: *' (X) put well presented ideas to the top of the organisation and worked for changes in the system and got things written down in black and white…. (She was) trusted at high level but networked with a range of people on the ground*'.

Influencing leaders and then formalizing agreements to achieve long term change is supported by another jurisdictional statewide leader in commenting that*:'…the most important thing is to engage with the people in leadership, the people in authority….so it can't be taken away*'.

Another perspective about change coming from the bottom up highlighted how this works in an opportunistic and informed manner: *'it comes from the bottom up…with change…you seize the opportunities when they're there…(it's) opportunistic but informed' (area-based leader).*

In addition to bottom-up influencing, a key change factor identified by various stakeholders in various jurisdictions is top-down influencing and leadership. Positional power provides opportunity to establish structures and processes for continuity and follow up at various levels of responsibility so that new ideas can be systematically established. Enthusing, building shared understandings and new language and mindsets is part of the leader's role.

6.4 Leadership commitment and reculturing

Connected with top-down influencing, a key skill identified for leaders is their capacity to work within and across organisations to reculture and build a shared vision and build towards new directions. Focus group participants in various government and non-government organisations across jurisdictions highlighted that this is a particularly significant focus for 'copmi'. A major reculturing is currently underway because services have traditionally supported the individual needs of adult consumers or children with mental health issues rather than operating within a family sensitive/recovery-oriented context and using early intervention approaches. As one government state coordinator has indicated in relation to individuals and organizations who are leading the way across whole systems within the jurisdiction in shifting the 'copmi' culture: *'Places like (X) have been a very strong voice to government saying, we need to work with whole families, we can't just work with individual clients, we need to take a systemic approach'.*

Working with whole families really does mean adopting a cross-sector as well as a systemic approach, with those in leadership roles working together and motivating and enthusing their own teams at all levels to rethink their work and ways of operating. This means considering 'copmi' in terms of adult mental health client needs for parenting skills and children's needs for support as carers and for knowledge about mental health and opportunities for respite and to share their experiences with others

or for counselling:

> *Different departments, education and community health are thinking of children but not thinking in 'copmi' terms. So it's like 'copmi' is the vehicle of mental health but it's almost like, you know we have to get another whole language to get people on board ...not talking about ''copmi'' but about children, families and mental health* (non-government leader).

It was highlighted in the focus groups that resolving conflict is a key high quality leadership skill which is important in cross-agency work given different agendas and different cultures. Leaders need to be able to support committee members and inter-team groups to sort through their differences and focus on improved services for 'copmi': *'it's a really valuable tool, conflict, if it's managed well'* (government leader response).

A particular barrier between services which was frequently highlighted in the consultations was division between adult and child mental health services:

> *…there's a clear divide between the adult sector and the child sector…there's not been a relationship…you've got to connect the adult sector with the child's problem if you want to address child abuse….but services aren't set up for that…even in mental health, CAMHS and adult mental health don't have that much to do with each other, only an individual case now and again but actually not planning services and understanding how each other works and it needs a strong driving force to address that* (area based leader).

The associated barrier when agencies operate as 'silos' and there is a lack of systematic sharing, partnership agreements and leadership is poor quality services for adults with mental health issues and for their children, apart from some individual workers and services. This is indicated in a jurisdictional leader's comment:

> *.....it shouldn't be about weaving your way from one control agency to another…. and if you can't do that, we'll pick that up...not signed off...otherwise you're leaving it up to individuals and personalities and if you've got someone good it's great.*

However, there was also a concern that shared approaches across services could result in loss of expertise and lack of ownership by any group of the 'copmi' work.

6.5 Professional learning

Focus group consultation attendees highlighted that ongoing professional learning and development is an important part of the reculturing process. This involves building new skills and knowledge for those working in the 'copmi' area and supporting the development of shared vision and values in relation to family-sensitive practices and early intervention, prevention and promotion.

Since the 1990s, one or two day conferences involving 'copmi' leaders within and across states and territories, nationally and internationally have played a significant enabling role, through sharing of information, development of strategic alliances and dissemination of new ideas into local contexts for future consideration.

In terms of the knowledge and skills of the mental health workforce across a range of roles, the comment was repeatedly made within the consultations about the poor level of understanding of issues. This is still seen as a barrier in terms of 'copmi' systems change as reflected in this comment from a jurisdictional training leader:

The issue is that we have a significant number of workers spread out doing all sorts of jobs with people in the community but they don't have the key bits of information that really help to make the best of the opportunities they have in the work with the individual and families they're engaged with… in the case of prevention, early intervention and really getting change happening… the opportunities aren't picked up on.

Nonetheless, over the past decade as more strategic 'copmi' approaches have been established within jurisdictions, training sessions have been used extensively to build the skills and understanding of adult mental health and other workers about the impact of adult mental health issues on families and children. The value of training programs is highlighted in the following interview comment: *'So I think training is about getting people to see that they've got a few extra skills ….if it's adult services they think what do I do with children ..So getting people to open up their minds and getting people to work a bit more holistically with the family ' (area-based 'copmi' leader).* Beyond information on services for referral purposes and developing an understanding of using a whole family approach, building the skills of clinicians in asking questions about whether there are dependent children and knowing how to conduct an assessment about parenting skills are key aspects of training which are currently receiving attention.

Some agencies in some jurisdictions have mandated training for all of their adult mental health workers, or induction of new staff involves 'copmi' as part of the orientation and training program. In other jurisdictions, cross-agency training involving child protection, education, adult mental health, child and adolescent mental health, nurses and general practitioners is occurring. Non-government organisations, consumer and carer groups, and jurisdictional bodies at the central or area level are the key providers.

The involvement of consumers in conferences and training sessions was noted as vitally important in many jurisdictions and across various stakeholder groups, as reflected in this comment by a statewide coordinator: *'One of the drivers for change is actually having people like...consumers and carers getting up there on an equal footing and speaking about the changes that have happened …And using that world (of consumers and carers) to get them (workshop attendees) to listen to you'.*

Consumers themselves commented on some of their past experiences and how they feel that sharing their stories at training sessions has made a difference and supported change for others using various services. This is reflected in the following story about the experiences of a pregnant woman with a mental illness being advised to have a termination:

..(I was) advised to have a termination and there was pressure to do this and I needed to seek support from various groups. Things changed for the better then but there was still a lot of judgment put upon me, constantly saying, are you doing the right thing? It's not that they weren't supporting but supporting in a way that made me feel like I was doing the wrong thing even though I felt so strongly about this. ...But I know now that there's a service....and they work with mothers and infants...and they're doing a lot of work about education and changing of attitudes.... I had a worker from the mother support program...and it didn't get through to her and she came to this workshop that I was speaking with...to find out more about what she could do to work with me and I was one of the presenters there....they don't know themselves what's the best thing.

Several organisational leaders in various jurisdications commented that, in addition to conferences and training sessions, they are also recognising that more ongoing professional learning approaches are needed. One leader of a statewide program reflects this in her interview comment:

..the whole idea of training we have to be careful about...you go along to the training and there's nice food and you have a nice chat...and within three days it's all forgotten and nothing changes.

And that's our big challenge, to look at the way we can organise change and support these families and it's real... so that people who can have these two day training (sessions), hear about real things and have a chance to make a difference and it's real language... (and) to go back to their team leader or their manager or their network and they can keep talking about it and keep getting support from somewhere and they can build local ownership.

Various approaches to ensuring more ongoing professional learning are occurring across jurisdictions and services. These include managers working alongside staff in delivery of services and modeling; 'copmi' as an ongoing item on team meeting agendas; co-locating services and teams to create opportunities for ongoing interaction; performance management processes highlighting 'copmi'; and developing e-learning programs. For example, one state has funded a statewide coordinator and some area-based positions, with regular meetings planned as a group and between the coordinator and area-based individuals, all linked to the performance management context and ensuring a coordinated approach to implementation of the state plan. Another area-based leader was working with her team of adult mental health workers in regard to 'copmi' in joint work with clients and she describes the benefits of the process as follows: '*it assists them….so that it's not just another job they have to do….it assists them in working with the client….and they have access to another clinician… and they do a better job ….and the clinicians learn extra skills'*.

Several focus group attendees also raised the issue of professional learning for health and other relevant professional undergraduates to ensure they were aware of the 'copmi' issues, although this was not widely occurring in the current context.

7. STRUCTURES, SYSTEMS AND PROCESSES

A key enabler in supporting strategic implementation is the establishment of relevant structures, systems and processes focused on achieving the outcomes and key performance indicators. Aspects are:

- National/state/area/team network alignment and local flexibility;
- Protocols within and across agencies and systematic data;
- Documented minutes and dissemination;
- Clear role statement and responsibilities; and
- Evaluation processes.

