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LITERATURE REVIEW

Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families

Literature review

NSW Department of Community Services

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Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families

Author

Dr Leone Huntsman

Produced by

Centre for Parenting & Research
Service System Development Division
NSW Department of Community Services

Head Office
4 – 6 Cavill Avenue
Ashfield NSW 2131
Phone (02) 9716 2222

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Executive summary

This report reviews research on the consequences for children of having a parent with mental health issues, and the effectiveness of strategies and interventions designed to support affected families. The review aims to address the following key questions:

- What is the evidence regarding parental mental health issues as a significant risk factor for child abuse and neglect?
- What is the impact of parental mental health issues on children's development?
- What factors reduce or increase the likelihood of adverse consequences for children of parental mental health issues?
- What factors need to be taken into account when conducting a risk assessment in the context of parental mental health issues?
- What effective strategies and interventions are available that will:
  - ensure the safety of children and provide support for them
  - support parents with a mental illness (including well-functioning parents where one parent only has a mental illness)
  - improve long-term outcomes for children?

Difficulties in defining the terms 'mental health issues', 'mental health problems, 'mental illness', 'psychiatric illness' and 'mental disorder' and distinguishing between them complicate the interpretation of research results.

For the purposes of this review and in accordance with definitions used in the Department of Community Services' manuals and assessments:

- The term 'mental health issues' has been used as a broad term to encompass both clinically diagnosable disorders and less severe problems that may not meet criteria for a diagnosis.
- The term 'mental illness' is used where research refers to a specific diagnosable mental disorder.
- The term 'mental health problem' is used to refer to difficulties which interfere with a person's daily functioning but to a lesser extent than mental illness.

Difficulties in defining and distinguishing between these terms also make it difficult to estimate the number of families affected. Nevertheless, the following conclusions have been drawn:

1. 'Parental mental health issues' is a significant reason for the reporting of children to child protection services.
2. There is strong evidence of a link between parental mental illness and child maltreatment.
3. Children whose parents have mental illness are at heightened risk of adverse consequences other than maltreatment, including:
   - developing mental health problems as they get older
   - perinatal complications and other health problems in infancy
   - social and behavioural problems in childhood and adolescence
   - suffering the consequences of stress associated with caring for parent with a mental illness.

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Research on the effects of parental mental illness on children's development was examined in order to enable the more effective targeting of interventions. There are a number of more commonly recognised and often severe forms of mental illness, namely schizophrenia; depression or mood disorder (including perinatal depression and bipolar illness); dual diagnosis of substance misuse and mental illness; and personality disorder. The most important conclusions regarding these were:

1. Schizophrenia is associated with an increased likelihood of loss of child custody, and of generally adverse child outcomes.
2. Maternal depression is associated with an increased likelihood of attachment disturbances in infants and young children; externalising and internalising behaviours in later childhood; and less competent parenting behaviour. Perinatal depression, in particular, is increasingly being linked to long-term adverse social, behavioural and cognitive outcomes for children.
3. There is substantial evidence that the co-occurrence of parental substance misuse and other mental health illness is associated with a significantly heightened risk of child maltreatment.
4. Parental personality disorders are a highly significant factor in child maltreatment.

Research on Munchausen's Syndrome by Proxy (now often called Factitious Illness Induced by Carer) was also examined as a direct cause of child abuse. It revealed different professional opinions as to whether or not this is a rare condition or consequence of parental mental illness.

This report identifies a range of factors associated with either the increased vulnerability or the increased resilience of families affected by parental mental illness. Some factors specific to families with parental mental illness, include:

1. the level of parental awareness of illness and insight into the effects on self and children
2. the severity and chronicity (including episodicity, especially where hospitalisation is involved) of mental illness and children's age at onset
3. whether or not the illness has been diagnosed and is being appropriately treated.

The review then considers policies and initiatives with respect to early intervention programs to support children and families affected by parental mental health issues in Australia. It concludes that while a public health framework within which such services can be located has been constructed, no substantial progress has been made in developing and trialling programs specifically designed to meet the needs of these families.

Reports on early intervention programs and strategies and their effectiveness were examined in order to determine:

- whether or not results were applicable to families with parental mental health issues
- whether there were programs specifically designed for parents and/or children in such families
- if such programs were found, whether or not they achieved positive outcomes.

