World Fellowship For Schizophrenia And Allied Disorders

Principles for Working With Families

In Comprehensive Mental Health Care

This information, available also in pamphlet form, was developed by members of the World Fellowship for Schizophrenia and Allied Disorders in conjunction with Professor R.H. Falloon, Professor Julian Leff and Professor William McFarlane, international psychiatric researcher clinicians working with families in many parts of the world. The principles were drawn up as part of the 'Families as Partners in Care' initiative and are based on positive research findings[1] found when family members were included in comprehensive treatment and care.

The text below lists the principles and explains the rationale for work with families. It is particularly relevant for countries where a mental health workforce is available to be trained in 'family interventions'.

Work on this program is ongoing as WFSAD considers the needs of families in countries where numbers of mental health professionals and services are minimal. Other booklets in the Families as Partners in Care initiative are:

Families as Partners in Care—A Work in Progress 2003

Families as Partners in Care—Guide to Professionals Doing Family Work in Developing Countries

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Goals for Working with Families

- **To achieve the best possible outcome for the individual with mental illness through collaborative treatment and management.**
- **To alleviate suffering among the members of the family by supporting them in their efforts to foster their loved one's recovery.**

Fifteen Principles for Working with Families

1. To coordinate all elements of treatment and rehabilitation to ensure that everyone is working towards the same goals in a collaborative, supportive relationship

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[1] Fallon, R.H. 1998. An Annotated Bibliography. Families as Partners in Care – A Work in Progress*. World Fellowship for Schizophrenia and Allied Disorders* WFSAD 1998. Also available at www.world-schizophrenia.org

Working together ensures that the goals for treatment and care are understood and agreed by the treatment team which includes the family. This will overcome the isolation that is experienced by both professionals and families.

2. To pay attention to the social, as well as the clinical needs of the patient

It is insufficient to focus exclusively on medication management. Needs for appropriate accommodation, employment or alternative occupation, economic support, recreation and a supportive social network must be taken into account.

3. To provide optimum medication management

Clinicians should be alert to signs of over medication and to the unpleasant and disabling side effects of antipsychotics. There should be regular reviews of the medication with the patient and family. Education about medications plus regular assessment, particularly in relation to side effects, will encourage compliance.

4. To listen to families and treat them as equal partners

Relatives have gained a great deal of experience in caring for their relative and have much to teach professional care givers. Their expertise should be acknowledged and valued. Clinicians should consult with family throughout the treatment and care program, to improve effectiveness, understanding and empathy. Speaking to families in their homes may help in initiating family contact.

5. To explore family members expectations

a) Of the treatment program

Each family member may have different expectations. Because these may be unrealistic it is important to explain what the team hopes to achieve.

b) For the patient

After an episode of illness, particularly at the beginning, family members may expect the person to return rapidly to their previous level of functioning. The family will need to adjust their expectations and form new goals. Throughout the treatment process, family and patient expectations have to be regularly evaluated.

6. To assess family's strengths and difficulties

It is too easy to focus on the family's problems and ignore their strengths. Simply staying together constitutes a strength. A major strength is their intimate knowledge of the patient and what they have learned through a process of trial and error. Caring for someone with a mental illness exacts an emotional toll. Anxiety and depression are commonly found among family carers and should not be neglected. These symptoms reduce their capacity to support the patient.

7. To help resolve family conflict by providing sensitive response to emotional stress

Anger, anxiety and guilt expressed by family members should be dealt with in a sensitive way. Anger can usually be reframed as showing concern. Expressions of warmth are encouraged. Recreational activities should be promoted that are likely to lead to family members enjoying things together. When conflicts stemming from antagonistic relationships arise clinicians need to listen to the differing viewpoints impartially and seek resolution through compromise.

8. To address feelings of loss

Family members experience loss of hopes and expectations for their sick relative. They also feel that the person they know has been changed by the illness. Their grief needs to be acknowledged. They need help in coming to terms with both these kinds of loss.

9. To provide relevant information for patient and family at appropriate times

An introductory education program is an effective way of engaging families, but needs to be followed by continuing education throughout the period of treatment and care. Clinicians and families need to appreciate each patient's individual signs of relapse in order to bring about an early treatment intervention. Each family has its own concerns which need to be addressed. In addition clinicians should recommend that the family attend a support group.

10. To provide an explicit Crisis Plan and professional response

The family should have access to the treatment team when they know that their relative is in danger of relapse. A provisional plan, which includes relevant telephone numbers of key contacts and services, should be in place.

11. To encourage clear communication among family members

In some families, members find it difficult to communicate with each other. They have stopped listening. It is common for the person with the mental illness to be left out of discussions. Clinicians need to suggest simple ground rules for clear communication and support the family in their efforts to observe them.

12. To provide training for the family in structured problem-solving techniques

This cognitive-behavioural approach is of great value in helping families to tackle the main problems they face in caring for a person with mental illness. It is sensible to guide the family towards applying the techniques to a simple problem first so that they are likely to achieve success.

13. To encourage the family to expand their social support networks

Families tend to withdraw from their natural support networks through burden, shame and embarrassment about the illness. Initially they benefit from social interaction through relatives support groups, multi-family problem solving groups. It is important that the caring role does not absorb all their life and that a balance be maintained. Patients may be helped to increase their social activity by social skills training often with the assistance of siblings and friends.

14. To be flexible in meeting the needs of the family

Clinicians may decide to work with a single family or groups of families. Family members and/or the patient may need to be seen separately. The patient may need to discuss some concern privately when they do not concern the family.

15. To provide the family with easy access to a professional in case of need if work with the family ceases

It is essential to leave the family with a phone number and a named person who will deal with any future enquiries. Sometimes a telephone discussion will suffice: at other times additional sessions may be required to help the family to cope with a crisis or a change in their circumstances.