Barriers identified in Chapter 3 of this report including lack of structures in agencies resulting in discontinuity; disconnection between mental health and general practitioner services, mental health intake data not being systematically mandated or followed up and confidentiality rules prohibiting data sharing, will also be discussed.

7.1 National/state/area/team network alignment & local flexibility

Many focus group participants within the states and territories highlighted alignment between national and jurisdictional and regional area directions linked to the broader early intervention/promotion/prevention policies. This includes documenting state policies, developing implementation plans and establishing structures such as statewide cross-sector advisory committees. These committees are frequently supported by a funded statewide coordinator role, with this person also representing the government on other relevant committees and maintaining other wider formal and informal contacts. Some states have also provided funds for area-based 'copmi' staff and increasingly there are considerations about dual roles involving combinations such as 'copmi' and drug and alcohol or 'copmi' and parenting. Processes for accountability and increasing effectiveness include regular individual and network team meetings involving the coordinator and area-based staff to ensure a systematic approach to achieving the planned outcomes. Area leaders have generally established their own area based cross-sector committees which are focused on the state planning directions but also on local area initiatives, with some funding resources available for these activities.

For example, typifying the statewide advisory committee membership, in one state it involves representatives from services such as mental health, early parenting, prisons, indigenous, education, housing, non-government training providers, housing, drug and alcohol, child protection, and consumers. In other states, police, general practitioners, perinatal are also involved. However, the disconnection between mental health services and general practitioners was also quite recognised as a barrier. Only a few jurisdictions have such representation on their cross-sector committee, although there are general practitioners attending training sessions.

In another state, there is a cross-sector committee developing protocols, but no designated funding for a statewide coordinator. However there are some area-based part-time positions for 'copmi' or a non-government organisation is funded to develop training packages and to provide support for area-based staff, with local cross-sector committees established.

While alignment between jurisdictional and area based groups was viewed as very important, the need for local flexibility and a sense of ownership of networks by those in area services was also emphasised. For example in one jurisdiction a statewide network was established including area based 'copmi' personnel to ensure a more coordinated approach to achieving the overall strategic goals. However, there were ownership issues as reflected in the following statement by an area-based coordinator: '*A lot of people in that network felt marginalized…they haven't been able to have local services feel that they control what happens in their area….the goals for the network have never really been clear'.*

7.2 Protocols and systematic data collection

A key mechanism cited by interviewees for ensuring alignment within and across agencies involves the development of protocols and templates, particularly in relation to systematic data collection. This means having systems in place to provide evidence of the extent of the need for various services: '*If anyone is going to be strategic they really need the data... the demographic data, the projected population data...you can actually put up a good argument'* (government leader in jurisdiction).

Adult mental health services intake and dependent children information is an aspect of data of significance. While some agencies and area-based services have developed protocols supported by staff training, it has been more problematic to develop whole of state or joint processes at the cross-sector level. Some jurisdictions have used their cross-sector committees to get draft agreements although implementation is still forthcoming. Other jurisdictions have only really established the relevant governing body for this purpose in recent times.

Those locations in which intake data is being systematically gathered indicate that aspects involved in the protocols variously include number and age of dependent children; other support people available if the parent is hospitalized; role children currently play in the context of parental illness; home support services needed; parent skills assessment and issues for children and referrals required. The importance of staff training to build capacity and skills such that there is an understanding and the ability to seek information in relation to children and conducting parenting assessment was also raised.

Interagency protocols in relation to intake data are particularly problematic in terms of confidentiality and follow-up processes available. Confidentiality was identified as a significant barrier to sharing as shown in this comment by a organisational leader: *…(there are) tight parameters around what is shared anyway,....but that's not to say that there aren't things that could be shared'*.

7.3 Documented minutes and dissemination

Key processes cited which support strategic approaches include statewide cross-sector committees and area-based network groups and involve documentation and dissemination and other ongoing linking and contact mechanisms. In relation to minutes in area based network meetings the importance was noted by the area-based coordinator: *'Logging all of that stuff is really important so it can go out to everyone on the network even if you haven't come to the meeting'*.

However, it was highlighted by various focus group members that minute taking and dissemination and other follow-up measures require a dedicated coordinator. For example, in one jurisdiction where there was a funded coordinator position, additional follow-up work was undertaken to provide members of the committee with extra material to disseminate to the leadership group and to other relevant people in their organization. This is indicated by a reference group member from a government based jurisdictional program:

> *(X) was absolutely brilliant...(she sent) information about all these sorts of things that were happening. Articles and things like that (were) disseminated around the department….(they) told you about all the projects that were coming up so that you could spread that through the department to make sure that they had that information.*

7.4 Clear structures, roles and responsibilities

The importance of documented structures, role statements and responsibilities including in relation to statewide coordinators, area-based leaders and cross-sector steering committee members, was emphasized by many research participants. This includes having clear terms of reference for committee members.

For example in one jurisdiction, to support wide dissemination of information from the cross-sector committee to the government and non-government and consumer agencies represented, the committee coordinator led a discussion with members about follow-up within their own agencies and who to make contact with and what to talk about. Some individual members were given further follow-up support with this task. The responsibilities of various people who were on other jurisdictional committees developing various relevant plans to ensure that 'copmi' issues were included, was also discussed. Every few months the cross-sector committee coordinator established wider network opportunities and they showcased new information and kept the momentum going, thereby building the profile of 'copmi' in the community. The coordinator outlined her role and the processes for carrying out the responsibilities as follows:

> *..in the steering committee ...accountability was an issue and we discussed this ....as well as who are you actually representing....how are you transferring what's happening in the steering committee into your workplace and how is that information communicated....We did it with the whole group...which partially worked to varying degrees depending on the people...Some people came because they just wanted to know what was happening and other people came to learn.....Contextually there was a lot of change happening ...and we were able to feed into all of these and get 'copmi' on all these plans as a priority...Steering committee members (were on other planning committees)...their responsibility was to champion 'copmi' through these networks.*

Similarly in another state within the area based projects involving cross-sector networks, there was an area coordinator for each committee who was funded part-time. They developed a working party protocol and developed programs of relevance to their community and each representative from the network committee then had a dissemination role within their own agency.

On the other hand, a barrier relates to lack of structures and funding for follow-up services. For example, while adult mental health intake forms in some jurisdictions or area health services do now require data to be gathered regarding dependent children, the follow-up support roles to provide the services for children are not always available. This is reflected in a jurisdictional area-based health leader's comment that questions are asked about dependent children: *'..but there's not funding to support..when people ask the question ..do you have any concerns..it's not every single child getting a safety plan…Then to be able to coordinate those resources you actually do need a committed position, to be able to ring child safety and say you need three nights of respite care ..A caseworker can't do that as well as caring for the adult as well'.*

7.5 Evaluation processes

An aspect which was recognised as very important but not currently systematically occurring relates to evaluation processes. Many jurisdictions and agencies have built evaluation processes into their strategic plans, recognising the importance of this aspect for all projects and programs undertaken and being accountable for the funding provided.

One state began to collect data regarding programs provided to support children of parents with a mental illness and how this impacted on their understanding of the parental situation, child vulnerability in terms of behaviour and level of contentment, with the data impacting on government funding follow-up: *' (X) program provided an evidence based approach for some of this work….The department really listened.... the need for workforce change and skilling up the workforce in a way that was sustainable. He had all the right language I think and produced some evidence'* (jurisdictional coordinator).

Significantly the use of evaluation data evidence has shifted the focus from short term to longer term programs and funding: '*shifting the way and convincing the senior people in the branch to take a much*

more long term view of this, to get away from this pilot, pilot, pilot' (jurisdictional coordinator).

However, lack of evidence and funding for evaluation was widely recognized as a barrier in ''copmi'' change: '*Evidence is a weakness and nationally....evidence is a big weakness'* (area- based leader).

Despite this, many jurisdictions have been gathering evaluation data immediately following training programs, and there are some examples of small scale pre and post evaluation questionnaires. However, there is little evidence examining changes in attitudes and behaviours of those attending training within a period of months following the event in terms of determining the impact of training within the workplace practice context. This type of evidence requires more sophisticated tools and this is an additional barrier reflected in one statement from an area-based leader: *'We get better outcomes for the families if the children do need to be removed…if one service is arguing with another service, it's not good for the family….Due to more collaborative approaches, there's more sharing of information about the families than what we had but I can't measure the evidence'.*

Engaging clients in data collection processes is also problematic as noted by an area-based leader: '*This client group is difficult to engage so sitting down with some questions is problematic'.*

The importance of staff training to build capacity and skills such that there was an understanding and the ability to seek information in relation to children and conducting parenting assessment was also raised.