There were a number of early interventions that have shown promising findings for mothers with depression. These include mother-infant psychotherapies, programs that utilise guidance regarding mother-infant interaction, cognitive behavioural therapy and family focused services. There is also some evidence that preventative interventions are effective such as intensive postpartum support by a health professional and identifying woman at risk of postnatal depression. There was a lack of child-focused interventions (apart from 'camps' and peer support). However, when asked what they need most, children of parents with mental health issues have identified that they needed more information about

their parent's mental health issues; to be informed and consulted by professionals who often focus exclusively on the parent's needs; someone to talk to; and help with practical issues around parent hospitalisation and respite.

Very few 'generic' programs such as child care, parenting or home visiting, were found to be specifically tailored for parents with mental health issues. These parents may not 'fit' in parenting groups, and there appears to be a need for home visitors to be trained to work with them. The possibility of adapting currently operating programs to incorporate aspects of tailored programs with positive outcomes could be considered. There is little information on the role of fathers in relation to the promotion of resilience in children. There may be a need for interventions that assist spouses who are generally supportive but under stress. Special considerations relating to the provision of services to Indigenous and Culturally and Linguistically Diverse (CALD) families where there is parental mental health issues are noted.

Difficulties associated with the overlapping service boundaries between child protection and mental health in the support of these families are great. Considerable collaboration between representatives of mental health and child protection will be needed to improve the delivery of services.

1. Introduction

1.1 Purpose and aims of this review

The purpose of this review is to analyse and critique the extant literature to identify effective strategies and interventions that support children and young people with parents with mental health issues. In particular the review aims to address the following key questions:

- What is the evidence regarding parental mental health issues as a significant risk factor for child abuse and neglect?
- What is the impact of parental mental health issues on children's development?
- What factors reduce or increase the likelihood of adverse consequences for children of parental mental health issues?
- What factors need to be taken into account when conducting a risk assessment in the context of parental mental health issues?
- What effective strategies and interventions are available that will:
  - support children and ensure their safety at all times
  - provide support to parents (both the parent with the mental illness and the well parent, where one parent only has a mental illness)
  - improve long-term outcomes for children?

1.2 Scope of the review and methodological considerations

Databases selected for searching purposes included AGIS, Cochrane Library, EBSCO Host, Ingenta, Informit, Medline, PsychArticles, PsychInfo, Ovid, Proquest, Science Direct. General internet searches on Google and Google Advanced Scholar were also undertaken.

A systematic map produced by the United Kingdom's (UK) Social Care Institute for Excellence on *The extent and impact of parental mental health problems on families and the acceptability, accessibility and effectiveness of interventions* published in 2006 was also used. This map provides an overview of research since 1985 on:

- the extent and detection of parental mental health issues in the UK
- the impact of parental mental health issues on the wider family
- the accessibility, acceptability and effectiveness of available and potential service interventions for parents with mental health issues.

It does not involve quality appraisal, data extraction or synthesis of findings, but provides a searchable overview of the existing literature. It was selectively drawn on for this review and updated for the remainder of 2006 where relevant (Bates & Coren, 2006).

Studies included in this review have used experimental designs with either random assignment to intervention and control groups or matched control and/or comparison groups. In their scoping report, AICAFMHA (2001) discerned six levels of research evidence underpinning programs:

- A systematic review of all relevant randomised controlled trials
- Evidence obtained from at least one randomised controlled trial
- Evidence obtained from well-designed pseudo-randomised controlled trials

- Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group
- Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series with a parallel control group
- Evidence obtained from case series, either post-test, or pre-test and post test.

Studies consulted for this study are overwhelmingly from the top four levels.

It is notable that the quality of research in this area has been steadily improving. Randomised controlled trials, prospective, longitudinal, population-based and cohort studies as well as comprehensive reviews and meta-analyses are much more common than they used to be. More rigorous research designs have been adopted and the use of structured diagnostic instruments, with subsequent increased inter-rater reliability and comparability of findings, has been a major advance (Beardslee et al., 1998).

Differences were noted between articles taken from journals in what might broadly be defined as the psychosocial/child behaviour and development ('social science') subject area, and those published in psychiatric and medical journals. In general in the medical and psychiatric, as compared with 'social science', articles:

- there was a higher proportion of randomised controlled trials, reviews and meta-analyses, which are more reliable in terms of results despite sample sizes being smaller.
- reports on individual studies did not specify instruments used and methods of data analysis in the detail that was given in the social science articles

Studies with a minimum number of subjects, below 50, are generally excluded, although a few dealing with focus groups of parents or children, or innovative or pilot interventions, have been included if they present a relevant perspective that would otherwise be absent.