8. RESOURCES

Funding resources for programs and sufficient personnel to carry out 'copmi' duties without work overload were key aspects raised as enablers. Sub-themes highlighted included:

- State, area level and specialist services coordinator positions;
- Recurrent funding and longevity of key personnel; and
- Funding for activities/materials.

Barriers as introduced in Figure 5 will also be documented including the child mental health funding focus; lack of funding for activities; lack of evaluation funding and short term position funding.

8.1 State, area level, specialist services coordinator positions

Many focus group participants raised the importance of funded positions for coordinators of 'copmi' work at the state, area-based levels and within specialist services. State level coordinators are particularly important and some jurisdictions have now achieved this although not always as a recurrent position. Where a statewide position has not been forthcoming, there have been appointments made in some jurisdictions for area level persons or for specialist services. For example at the district level in one jurisdiction, early intervention funding resulted in a funded position to develop a resource kit including brochures, tip sheets for supporting young 'copmi' in peer support groups, also training and promotion regarding 'copmi', also conferences. Given that there was no statewide coordinator, children began to be referred to this district from other regions. This project would not have been possible without funding availability.

However area and statewide positions to ensure overall coordination of the strategic plan and network links within regional areas is the desired funding requirement identified by many of the focus group participants. The importance of funded positions is indicated by one area level coordinator, who also highlights lack of funding and the pressure this places on existing roles available at an area level:

> *Getting 'copmi' on the agenda and the statewide policies and strategic plan ....if there is a strategic plan and …. There's someone there to be able to dedicate funding to different districts or at least having a part-time position ....if it's on the agenda it has to happen. If the funding's there for it then the services can grow within each of the individual service districts and the support is there structurally ...to get the training. Whereas without someone coordinating all of that it's basically up to individuals to get out there and promote it ...there's no-one else ...*

8.2 Recurrent funding and longevity of key personnel

Some jurisdictions have now achieved recurrent funding for 'copmi', particularly for a statewide coordination role and this is recognised as a key enabler both currently and for the future.

However, most states in the past decade and currently have been providing some funding for 'copmi' state, area-based or training roles and project activities but essentially on a non-recurrent basis, and this is viewed as a significant barrier:

> *From my point of view we have a bit of a track record…and I suspect from across the world, of funding projects for about two years and setting up a whole host of expectations. And something that should be a ten year project from a project management point of view is managed as a twelve month project.... ..getting adult services involved...but the core business issue is to do with adult mental issues but we've dropped the ball before we've done 20% of the job (*jurisdictional government service leader).

This means that cross–sector committees may be established, support projects for children, resource materials development and training, often accompanied by high levels of enthusiasm and achievement. However, given their time-limited nature, as the funding finalisation nears and there are staff changes, people are not replaced. Staff uncertain of their futures, begin to seek other employment and committees lose their sense of purpose. The following statement from an area-based coordinator reflects this barrier:

> *After the two year funding period I collated some stats and collated a report and put it up to the Mental Health branch and said about all these great things we'd done and the fact that we'd got 38% of enquiries from outside the area and the type of young people we were getting..I was ready to go to the next level and try and get a statewide approach going ....and we needed people on the ground but at that point there was no interest…That was part of my frustration…unless there was a strategic move in the area of 'copmi' I had done what I wanted to do... And there was no commitment from the state to develop strategically …Things like getting a line in the assessment form (about whether adult mental health clients had dependent children) ..Now one of the hospitals took it on board…. and they added in do you have any children…things like that…. So policy would mean that those sorts of things are implemented in the procedures.*

Several focus group representatives spoke about 'copmi' staff who have been highly influential and built strong personal links within their communities and wider networks because of their ongoing commitment to 'copmi' over time. Some non-government organisations who were previously funded for specific 'copmi' projects have used their own funding to ensure that some 'copmi' services and a degree of continuity of employment for key personnel occurred, even when government funding was not available.

Other concerns raised by area-based staff were that part-time positions were sometimes funded from central funding sources for periods of time of perhaps two or three years, with area health services making resources available after this timeframe and overstretching existing staff: *'Up to earlier this year there was a statewide mental health officer dedicated to 'copmi', linked to the national agenda and coordinating. However the region's groups, using their staff, have sometimes taken up the 'copmi' cause (after statewide resourcing ended)'*.

The impact of the additional workload from existing staff were required to take on 'copmi' work when other funding ceased was recognized as a significant problem: '*one person in another service has started 'copmi' work and adding this to her other work and it's to breaking point'*.

8.3 Funding for activities

Funding for key coordination staff and those developing training programs has been discussed as one aspect of resourcing in terms of being an enabler and other costs for conducting children's 'copmi' camps or training programs was also highlighted in the consultations.

However, sometimes, when funding for these activities ceases, this becomes a significant barrier. For example, one area-based program was provided with staff to conduct 'copmi' children's camps and a database of children was established. The difficulty was that no funding was provided for the costs associated with the camp program. In another area-based children's camp program, they were reliant on local service clubs for the activity program costs. Similarly, in another jurisdiction, the cost of staffing in order to develop training materials was made available, but the resourcing for actually conducting any training programs was not subsidised.

8.4 Interconnected resources

Various organisations and jurisdictions highlighted the increasing use of interconnected resources involving various services to more effectively deliver 'copmi' programs to as many children as possible. Various combinations of interconnected services were described including dual 'copmi' and parenting positions, 'copmi' and drug and alcohol roles.

Sometimes interconnectedness occurred through arranging various services within a team and having an interagency manager bringing the group of individuals and services together for regular meetings, to share information about their work or for joint training. Interconnectedness of resources is also occurring through 'copmi' and other organisations pooling resources for joint national conferences. In one jurisdiction, early intervention funding given to district has been supported to be more effective through additional resourcing provided by a university and their post-graduate student involvement with young people enabling small group work to occur.

9. 'COPMI' CHANGE FUTURES

This section summarises key 'copmi' future directions themes highlighted by various stakeholders in the states and territories and nationally arising from the 'copmi' systems change enablers and barriers previously outlined and future directions. A 'copmi' systems change and sustainability maturity phases matrix is introduced. The purpose of this matrix is to support individual organisations and jurisdictions in current and future planning for sustainability and systems change.

9.1 Introducing 'copmi' change future directions

The key future change directions identified by jurisdictional and national government and non-government representatives and consumer and carer stakeholders are summarized in Figure 6. These key themes relate to interviewee responses to questions about examining the current directions and trends in their organisation and the local and national context and predicting future directions.

Similar to current enablers and barriers outlined in chapters 4 to 8, the emergent 'copmi' future directions issues can be summarized within broad themes:

- Big Picture Context and Leadership
- Policy and Strategy
- People, Culture and Management
- Structures, Systems and Processes
- Resources.

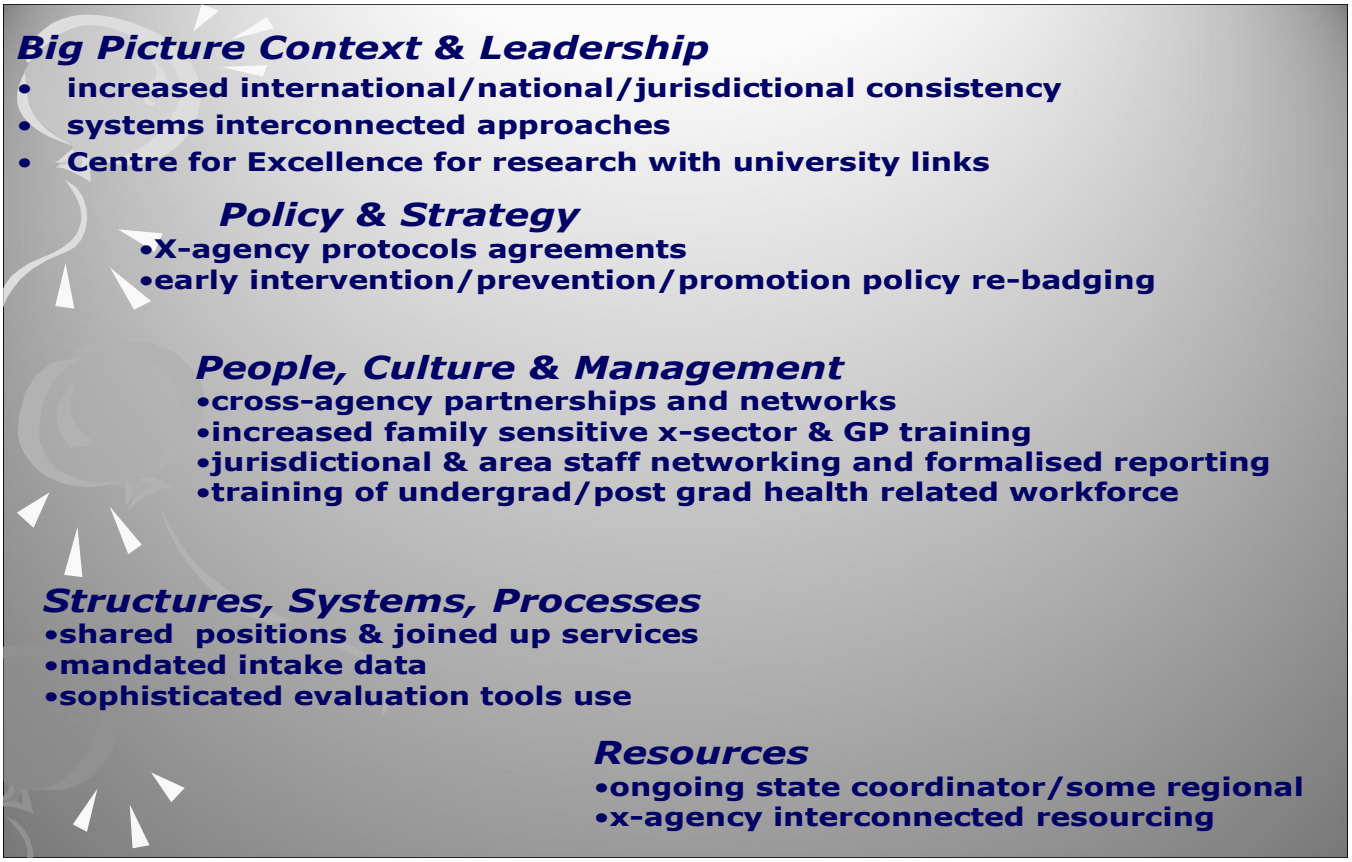

Figure 6: 'Copmi' change future directions key themes

Each of these key themes will now be discussed, together with the sub-themes identified.

9.2 Big Picture Context and Leadership

Relevant to the Big Picture Context and Leadership key theme for 'copmi' future directions are the sub-themes outlined in Figure 6 regarding:

- increased international/national and jurisdictional consistency
- systemic interconnected approaches
- Centre for Excellence for research

While national COPMI and federal government mental health policy frameworks are recognised by some individual interviewees as providing an Australia-wide context and having continuing impact for the future, jurisdictional legislation and policy which are varied in emphasis continue to predominate. Given a national political health context of working cooperatively for consistency across Australia, several stakeholders from key 'copmi' leadership backgrounds, identified this aspect as significant for the future change directions of 'copmi'.

The potential for greater national consistency was highlighted as important for achieving more equality of services for adult mental health consumers and their children as indicated in the follow responses from a 'copmi' leader: *'You need to somehow get into the ear of some of the Canberra politicians and there needs to be coercion at a national level to get some uniformity so that equity as a political thing and recognition of services across the country happens for families'.*

The global interconnections including international conferences, technological communications including teleconferences, videoconferencing and skype, wikis and various other formats for two-way communications were indicated as an important part of this context by some individuals.

Linked to this and building on current trends still evolving within jurisdictions, more interconnected government and non-government approaches were also highlighted as an important 'copmi' future direction by a range of stakeholders across jurisdictions and nationally. This is reflected in the following comment:

> *...I think that change is driven by a finance and departmental commitment to that change, that builds the structure for that change to continue to happen in the most effective way by building collaborative practice, by funding non government organisations to be providing safe and appropriate link with parents and children with a mental illness....We need to be using our recovery models to build programs that are about building resilience for the people that are experiencing the mental illness... with parenting as a motivator, it's a really good motivator for parents. It's about doing that across agencies…it's about building the experience of child and family nurses, child protection...mental health and CAMHS and all of those sorts of services.*

At the big picture level specifically, examples were given about the importance of national committees and conferences consciously avoiding insularity and ensuring an ever-widening range of key personnel from various background and perspectives being involved. This includes continuing connections to international groups and individuals, involvement of key Australian and overseas consumers groups such as COMIC and facilitating links within child protection, business, education and the media and communication areas. It also involves strengthening links to other major mental health promotion projects such as Mind Matters.

Individual interviewees highlighted the importance of these interconnections in leveraging off other

agenda to build the sustainability of 'copmi' for the future. This involves identifying critical government funding non-negotiable priorities and positioning 'copmi' within this framework. One interviewee highlighted the Australian Health Ministers Advisory Committee as a key political body to target to raise awareness in terms of ongoing funding and influence in relation to national and state agenda.

Nationally and internationally, it was highlighted by various individual interviewees, that the national COPMI initiative has established a significant reputation for quality resources and frameworks. This has global significance through the website, with international quality accountability processes through links to independent internationally-acclaimed 'copmi' experts. Interviewees believed that this role could potentially be further expanded in the future through establishing a National Clearing House function and National Centre for Excellence in 'copmi' research, with university links and student researchers involved. This service could be principally for Australian 'copmi' and other organisations related to children of parents with a mental illness but would also have an international presence through the website function, thereby further establishing a wider reputation.

9.3 Policy and Strategy

Relevant to Policy and Strategy, future 'copmi' direction sub-themes identified by stakeholders relate to:

- Cross agency protocols agreements
- Early intervention, prevention, promotion policy re-badging

In terms of Policy and Strategy, many jurisdictions are beginning to establish or to re-establish high level cross-sector committees in relation to 'copmi', with clear leadership directions and terms of reference and various sub-committees. Whilst usually driven by the mental health government department, there is a focus on developing cross-sector protocols and achieving formal signatory agreements for other government departments, and with linkages to non-government organisation services and to key consumer and carer groups. In these jurisdictions, funded statewide coordinator roles and/or area-based positions have been provided, although with varying recurrent or non-recurrent funding status.

The protocols and resources are framed within jurisdictional strategic implementation plans, including network groups within area-based regions and locally-implemented training programs. These directions are sometimes linked to the national COPMI directions and with accountability and evaluation expectations, as reflected in the following response from a jurisdictional service representative:

> *..I think to get sustainable change it has to be driven by a national agenda and a whole of government agenda, it's not just the responsibility of health. And then it needs to be linked probably to the agreements with the states and territories and through that you get your monitoring and evaluation*

A direction which is currently underway and which could be further developed (as highlighted by some experienced government background leader interviewees), concerns leveraging from other jurisdictional directions such as drug and alcohol services, education and nursing programs.

Overall some individuals highlighted the importance of renewal of the message related to intervention, promotion and prevention and building on 'copmi' learning to date and finding fresh ways forward. In the current political context of ore openness about mental illness, there is an increasing recognition of the range of people affected including key political figures. Within this environment, re-badging the 'copmi' message for politicians and bureaucrats and highlighting children as the future and focusing on various types of mental illness was indicated as a way forward. Specifically, living well with mental illness, resilience, population health approaches, differential needs, and using 'just in time' philosophies were aspects highlighted.

9.4 People, Culture and Management

Regarding People, Culture and Management and future directions, Figure 6 has introduced key sub-themes of:

- Cross-agency partnerships and networks
- Increased family-sensitive cross-sector and GP training
- Jurisdictional and area staff networks and formalised reporting
- Training of undergraduate/postgraduate health-related workforce groups.

People working together within cross-agency partnerships and formalised networks are identified as an essential aspect in terms of future systems change in relation to 'copmi'. While the strategies and structural supports are important, the people networks through formal and informal alliances were emphasized repeatedly by various stakeholders across jurisdictions, as evident from this consultation statement: *'Strategic goals and implementation is important but it's the ongoing contact and communication that leads to gaining awareness and ensuring it's at the forefront of practitioner minds'* (government leader).

While nationally and within some states and territories there is a high awareness of the importance of consumer and carer partnerships, ensuring sufficient levels of consumer and carer participation in planning and delivery of services, particularly in relation to young people and across various aspects related to promotion and prevention and recovery, was highlighted as an area for further attention.

Additionally in terms of building alliances, 'Copmi' conferences at the national and international level were also noted as important future directions which are evident. This is about bringing in key people and political figures and linking to other relevant conference groups to use funding efficiently. It may also involve speakers from business and the media, and thinking outside the usual 'copmi' framework at the level of health and aging and respite care and ensuring child protection agency inclusion, and listening and learning from each other.