With respect to retrospective studies, Hardt and Rutter (2004) reviewed findings on the validity of retrospective recall for childhood maltreatment and chronic family conflict. They found that retrospective reports in adulthood of major adverse experiences in childhood involve a substantial rate of false negatives and measurement error. However, Dube et al. (2004) used data from the Adverse Childhood Experiences Study questionnaire to assess the test-retest reliability of adult reports of childhood abuse and other household dysfunction. They found that the test-retest reliability in the responses and the resulting Adverse Childhood Experiences (ACE) score were impressively high. They concluded that retrospective studies are generally stable over time, and reliability statistics support the use of retrospective cohort studies. Kendall-Tackett and Becker-Blease (2004) examined work on the importance of retrospective findings in child maltreatment research. They concluded that prospective findings are valuable but that retrospective findings measure a segment of the population of adult survivors missed by prospective studies, and the maltreatment field would lose valuable information if retrospective findings were discarded (Paz et al., 2005).

It was accordingly decided to include findings from retrospective studies in this report if they were of otherwise good quality.

2. Definitions and prevalence

2.1 What are 'parental mental health issues'?

The very vagueness of the term 'mental health issue' points to one of the great difficulties posed in reviewing this area of research. There are difficulties in defining the terms 'mental health issue', 'mental illness', psychiatric illness' and 'mental disorder' and distinguishing between them.

The terms 'mental illness' ,'mental disorder' and 'psychiatric illness' are more commonly used when referring to a diagnosable and clinically recognisable set of symptoms or behaviours that interfere with social, academic or occupational functioning (American Psychiatric Association, 1994, see Appendix A). However, consensual psychiatric descriptions of disorders are lacking, as are agreed ways of defining and measuring them (Tomison, 1996). 'Mental illness' is also used in a legal context in Australia to refer to persons who are dealt with as patients under various state and territory Mental Health Acts (McDermott & Carter, 1995), and is defined as 'the full range of recognised, medically diagnosable illnesses that result in significant impairment of an individual's cognitive, affective or relational abilities' (Australian Health Ministers, 1998: 27).

In line with this usage, the *Dual Diagnosis Manual for Caseworkers* (DoCS, 2005: 23) provides the following definitions:

> *A mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. Diagnosis is generally made according to a classification system and requires the presence of one or more of the following: hallucinations, thought disorder, severe disturbance of moods, sustained irrational behaviour indicating the presence of hallucinations or delusions.*
>
> *Mental health problems also interfere with a person's cognitive, emotional or social abilities, but to a lesser extent than mental illness. Mental health problems are typically less severe and of shorter duration than mental illness and may include mental ill health temporarily experienced as a reaction to life stressors.*

The definition of what constitutes a mental health issue also raises questions. The proliferation of types of disorder described in psychiatric texts tends to blur the very concept of mental illness. For instance 'caffeine dependence disorder' and crystal methamphetamine ('ice') addiction are both considered substance related disorders according to the 943 page 'Diagnostic and Statistical Manual of Mental Disorders (DSM IV)'. However these two types of substance related disorders will clearly have markedly different impacts on the users and their families. The lack of agreement about what should be counted as a 'mental health issue' limits the comparability of research data and makes it difficult to determine how many children and families are affected.

For the purposes of this review, the term 'mental health issues' has been used as a broad term to encompass both clinically diagnosable disorders and less severe problems that may not meet criteria for a diagnosis. The term 'mental illness' is used to refer to a diagnosable disorder and the term 'mental health problem' is used to refer to difficulties which interfere with a person's daily functioning but to a lesser extent than mental illness.

Sometimes parents with a mental illness are classified as parents *with a disability*, alongside parents with intellectual, physical and sensory disabilities, further complicating the picture (McConnell et al., 2000). Nevertheless, attempts to estimate the prevalence of parental mental health issues have been made and are reviewed in the next section.

2.2 How many children have parents with mental health issues?

There have been many attempts, in Australia and overseas, to estimate the percentage of the population who have mental health issues, mainly using census or epidemiological data. Generally the percentage is between 20 per cent and 30 per cent (Andrews et al., 1999; Falkov, 1998; Nicholson et al., 2001; Tunnard, 2004). More pertinent for the purposes of this report is the percentage of the population with mental health issues who are parents of dependent children, and the number of children affected. These questions cannot be answered with any precision, for two main reasons:

a) Adult mental health services do not (or have only recently begun to) record whether their clients have children (AICAFMA, 2001).

b) Studies have found that a substantial percentage of those who have mental health issues have not been diagnosed or are not receiving treatment for their condition. Australian data suggest that only 38 per cent of adults and one quarter of children experiencing mental health issues seek assistance from a health service (Department of Health and Aging, 2006) and almost 50 per cent of people with mental health issues are not recognised by their General

Despite these difficulties, estimates in Australia have been attempted and tend to arrive at similar figures. Maybery et al.'s (2005) methodologically detailed analysis concluded that between 21 per cent and 23 per cent of children living in Australian households have a least one parent with a mental health issue. This is not too different from earlier surveys that found between 29 per cent and 35 per cent of mental health services clients were female parents of dependent children under the age of 18 (Cowling, 1999; Hearle et al., 1999; Farrell et al., 1999).

If Maybery and colleagues' percentage is close to being accurate, this equates to just over a million Australian children in 2005 under the age of 18 having at least one parent with mental health issues. A significant number of children in New South Wales (around 300,000) will form a subset of this population.

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3. Significance of parental mental health in relationship to developmental outcomes for children

3.1 Is there evidence that parents with mental health issues are more likely to abuse or neglect their children?

The answer to this question would have seemed self-evident in the early days of the 'discovery' of child abuse, when the initial paper on 'the battered child syndrome' stated that 'Psychiatric factors are probably of prime importance in the pathogenesis of the disorder' (Kempe et al., 1962: 17). It was reasoned that only parents who were severely psychiatrically disturbed could show the lack of control or concern evident in cases of child maltreatment (Tomison, 1996). As later explanations focused on sociological factors, with Belsky (1993) noting that there are likely multiple pathways to abuse and neglect, there has been less consideration of the contribution to child maltreatment of parental mental illness *per se*.

There is considerable evidence, however, that parents with mental health issues are over-represented among maltreating families (Sheppard, 1997; Berger, 2005; De Bellis, et al., 2001; Cleaver et al., 2000; Blanch et al., 1994; Hetherington et al., 2002; Queensland Department of Families Youth and Community Care, 1994; Trocme & Wolfe, 2001). A large prospective community-based sample in the United States (US) reinforced the association between types of parental psychiatric disorder and the later development of child abuse and neglect (Chaffin et al., 1996). Research into serious injuries sustained by children under two years suggested that many parents had poor mental health, although a formal diagnosis was relatively rare (Dale et al., 2002).

It is often the case that parents come to the attention of child protection agencies because of child maltreatment and are found to have mental health issues. The prevalence of identified parental mental illness and substance abuse increases along with the level of child protection intervention: mental illness in 13%, substance abuse 20% of cases referred for child protection concerns, progressing to 42% and 70% respectively in cases subject to care proceedings (Bell et al., 1996; Hunt et al., 1999). A review of care and protection matters finalised at two Sydney Children's Courts in 1998-99 found that 21.8% of cases initiated by a DoCS care application involved parents with a 'psychiatric disability' (McConnell et al., 2000). In a survey of 114 cases referred to the Melbourne Children's Court in early 2002 for pre-hearing conferences, 25% of the parents (28 parents) had mental health issues but only nine of these were currently clients of a mental health service (Sheehan and Levine, 2005). A comparison of parents whose children had been removed because of severe maltreatment with non-abusing parents found a higher lifetime incidence of affective disorders, few previously diagnosed or treated, among the former (Famularo et al., 1986).

It can therefore be concluded that parents in a significant number of cases that come to the attention of the statutory child protection agencies have mental health issues, and that these may not be obvious on the basis of the primary issue that prompted reporting or contact, and may or may not have been diagnosed or treated. As Hetherington et al. (2002:183) noted 'there are some figures about mentally ill adults who are parents. There are some figures about children in need of protection who have mentally ill parents. But these figures do not join up.'

3.2 What are the short- and long-term impacts on children of parental mental health disorders?

This section summarises research that looks specifically at what might be adverse consequences other than maltreatment for children having a parent with mental health issues.

Mental illness in a parent does not necessarily constitute a protective concern (Darlington et al., 2005a). Nevertheless, evidence that children in such families are at heightened risk for a number of adverse outcomes is substantial.