Another future focus underway but needing further development includes building the training focus on family-sensitive practices within cross-sector groups and also including general practitioners. There is a need for various workforce groups to understand about mental illness and its impact on children and about working with the whole family. This includes working with mentally-ill parents to improve their parenting skills and with children to build resilience through a range of training and workshop programs. The involvement of consumers and carers in these training sessions through telling their stories to build understanding of relevant workforce groups about the issues was underlined as important to continue in the future.

This is shown in this comment from a training leader about what needs to be understood by those working with mentally-ill adults:

> *..parenting is important to them and having a mental illness..it doesn't mean they don't care about them...They're still concerned about their children...They want the best for their children but they know they can't do the best...There are financial problems or they can't get out of bed in the morning....*

While cross-sector professional learning in the general sense is important, an identification of who the key groups are and ensuring they are included in professional development programs is also a significant direction which is only just beginning: *'..the 'copmi' initiative is funded from DOHA (Department of Health and Ageing)...it is around education.. Professional development and strategic*

planning..(They) need to ask who are the key populations for professional development – GPs, workers in mental health services…It should be for all (of those people who are) working with adult mental health (consumers)'.

At the national level, a current key focus to improve 'copmi' training materials is underway through national COPMI which is researching and developing flexible high-quality materials which will be available online as a stand-alone program or as the basis for jurisdictions and groups developing their own individualised programs.

In terms of people capacity-building, beyond formalised training programs there are the beginnings of recognising the wider and more ongoing professional learning processes. This is about using team meetings and other day-to-day opportunities to build the skills and knowledge of each worker. This involves getting 'buy-in' from those who are managers of people, linking them to the area and jurisdictional services and ensuring that formalised reporting structures are connecting individual people to the overall directions and more strategically providing quality services for 'copmi' within a framework. As noted in the consultations in relation to the role of team leaders in continually questioning their staff about 'copmi' in dealing with adult mental health issues: *(You need to get) 'team leader level buy in...they're the people that staff go to ...if the team leader is saying what's happening to the kids'?*

Ensuring that university students, in relevant pre-training and post-graduate studies programs have a knowledge of 'copmi' is another future direction of importance which is only really in its infancy.

9.5 Structures, Systems and Processes

Figure 6 introduces sub-themes for future 'copmi' related to Structures, Systems and Processes of

- Shared positions and joined up services
- Mandated intake data
- Sophisticated evaluation tools use

Child protection, education, drug and alcohol, perinatal, nursing, police, disabilities, housing, general practitioners…these represent the types of services which are increasingly identified by various stakeholders in various jurisdictions as being involved in 'copmi', with formalized structures and systems being developed to more effectively provide support. The importance of leaders being involved in building systems to support change and 'copmi' service improvement is underlined by one jurisdictional service provider leader about the importance of establishing: '*systems that allow you to collaborate....between different services… (it's important to) identify systems issues and have the responsibility and the power to actually put processes in place...that needs to come from the top down to give you the authority...and then be supported '*

One of the key aspects identified in the consultations which is underway to a greater or lesser extent within jurisdictions and within area services currently and which needs further development is ensuring intake data is systematically collected when adults enter mental health services. Data aspects currently being collected relate to number and age of dependent children, support available for them, conducting parenting assessments and the need for support services for the children and for counselling. Representative of the range of views consistently expressed around the importance of this issue for the future is this comment which places the issue within the emerging framework of child protection: '*The child protection model is the future. There are formal structures for response. 'Copmi' are sometimes referred to child protection especially due to neglect … Mental health services being required to ask parents if they have children and who's looking after them'.*

Evaluation is also identified by many stakeholders across jurisdictions and nationally as an important area for the future which is underway but with more systematic processes needing to be developed, as

well as sophisticated tools for qualitative research. The national COPMI is currently undertaking some work in this area. Evaluation at the NHMRC standard of quality and needing to work with universities and to attract PhD students' involvement in working in 'copmi' was highlighted by a few key leaders as a future direction.

9.6 Resources

Future directions which were identified in terms of resources include:

- Ongoing state coordinator/some regional staff position
- Cross-agency interconnected resourcing

Recurrent funding for 'copmi; sates and territory leadership positions and establishing 'copmi' as a program rather than a project are new directions which only a limited number of jurisdictions have embraced. However this was repeated emphasized through the consultations as essential for sustainability in terms of building the networks and providing long term directions. Some area-based positions provided through jurisdictional centralized funding sources or through area-based resources are increasingly being provided, although generally involving non-recurrent funding. However, increasingly area-based funding is provided on the basis of increased linked and formalised reporting between area and centralized 'copmi' personnel.

An additional 'copmi' resourcing aspect which is emerging involves interconnected resources across various services. Drug and alcohol and mental health services being jointly funded is a particular example of this.

9.7 'Copmi' systems change maturity phases

Given future directions which are emerging in 'copmi' nationally and within jurisdictions and relating this to issues of strategic change management and sustainability, it is evident that specific government and non-government, consumer/carer organisations in various states and territories are trying to build towards the long term but are at different points in achieving this. Reference to the strategic change management and sustainability matrix introduced in Chapter 3 within the 'copmi' context seems useful as an aspect of this report.

Table 3 has been developed to provide a framework for consideration by organisations. It outlines a possible interpretation of the key identified elements for this consultation in terms of Policy and Strategy; Structures, Systems and Processes; People, Culture and Management; and Resources. This is outlined for individual organisations within the broader situation of Big Picture Context and Leadership (which is often external to that particular organisation's direct influence).

A five phase matrix is provided from Immature to Early Maturing, Defined, Managed and Integrated/Sustainable. The Immature phase shows little connectedness in terms of developing policy and links to resources and training or funding of positions, with the Early Maturing phase beginning to show some connectedness. At the Defined phase, planning and documentation shows evidence of planning for the use of a project management approach. This includes a documented policy supported by funded positions and evaluation, with people working in teams and being trained and with agreed structures, responsibilities and systems operational. At the Managed level, widespread implementation of the more coordinated approach is underway, with the final stage of Integration/Sustainable indicating change being integrated with other projects and linked to wider contexts.

Table 3: 'Copmi' systems change maturity matrix

Big Picture Context and Leadership

	Immature	Early Maturing	Defined	Managed	Integration/ Sustainable
Policy & strategy • Strategic implementation plans • Policy alignment • Vision/mission • Change management	• Low level of ownership • Ad hoc & incongruent goals/outcomes • Low accountability for resources • No consistent approach to change management	• Some alignment of policies & responsibilities with objectives but mostly 'bottom up' • Strategies and some practices documented but not communicated • Project management approach still under development	• Large change management projects identifiable and show alignment to overall change agenda • Overall awareness of strategies and priorities • Resource plan available and needs identified within context of other projects	• Evaluation of programs and resources systematically occurring • Performance and resources assessed against organisational needs • Processes, systems and services integrated • Strategies & policies implemented	• Integrated strategic change management planning occurring in regard to other projects
Structures, systems, processes • Protocols & data • Documentation • Clear structures & responsibilities	• No evaluation & accountability • Little documentation of processes • Unclear roles & responsibilities • No process alignment	• Some data but not systematically collected • Some understanding of roles & responsibilities • Some documentation of minutes, structures and processes but not systematic	• Data collection processes outlined • Roles & responsibilities chart available • Systematic documentation occurring • Documented systems planning	• Evaluation of programs & resources systematically occurring • Roles and responsibilities articulated and understood • Documentation of processes systematically occurring	• Systematic evaluation of structures, systems processes occurring and informing future decision making
People, culture & management • Training • Alliances & teas • Leadership commitment • Champions	• Little training • Few alliances & little teamwork & leaders • Isolated champions	• Some individual & group training • Some team meetings & alliances including a learning focus • Some leadership support for champions	• Internal groups planning to share practices within team meetings • Training needs plan established for all organizational members • Leadership support for champions	• Training program established and evaluated • Formal networks & teams established & consistently supported by leaders	• Ongoing formal and informal learning cultures established across organisation and with others
Resources • Funded positions • Recurrent funding • Funding for activities • Interconnected resources	• Ad hoc funding • No accountability for resources • Positions ad hoc & little connection to planning directions	• Some funding linked to planning directions • Some accountability for resources • Some positions linked to planning	• Funding linked to project manning • Some recurrent funding for positions	• Funding and activities evaluation against change directions	• Integrated resource utilization and decision making

Big Picture Context and Leadership (often beyond organisation's control)

Underlying this strategic change management matrix, there is an evolutionary process of change which was also discussed in Chapter 3. This involves change happening on an ongoing basis at all levels of organisation and across organisations and people. Evolutionary change happens in formal and informal situations, with people and organisations interacting and connecting around areas of common interest and concern. It involves people working individually and in small teams within and across organisations, experimenting and trialling new ideas on a daily basis, and networking and sharing those practices and

the refinement which happens and the gradual influencing of others to do things differently which happens over time.