Research on the development of these children is complicated by the heterogeneity and lack of agreement on definitions and measurement of 'mental health issues'. The frequent co-existence of other family stressors also makes it difficult to measure the specific contribution of parental mental health issues to particular outcomes. There is also ongoing debate about the degree to which genetic factors interact with the environmental context to affect child outcomes (Hyman, 2000; Curtis, 2008). Bearing in mind these limitations, findings are summarised as follows:

Problems in infancy

Foetal exposure to adverse conditions such as mothers' stress and the side effects of medication are associated with increased risk of perinatal complications and behaviour problems such as irritability and diminished responsiveness during early infancy (Connell & Goodman, 2002). There is also evidence of neuro-behavioural disruptions in infants born to mothers using antidepressant medication during pregnancy, although longer-lasting effects have not yet been identified (Zeskind & Stephens, 2004). Young children of parents with a mental illness are at increased risk of medical problems, including injuries, convulsive disorders and increased frequency of hospitalisation (Weissman et al., 1986, cited in Cleaver et al., 2001).

Social and behavioural problems in childhood

Current research consistently shows a higher rate of behavioural, developmental and emotional problems in children of parents with a mental disorder compared with those in the general community (Beardslee et al., 1998; Cicchetti et al., 1998; Klimes-Dougan et al., 1999; VanDeMark et al., 2005).

Mental health issues

The most frequently reported finding is that children whose parents have mental health issues are at substantially greater risk of developing mental health issues later in life (Weissman et al., 1997; Shiner & Mormenstein., 1998; Andrews et al., 1990; Farrell et al., 1999); Rutter & Quinton, 1984; Cytryn et al., 1984, Watt et al., 1984; Beardslee et al., 1998; Zubrick et al., 1995).

Criminal and suicidal behaviour in adolescence

A study of a large random sample of youth committed and detained by a juvenile justice system in northeast US found those who had a mother with a mental illness were four times as likely to commit serious criminal behaviours (Preski & Shelton, 2001). A study of all children born in 1966 in Denmark found that first time suicide attempts, at the age of 14 to 27 years, were associated with parental psychiatric disorder (Christoffersen et al., 2003).

The stress of caring for a parent with a mental illness

Some children of parents with a mental illness, particularly those in sole parent families (Dearden & Becker, 1995), take on the role of carer to the parent. It is not only older children who are involved with children as young as three and a half found in one study (Frank, 1995). These are frequently referred to as 'invisible children' (Fudge & Mason, 2004; Handley et al., 2001) because adult mental health professionals are often unaware that their clients are parents, or parents are not receiving treatment for their illness. While children's experiences of caring responsibilities can be both positive and negative, a Siskowski survey found child carers to be less happy than other pupils at school, more depressed, with lower self-esteem and more likely to leave home earlier (Siskowski, 2001). Children living alone with a parent with schizophrenia were especially isolated and a pilot study of adolescent carers concluded that further enquiries into their situation are urgently needed (Valiakalayil et al., 2004).

Children may give up on childhood needs and take on a surrogate spousal role, that is a kind of reverse parenting (parentification). They want their parents to be well, to get the attention they need and are frustrated at being ignored during assessments of their parents' needs (Aldridge & Becker, 2003).

Many of these children hide their distress because of fear, shame, loyalty or stigma (Cooklin, 2006; Corrigan & Miller, 2004). Rather than manifesting their distress or disturbance children may dissociate and be regarded as unusually quiet and good; and if they do 'act out' the source of the problem may be perceived as being the child, a problem 'solved' through medication (Cousins, 2004; Cooklin, 2006).

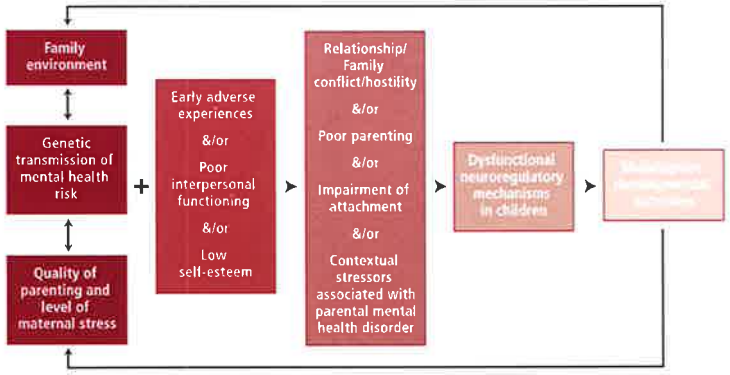
Evidence suggests that these children are not at inevitable risk of harm, neglect or developmental delay simply on the basis of their parents' mental illness, nor will there necessarily be a negative impact on parent-child relationships. The degree to which they are affected is likely to be a function of the severity of the illness and frequency of episodes of illness. Where parents had insight into their condition, welfare agencies could work successfully with them. It was conceded, however, that long-term and disproportionate caring was detrimental to children (Aldridge, 2006).