10. CONCLUSION

This report provides details of a study regarding 'copmi' systems change in Australia involving government, non-government and consumer/carer organisations at the national and jurisdictional levels.

Following a literature review including examination of policies, frameworks and other materials, a brief summary of 'copmi' history development nationally and in states and territories is provided. Respondents within interview and focus group consultations outlined enablers for systems change, barriers and future directions.

Five key themes emerged for the consultation and focus group collated information:

- Big Picture Context and Leadership
- Policy and Strategy
- People, Culture and Management
- Structures, Systems and Processes
- Resources.

Appendix C provides details in summary table format. These themes and their associated sub-themes can be linked to systems change literature concerning strategic change approaches and evolutionary approaches which are all relevant within the context of sustainability. The key message is that evolutionary and ongoing processes for change which occur through individual efforts at all levels, team and as individual organisations on a daily basis and within interactions with other organisations and groups, are all an important part of change happening over time.

These evolutionary approaches can be highly influential as individual people and teams experiment on a daily basis within their work, sharing new ideas with others and influencing networks and organisations, including those in leadership roles. Over time within the big picture context and with organisational leaders shaping particular directions, new ideas can be built into strategic change management approaches for organisations. Policies and frameworks are developed and strategic planning and processes are devised, with funding and resources for key positions provided and accountability occurring, also including the training and motivating of people to carry out new directions.

In this report, one view of a 'copmi' change management and sustainability matrix has been provided which recognises the big picture context and policies, strategies, resources, and people aspects. Various phases of organisational change and sustainability are outlined in terms of Immature, Early Maturity, Defined, Managed and Integrated/Sustainable.

Many 'Copmi' organisations seem to be currently working towards sustainability and are probably operating at the Early Maturing or Defined stage, with planning occurring towards more mature stages although with implementation still happening in a fairly haphazard way. Despite the ongoing passion and leadership by individuals across consumer/carer and various government and non-government services, the need for a real commitment from government at the jurisdictional level for provision of recurrent funding for some key 'copmi' coordination roles is certainly an issue in terms of building sustainability.

While individual champions have networked and built informal links across organisations to really provide integrated 'copmi' services, the formalisation of systems and structures are reliant on high level leadership and commitment. This involves developing policies, frameworks and cross-sector protocols and accountability mechanisms to provide ongoing staffing and to establish sustainability beyond individual efforts.

It is suggested that organisations and jurisdictions use the 'copmi' change management and sustainability matrix or a modified alternative version which they devise as a checklist to determine their current progress in terms of sustainability across various aspects such as big picture context, policy and strategy, structures, people and resources. After 'mapping' their current situation, they can formulate a vision for the future at different time periods and begin to devise a plan of action towards achieving this. In terms of timing this needs to be realistic because reaching optimisation/sustainability takes time and will perhaps require a mapping of the stepwise actions required to work towards this over a number of years. While this process could occur within individual organisations, it would certainly be interesting for government, non-government and consumer/carer organisations within each jurisdiction to come together or to work within their cross-sector committees to plot the overall current situation and to map future action for systematically achieving sustainability. This would also be a useful future step for national groups related to children of parents with a mental illness.

The 'mapping' by organisations and across organisations and planning for future action using a sustainability checklist represents a first step in a self-audit and empowering process within the control of individual groups.

An additional future action involves continuing the sharing which occurred through this research study through organisations including representatives from government, non-government and consumers/carer groups coming together within a workshop session to document their 'copmi' systems change stories in a collaborative process. This could be done within the context of the 'copmi' change management and sustainability matrix. Perhaps some initial case studies could be written to provide examples and this process could be replicated with a workshop day happening involving a wider group of participants who bring their policies, frameworks and materials and work collaboratively in small groups to share their achievements while supporting each other to document their current situation and achievements. Other sustainability matrix models for reflective practice may be an outcome from this process.

Over time and with the support of collaborative workshops and documentation and dissemination of examples of various processes and case studies representative of phases of maturity of sustainability, national mapping of 'copmi' groups may occur. National and jurisdictional 'copmi' organisations and groups including government, non-government and consumer/carer services could be included, the purpose being in working towards greater 'copmi' sustainability within a national context for the future.

Recommendation: That national COPMI provides opportunities through collaborative workshops for documentation of 'copmi' systems change case studies reflecting differing phases within a sustainability matrix to provide support towards more ongoing and sustainable interconnections for the future within a national context.

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GLOSSARY and NOTES

Aboriginal—a person of Aboriginal descent who identifies as an Aboriginal and is accepted as such by the community in which he or she lives.1

Adult mental health service—an organisation that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and support to adults with mental disorders and/or mental health problems. The mental health service should be specialised and complimentary to other health services. The definition includes service providers in both the private and public sector.2

Adult mental health worker—a person who works with adults with a mental disorder and/or mental health problem and their families.

AICAFHMA – Australian Infant Child Adolescent and Family Mental Health Association

ARAFMI - Association for Relatives and Friends of the Mentally Ill

AUSIENET – Australian Network for Promotion, Prevention and Early Intervention for Mental Health

Carer—'A person whose life is affected by virtue of close relationship and a caring role with a consumer'.3

Child—a person aged 0–18 years. The term 'young people' is also used to denote children but specifically refers to those aged more than 12 years.

Child and adolescent mental health service (CAMHS)—an organisation that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and support to children and adolescents with mental disorders and/or mental health problems. The mental health service should be specialised and complimentary to other health services. The definition includes service providers in both the private and public sector.4

Child and adolescent mental health worker—a person who works with children and adolescents with a mental disorder and/or mental health problem and their families.

Child and family health service/worker—an organisation or individual practitioner who provides primary, secondary or tertiary health care services to children and/or families (examples include general practitioners, paediatricians, infant and maternal health nurses, community child health services, allied health practitioners, midwives and other peri-natal service providers).

Child protection services—agencies operating under state/territory legislation relating to the care and protection of children. Services provided include investigation into concerns regarding child maltreatment or neglect, assessment, case planning, protective intervention and supervision of children and families under relevant court orders.

COMIC – Children of Mentally Ill Consumers

Community service provider—an organisation that provides a direct welfare or social support service to individuals, groups and families in the community.

Community service worker—a person who works with individuals, groups and families in the community to enhance their welfare.

Co-morbidity—'Co-existence in one person of more than one illness or disorder'.5

Complexity Theory- Evolutionary change process which is constant and occurs through interaction with other organisations or the environment, with multiple approaches occurring over time [5a]

Consumer—'A person making use of, or being significantly affected by, a mental health service'.6

Continuity of care—integration and linkage of components of individualised treatment and/or care across agencies according to individual needs.

COPMI – Children of Parents with a Mental Illness

Debriefing—the act of discussing or talking through a recent experience, such as a crisis.7

Early childhood —the first 6 years of childhood.

Early intervention—'Interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder. Early intervention also encompasses the early identification of people suffering from a first episode of a disorder'.8

Education sector—systems and individual services that provide, as their core business, education to the community. The sector involves both private and publicly funded services and includes pre-schools, schools, universities and vocational training services.

Effectiveness—a measure of the extent to which a specific intervention, procedure, regimen, or service, when deployed in routine circumstances, does what it is intended to do for a specified population.9

Evidence-based practice—a process through which professionals use the best available evidence integrated with professional expertise to make decisions regarding the care of an individual. It is a concept which is now widely promoted in the medical and allied health fields and requires practitioners to seek the best evidence from a variety of sources; critically appraise the evidence; decide what outcome is to be achieved; apply the evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in this process'.10

Family—There is wide variation in the composition of Australian families which can include combinations of mother, father, same-sex parents, stepmother, stepfather, infants, children, young people, other family members, and non-related carers.11

Family preservation—In the context of this document, family preservation refers to the promotion and preservation of the wellbeing of families where children are at risk of being removed owing to concerns about their safety. Family preservation strategies include, but are not restricted to, increasing parenting skills and confidence, addressing poverty and housing issues, enhancing family relationships, and the provision of in-home intensive support at times of crisis.