While the negative outcomes for children outlined in this section do not necessarily co-occur with child abuse and neglect, they contribute to other risk factors and are implicated in processes that increase the likelihood that dysfunctional parenting will be transmitted to another generation of families.

3.3 What are the mechanisms or processes whereby parents' mental health issues may adversely affect the development of their children?

Researchers have moved on from the enumeration of risk factors to attempts to tease out the mechanisms or 'pathways' determining progression towards favourable or adverse developmental outcomes. The following simplified diagram applies frequently cited links implicated in intergenerational transmission in presenting a suggested developmental pathway from parental mental illness to negative consequences for children (see Figure 1). Positive experiences and relationships with others may increase the resilience of children and buffer the negative impact of parental mental illness.

Figure 1: Suggested intergenerational pathways: how parental mental health issues may adversely affect children's development



Genetic transmission of vulnerability: The intergenerational transmission of psychiatric risk clearly has a strong genetic component (Barnes & Stein, 2000; Gatz et al., 1992; Kendler, 2001; Goodman & Gotlib, 1999; Radke-Yarrow et al., 1992). It is also evident, however, that family environment, parenting and maternal stress are at least as potent as genetic vulnerability (Beardslee et al., 1998; Rutter & Quinton, 1984; Benjet et al., 2003). Tienari et al. (1994) in a nationwide sample comparing children of parents with schizophrenia who were given up for adoption, with matched controls found that differences between the groups only emerged in disturbed families. Thus genetic effect was only manifested in the presence of a disturbed family environment. The corollary is probably also true, that a nurturing environment acts to protect those genetically predisposed to mental disorder, however the genetic structure of the transmission is not yet fully understood (Curtis, 2008).

There are other contributions to parental vulnerability as often parents suffer from the effects of early adverse experiences, poor interpersonal functioning and low self-esteem (Bifulco et al., 2002; Dixon et al., 2005; Sidebotham et al., 2006) which exacerbates any existing pre-disposition.

This combination makes dysfunctional family relationships characterised by family conflict and hostility more likely (Downey & Coyne, 1990; Rutter & Quinton, 1984; Murray & Cooper 2003) including poor parenting practices (Rogosch et al., 2004; Leventhal et al., 2004; Johnson et al., 2001).

Along with the poor parenting children are likely to be exposed to parent's maladaptive affect, behaviour and cognitions, partly resulting from effects of illness, medication or co-occuring substance/alcohol abuse, with consequent impairment of attachment (Connell & Goodman, 2002; Tebes et al., 2001; Thomas & Kalucy, 2003; Salmon et al., 2004; Mullick et al., 2001).

Compounding the situation are other contextual stressors associated with parental depression, such as poverty, lack of social support and domestic violence (Menard et al., 2004; Dixon et al., 2005; Sidebotham et al., 2006). As a result children develop dysfunctional neuroregulatory mechanisms and there are consequent maladaptive developmental outcomes.

Similar psychopathological processes may be fostered by all family-level and other contextual stressors conveying the same essential message to the child: I am unsafe (Waters & Cummings, 2000; Herman, 1992). Hence while some of the mechanisms summarised previously have features that are specific to parents with mental health issues, many are essentially the same as those operating in the case of other vulnerable children and families – as are many of the factors associated with vulnerability and resilience summarised in a later section.

3.4 Is there evidence of specific adverse outcomes linked to particular mental health disorders?

There has been considerable research on the effects on parenting of common psychiatric disorders: major depression, schizophrenia and bipolar disorder. Such findings are summarised in this section, together with those relating to some less common disorders that have been linked to child protection concerns. Definitions of disorders are taken from the *Dual Diagnosis Manual for Caseworkers* (reproduced in Appendix B). It should be noted that there are differing subtypes of major depression (eg. with melancholic features with catatonic features), schizophrenia (eg. paranoid type, disorganised type) and bipolar disorder (eg. bipolar I and II disorder). In general, research has *not* distinguished between different subtypes of disorders but looks a broad categories of mental disorder. It is likely that the degree to which parenting ability is disrupted is more critical to child outcomes. This includes such factors as the severity of the impaired functioning (eg. psychotic features or not) and frequency of episode (eg. brief reactive or endogenous). Another limitation of research, common to developmental psychology outcome research, is that the focus remains on the mother and fathers have tended to be overlooked.

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Schizophrenia

The offspring of women with schizophrenia represent a particularly vulnerable group (Abel et al., 2005). Overall findings indicate that over 50 per cent of women with schizophrenia recruited from treatment facilities become parents with about half of these children being born prior to the diagnosis being made (Barkla et al., 2000). Approximately half retain some custody of their children, although the children may actually be brought up by others, usually grandmothers (Seeman, 2004).

There is a plethora of studies indicating adverse outcomes for children (Hipwell & Kumar,1996; Howard et al., 2003; Nierni et al., 2003; Riordan et al., 1999; Snellen et al., 1999). These may first occur during pregnancy where medication and an unhealthy lifestyle lead to a rate of premature delivery and low birth weight infants 50 per cent higher than that of the general population (Miller & Finnerty, 1996). Later mother-child interaction and parenting skills may also be impaired by the effects of the illness and associated circumstances (Goodman & Bromley, 1990; Kumar et al., 1995; Seeman, 1998; Appleby & Dickens, 1993; Leventhal et al., 2004; Jacobsen & Miller, 1998). Diagnosis does not, however, necessarily determine parenting outcome. Protective factors associated with favourable outcomes are noted later in this report.

Depression

There has been substantially more research on the effects of depression on parenting and the outcomes for children than on any other mental health issue. This reflects the fact that depression is the leading cause of non-fatal disability in Australian society (*beyondblue* website[1]).

Reasons for sometimes contradictory results in this area relate to variability in severity, duration and chronicity of depression. Whether depression is assessed by self-report, clinical diagnosis or validated mental health measures is also a factor, as is the mental health status of the parent at the time of assessment (Puckering, 2004; Brennan et al., 2000; Cicchetti et al., 1998; Shiner & Marmonstein, 1998; Nylen et al., 2006). Criteria for the diagnosis of depression vary across studies and it is sometimes included in the more general category of affective disorder (Beardslee et al., 1997; Beardslee et al., 1998).

Interpretation of results is further complicated by the strong association between depression and contextual factors. The highest rates of depression have been found in deprived neighbourhoods more commonly featured in the lives of depressed than non-depressed mothers (Office of the Deputy Prime Minister UK, 2004; Ghate & Hazel, 2002; Sheppard, 1997). Depression is frequently associated with a low income, a perceived lack of social support, marital discord including domestic violence, and dysfunctional family environments (Hammen, 1992; Barnett & Gotlib, 1988). The direction of effects in the case of depression and contextual factors is questionable: what is cause and what is effect? Taking marital conflict as an example, Rutter and Quinton (1984) suggest that at least three mechanisms could be involved:

- Marital discord predisposes to psychiatric disorder (Brown & Harris, 1978; Quinton et al., 1984).
- Psychiatric disorder impairs marital relationships (Cox & Mills, 1983).
- Both are caused by prior conditions (for example, childhood adversities, genetic predispositions and current circumstances) (Rutter et al., 1983).

The following generalisations can be made about the impact of parental depressive disorders on children.

Attachment

Substantial percentages of infants and toddlers have been shown to establish secure attachments to their depressed mothers (Cohn & Campbell, 1992; Cohn et al., 1986; DeMulder & Radke-Yarrow, 1991; Campbell & Cohn, 1996). Sameroff et al. (1982) found no systematic influences on attachment of any psychiatric diagnosis, no matter what its chronicity or severity. However, a large number of other studies of depressed mothers show disrupted or impaired patterns of mother-infant or mother-toddler interaction (Cohn et al., 1986; Field et al., 1990; Jameson et al., 1997; Moehler et al., 2006; Puckering, 2004). Cicchetti et al. (1998) found that contextual risk did not significantly add to or mediate the relationship between depression and insecure attachment.

Behaviour problems

Parental depression has been linked with internalising and externalising problems in children (Beardslee et al., 1983; Weissman et al., 1997). A meta-analysis of 33 studies found a moderate relationship between maternal depression and behaviour problems in children. Children aged one to eighteen years with depressed mothers displayed more conduct disorder problems than children of non-depressed mothers (Beck, 1999). When asked to report problems in the behaviour of children under the age of 16, child caregivers of depressed parents reported difficult behaviour, loss of appetite, sleeplessness, playing less with friends, and being less attentive at school (van Wijngaarden et al., 2004).

On the other hand, while Bifulco et al. (2002) found a fourfold increase in rates of psychiatric disorder in offspring of mothers assessed as depressed six years earlier, maternal depression had no direct effect on offspring disorder. The effects were entirely mediated by offspring neglect/abuse. This was a relatively high-risk sample which perhaps limits the generalisability of results.