Health—a state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities.12

Infants—children aged less than one year.[13]

Information services—services that provide information to the community, including via telephone 'information-lines', and websites.

Justice sector—systems and individuals that provide, as their core business, services in relation to law and justice in the community. The sector includes police, the courts and legal professionals.

Mental health promotion—'Action to maximise mental health and wellbeing among populations and individuals'.[14]

Mental health—the capacity of individuals and groups to interact with one another and their environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.[15]

Mental health service—an organisation or individual that provides, as its core business, primary, secondary and, in some cases, tertiary treatments and support to children and/or adults with mental disorders and/or mental health problems. A mental health service should be specialised and complimentary to other health services. The definition includes services in both the private and public sector.[16]

Mental health workforce—the personnel employed in the provision of mental health services (see above). In Australia, five professions make up the bulk of the mental health workforce: mental health nursing, occupational therapy, psychiatry, psychology and social work.[17]

Mental illness/disorder—a significant impairment of an individual's cognitive affective and/or relational abilities which may require intervention and may be a recognised, medically diagnosable illness or disorder. Mental illnesses/disorders are of different types and degree of severity and some of the major mental disorders perceived to be public health issues are depression, anxiety, substance abuse disorders, psychosis and dementia.[18]

Organisational Development – planned change within an organisation focusing on people and involving overlap between individuals and organisational goals [5a]

Outcome—a measurable change in the health of an individual, or group of people or population, which is attributable to an intervention or series of interventions.[19]

Parent/s—'The person or people who are a child's primary care givers. There is wide variation in the composition of Australian families, and parenting can include combinations of mother, father, stepmother, stepfather, other family members, and non-related carers. Regardless of the combination, parents (both male and female) have a profound influence on child development and mental health'.[20]

Peri-natal—relating to the periods shortly before and shortly after the birth of a baby.

Prevention interventions—'Interventions that occur before the initial onset of the disorder to prevent the development of disorder. The goal of prevention interventions is to reduce the incidence and prevalence of mental health problems and mental disorders.'[21]

Protective factors—factors which help mitigate negative effects and adversities. They may be intrinsic to the individual (e.g. good social skills, temperament) or external to the individual (e.g. social support, cultural context).[22]

Respite care—a service that provides a break for people who have a caring responsibility (e.g. parents and young carers). It can be provided in the home or in another location.

Resilience—'Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place the person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills and strategies for dealing with adversity, such as problem-solving, good communication and social skills, optimistic thinking and help-seeking.'23

Risk factors—'Those characteristics, variables or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder'.24

Service provider—a person (usually with professional qualifications) who receives remuneration for providing services to people and/or families. The definition includes service providers in both the private and public sector.

Selective prevention interventions (for mental health)—interventions targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average. The risk may be imminent or it may be a lifetime risk. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of mental disorder.25

Social Worlds – change process involving constant and evolutionary process of one organisation interacting with other organisations or the environment and using difference of opinions and conflict to synthesise into new order [5a]

Stakeholder—any party to a transaction which has particular interests in its outcome.26

Strengths-based approach—a strengths-based approach involves starting with peoples' strengths and building upon them rather than focusing on deficits and failure. In the family context, it is based on the assumption that all parents have strengths to bring to the parenting task and that families are often the best people to develop their own solutions (although they may need help to do so).

Systems Theory – planned and intended change model involving clear goals, measurement and feedback [5a]

Torres Strait Islander—a person of Torres Strait Islander descent who identifies as a Torres Strait islander and is accepted as such by the community in which he or she lives.27

Young carer—a child or young person who 'provides care to another family member, usually a parent, who has a physical illness or disability, mental ill health, a sensory disability, is misusing drugs or alcohol, or who is frail'.28

Notes

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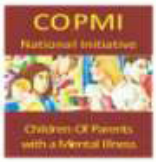
APPENDIX A: REFERENCE GROUP COMMITTEE MEMBERS



The national COPMI initiative

National Reference Group

Membership - July 2008

Chair: Mr Phil Robinson, Chair, AICAFMHA Board of Directors

Accountability: The Reference Group is accountable to the Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA) Board.

Name	Position	Key Contribution Area
Christie Wallis	National Young Carers Project Co-ordinator, Carers Australia.	National overview of young carer issues, resources and networks.
Adrian Falkov	Deputy Director, Consultant Child and Adolescent Psychiatrist, MH-Kids, NSW	Clinical experience; experience in evaluation of clinical 'copmi' services, development of education and training resources
Angela Obradovic	Chief Social Worker/Family Work Development Coordinator, Northern Area Mental Health Service, VIC	Adult mental health copmi-related workforce development and services. Interagency collaboration at a regional level.
Carly Dolinski	Senior Program Officer, Mental Health Network, Mental Health Division, Department of Health, W.A.	Experience in development of interagency protocols at a state-wide level.
David Hay	Professor of Psychology, School of Psychology, Curtin University, W.A.	Evaluation of 'copmi' initiatives and of relevant workforce development. Extensive knowledge of the literature.
Jennie Parham	Project Manager, Auseinet, SA	Experience working with consumers and carers in the PPEI area. Facilitating networks, exchange of information and PPEI learning's. PPEI workforce development.
Margaret Cook	Mental Health Consumer Consultant, WA	Consumer and carer perspective. Extensive advocacy experience in the field. Links with consumer organizations nationally.
Nick Kowalenko	Clinical Director, Department of Child and Adolescent Psychiatry, Royal North Shore Hospital, N.S.W.	Clinical and evaluation expertise with 2-8 year olds and their families. Links with beyondblue perinatal and infant mental health program.
Rose Cuff	VicChamps Co-ordinator, Eastern Mental Health Program, Victoria	Experience in service provision for young 'copmi' and their families. Experience in workforce development and consumer and carer participation.
Jane Westley	Coordinator, National Primary Mental Health Care Network Australian General Practice Network, ACT	Links to the National Primary Health Care Network
Bridget Dillon	MHACT COPMI Coordinator, CAMHS, ACT	Mental health and child protection workforce development. Facilitation of interagency linkages-government and NGOs.
Nikki de Bondt	Social Worker, Koping Program Co-ordinator, Child and Youth Mental Health Service, QLD	Clinical and education services and facilitation of multi-agency forum. Strong links with young people, families and service providers.

Jane Austin	Policy Consultant – Promotion, Prevention and Early Intervention, Mental Health Services, Tasmania.	Link with statewide pilot program for 'copmi'. Experienced primary school teacher and radio journalist.
Vicki Cowling	Child and Adolescent Mental Health Service, Hunter New England Area Health Service, Newcastle	Experience in research, conceptualising and developing projects, professional education, publication, consumer and carer advocacy. Strong international links.
Representatives - TBA	Consumer & Carer Advisory Group	Consumer and carer perspective.
Jo Mason	*MindMatters*.	Links with relevant Australian government funded mental health initiatives.
Brenda Dobia	Representative *KidsMatter*	
Matt O'Brien	Representative *headspace*	
Margaret Young	National President and representative of Early Childhood Australia (acting as COPMI National Family Forum representative until selection of new representatives)	Links with early childhood sector (services, researchers, planners etc.).
Pam Linke	President, Australian Association for Infant Mental Health & representative for Niftey (National Initiative for the Early Years)	Links with infant mental health and parenting sector.
Janne McMahon	Representative Private mental Health Alliance (PMHA)	Links to private sector service providers and workforce.
Barbara Hocking	Representative SANE	Advocacy, awareness raising, links with community.
Michelle Swallow	Representative NGO mental health services	Links to NGO services planning delivering and evaluating services for 'copmi' and families.
Stanford Harrison (or his representative)	Director, Children and Youth Mental Health Programs Section	Representative of the Department of Health and Ageing

APPENDIX B: 'COPMI' CONSULTATIONS BACKGROUND PAPER

COPMI Interview Paper

Introduction

Nationally in Australia, it is estimated that one in five adults experiences a mental health problem in their lifetime, with around 35% of females attending mental health services having dependent children (Farrell et al, 1999; Victorian Government Dept. of Human Services, 2007). Over one million children and adolescents are affected (Maybery et al., 2006). While there is considerable variation in response to parental illness, about half of these children will subsequently develop mental health problems themselves (Commonwealth Dept of Health and Aged Care, 2001).

In the past few decades, various state and territory government and non-government organisations and `groups have been established for the purpose of supporting children of parents with a mental illness. In addition, since 2002, the national Children of Parents with a Mental Illness (COPMI) initiative has been undertaken by the Australian Infant Child Adolescent and Family Mental Health Association (AICAFMHA), with funding from the Australian Government Department of Health and Ageing. Its focus is on sharing information; promoting best practice principles; advocacy; and collaboration with other organisations and groups in Australia and overseas

This current research initiative involves undertaking a critical analysis of systems and organisational changes implemented within Australia and internationally, including the sustainability of programs supporting children of parents with a mental illness 'copmi'.

A significant aspect of this research is interviewing national and state and territory organisations and key individuals about historical events and processes of change within their context, including the drivers and influences which have supported or detracted from improvements and sustainability.

Systems Change

Government and non-government organisations and interest groups focused on a particular aspect of society are part of a system. Systems change cannot be precisely defined but it is about loosely connected organisations and groups, both formal and informal. The health and human services area is:

> *…composed of many interconnected systems and subsystems such as hospitals, social workers, home care providers, community service organisations and even individual families. These groups are not always directly connected to one another. For example, families and other informal caregivers are often the backbone of any care system yet many families remain remote and disengaged from the formal service systems. When we refer to the systems involved in 'systems change', we are talking about all these system levels, both formal and informal* (Kendrick, Jones, Bezanson & Petty, 2006: 3).

Systems change can be about minor or major systems components focused on policies, protocols, initiatives or workforce aspects. Change may start with individuals and interest groups, sometimes within formal organisations, then involve other groups and organisations and become more comprehensive over time. Both systematic and non-rational elements are involved. There are vested interests, attitudes and habits, so change is complex and not always entirely predictable or easy to implement (Kendrick et al, 2006).

Systems change theory highlights a range of processes which support and influence the evolution and direction setting of organisations and groups over time and these differ from one situation to another. Some models highlight the use of structured change processes while others are more evolutionary in nature.

Table 1 outlines a model comparing four change theories and their similarities and differences.

Table 1: Change theories: similarities and differences

	Systems theory *Goals*	**Organisational Development** *People*	**Complexity** *Evolution*	**Social Worlds** *Conflict*
Broad change approach	Change is infrequent and intentional		Change is constant, evolving and cumulative	
Analytical framework	Change takes place at the level of a single organisation or group		Change takes place through interaction with other organisations or the environment	
Trigger for change	Clear goals, measurement & feedback	Overlap between individual and organisational goals	Multiple approaches and letting directions arise gradually over time	Difference of opinion
Change process	Change as goal achievement	Change as people focused process	Change as ongoing and without end	Change as conflict followed by synthesis into new order
Role of leader	To establish measurement and feedback process	To encourage participation	To interpret emerging change with team	To take a strategic view of multiple agendas

(Adapted from Rydderch et al, 2004)

Table 1 shows systems theory and organisational development approaches as planned change models which are focused within the organisation or group concerned. In these models, processes include building teamwork and shared vision. Systems theory highlights triggers for change including goal setting, feedback, and measuring the degree to which outcomes have been achieved. Organisational development models reflect the people aspects, with building a link between personal and organisational goal directions, participatory decision-making and teamwork being significant focii (Senge, 1994; DFID, 2003).

As indicated in Table 1, complexity theory and social worlds approaches go beyond the particular organisation and focus on interactions with other groups. Change is highlighted as constant, evolutionary and to some extent, unpredictable. Multiple directions are important in complexity theory and conflict between ideas and directions is a key trigger for social worlds approaches. In these models, informal review processes and structures help those involved to make sense of what works well and areas for improvement (Rhydderch et al., 2004).

In considering change in relation to children of parents with a mental illness, current structures and operational directions reflect various influences and events including state and territory funding sources, locally-based political events, the patronage of key individuals and national and local research reports.

Reports

Research reports can provide a key trigger for change, establishing directions and sometimes initiating funding for relevant projects. Some key national reports for Australia in relation to children of parents with a mental illness are:

- *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin et al., 1993)
- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000* (2000)
- *Second National Mental Health Plan: 1998-2003* (1999) also 2003-2008 (2003).
- *Promoting the Mental Health of Children and Young People* (Raphael, 2000)
- *Children of Parents Affected by a Mental Illness Scoping Project* (2001)
- *Mental Health Promotion and Prevention National Action Plan* (1999)
- *Principles and Action for Services and People Working With Children of Parents with a Mental Illness (*2004).

There are also a range of state and territory reports which will be further explored in the consultations. Some of these have provided key strategic project directions at the local level and interstate and resulted in systems and organisational change. This current research involving semi-structured interviews with individuals and within focus groups seeks to explore relevant influences on systems change and sustainability in relation to 'copmi'.

Interview Guide questions

This current research is about consulting with various organisations and groups about the research work, people and events which have shaped the response and structures in their states and territories or nationally within Australia. A brief literature review has been conducted. Semi-structured interviews with key personnel are underway.

Questions will be asked in a conversational way and individualized to the situation as issues arise. Some broad areas for questions are:

- How long has your organisation/group had a systematic response regarding children of parents with a mental illness? What has been the focus of the response and what people or events led to this?

- How has the organisation or response changed over time?

- Are changes driven by internal events, people and processes or by other factors outside of the organisation or group itself?

- Does the organisation/group use essentially internally based goal-focused approaches in setting change directions or does change evolve continuously over time involving multi-faceted approaches and external forces ?

- What is the main driver of change generally for the organisation and has it been different for 'copmi'?

- What factors have led to sustainability of the organisation or group?

- Have any policy, research or position papers been a driver for action (or had a negative impact) in your state/territory?

- How are policies, procedures and protocols disseminated?

- What can other states/territories and countries learn based on the work in your organisation and region of Australia?

- Based on events which have influenced change in your state/territory over time, what would you say needs to happen in the future?

- What linkages between your organisation/group and others have been successful and how were these fostered?

- To what extent has organisational change been dependent on the interaction between this organisation/group and other organizations and been multi-faceted, evolutionary and unstructured?

Conclusion

I look forward to meeting with you in the coming weeks and wish to thank you in advance for your participation.

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APPENDIX C: CONSULTATION KEY THEMES AND SUB-THEMES FOR ENABLERS, BARRIERS AND FUTURE DIRECTIONS

Big Picture Context and Leadership enablers, barriers and future directions

Enablers	Barriers	Future Directions
• Legal and policy interconnected contexts • Critical incidents • High level influential champions and national contexts • Historical/social issues and timing.	• Poor high level government commitment across agencies • Changing political agenda, crisis not prevention driven • Changing senior managers & little interest & support • Insufficient national/state links	• Increased international/national and jurisdictional consistency • Systemic interconnected approaches • Centre for Excellence for research

Policy and Strategy enablers, barriers and future directions

Enablers	Barriers	Future Directions
• Having high level cross-agency governance and policy or formal signatory documentation such as Memoranda of Understanding; • Developing strategic implementation plans at the state and territory level; • National and jurisdictional and regionally aligned policies; and, • Ensuring there is a clearly articulated mission/vision.	• Few cross sector policies & protocols MOU • Policy but no implementation plan & resources • State-regional links needing some local flexibility	• Cross agency protocols agreements • Early intervention, prevention, promotion policy re-badging

People, Culture and Management enablers, barriers and future directions

Enablers	Barriers	Future Directions
• Champions at all levels including consumers; building formal/informal alliances • Bottom-up and top-down influencing • Leadership commitment and reculturing • Professional learning including joint conferences, mentors and team meetings.	• Government agency 'solos; & lack of sharing • Lack of training in parenting assessment/recovery model • Frequent personnel changes & intermittent services • Over-reliance on NGOs/advocates for continuity	• Cross-agency partnerships and networks • Increased family-sensitive cross-sector and GP training • Jurisdictional and area staff networks and formalised reporting • Undergraduate/postgraduate health-related workforce groups

Structures, Systems, Processes enablers, barriers and future directions

Enablers	Barriers	Future Directions
• National/state/area/team network alignment and local flexibility • Protocols within and across agencies and systematic data • Documented minutes and dissemination • Clear role statement and responsibilities • Evaluation processes.	• Few structures/policies for continuity in agency • Disconnect of Mental health with GP services • MH intake data not mandated & poor follow-up • Confidentiality rules & concerns re data sharing	• Shared positions and joined services • Mandated intake data • Sophisticated evaluation tools use

Resources enablers, barriers and future directions

Enablers	Barriers	Future Directions
• State, area level, specialist services coordinator positions • Recurrent funding and longevity of key personnel • Funding for activities/materials.	• Child MH funding focus • No funding for expenses • No funding for evaluation • Short term position funds	• Ongoing state coordinator/some regional staff position • Cross-agency interconnected resourcing