Parenting behaviour

There is evidence of an association between parental depression and less competent and responsive parenting behaviour (Tebes et al., 2001; Miller et al., 2002; Miller et al., 1999) which may provide the link between depression and impaired attachment and other adverse outcomes. McLennon and Kotelchuck (2000) found that parental safety practices (such as, car seats, safety plugs for power points, safe storage of dangerous medicines) were significantly less well observed by mothers with high levels of depressive symptoms.

Postnatal depression (perinatal mental health disorder)

There is also the special case of what has traditionally been called postnatal or postpartum depression, which is said to affect 14 per cent of new mothers in Australia (*beyondblue* website). The term does not include the very common 'maternity blues' (Seneviratne & Conroy, 2004). The conceptualisation of this disorder has been quite variable, including acute psychosis and antenatal depression which is often exacerbated postpartum (Kumar & O'Dowd, 2000). The terms perinatal mental illness or perinatal mood disorder are coming into more common use (Seneviratne & Conroy, 2004; Nylen et al., 2006).

Findings in the case of perinatal depression are disturbing. Despite reluctance on the part of developmental psychologists to invoke the idea of sensitive periods, it does seem that the very young infant is 'primed' for the development of social behaviour (Moehler et al., 2006) and that early mother-infant interactions may set in train expectations that serve to form later relationships. Early experience of a depressed caregiver may have an enduring effect even when the mother's depression has been transitory. Austin and Priest (2005) found that exposure to postnatal depression during infancy seems to have a long-term impact on neuroendocrine regulatory processes and Halligan et al. (2004) found abnormal cortisol levels in the adolescent offspring of women who experienced postnatal depression during their infancy. There is also evidence of long-term impairment of cognitive outcomes for children of postnatally depressed mothers (Coghill et al., 1986; Sharp et al., 1995; Murray et al., 1995; Breznitz & Friedman, 1998; Hart et al., 1998; Hay et al., 2001). Kurstjens and Wolke (2001), however, attributed the majority of the difference in the IQs of children of postnatally depressed women to the adverse socioeconomic circumstances commonly associated with depression.

An association between postpartum depression and childhood behaviour problems has been found (Beck, 1999). Hay et al., (2003) hypothesised a link between postnatal depression and later violent behaviour through the child's problems in regulating attention and activity, and controlling anger. During the first months of life infants learn to regulate both attention and emotion in their interactions with their caregivers, a process disrupted by postnatal depression. They found that children's violent behaviour at age 11, associated with Attention Deficit Hyperactivity Disorder (ADHD) and problems with anger management, were predicted by the mother's postnatal depression.

Given that the World Health Organisation estimates that clinical depression will be the second most common cause of morbidity by the year 2020 (Murray & Lopez, 1996) evidence regarding the detrimental consequences of parental depression, particularly perinatal mental illness, is a major concern in the context of the welfare of children.

Bipolar disorder (manic depressive psychosis)

Another condition that is closely linked with the idea of mental disorder or psychosis is bipolar mood disorder, previously called 'manic depressive psychosis' (Dual Diagnosis:14). There has been much less research on the effects of this disorder on children and what there is is contradictory (Seneviratne et al., 2003). This may be partly because assessments will differ according to whether a subject is in the manic or depressive stage of the disorder, or the 'normal' period in between. Childbirth may trigger a bipolar psychosis (Seneviratne & Conroy, 2004), with Terp and Mortensen (1998) reporting a relative risk of 6.82 for a first-episode bipolar psychosis occurring between two to twenty eight days following delivery. A history of bipolar disorder confers an extremely high risk of relapse following childbirth (Seneviratne & Conroy, 2003). There appears to be a strong genetic component in this disorder (Risley-Curtiss et al., 2004; Jones & Craddock, 2001).

Munchausen Syndrome by Proxy (MSbP) and Fabricated or Induced Illness by Carers (FIIC)

MSbP is a term coined in 1977 to label cases where a parent induces or fabricates illness or injury in a child for self-serving psychological purposes. It was believed that:

a) parents who perpetrated such behaviour had a psychiatric disorder

b) the condition was rare.

Both these assumptions have come under intense scrutiny in recent years, as has the definition itself. A new label, FIIC, is now preferred as it is considered more accurate because it describes a pattern of behaviour rather than a psychiatric syndrome. MSbP is not included in the DSM-IV, and Boros et al. (1995) argue that it is not a symptom of psychopathology but another very dangerous form of child abuse which they call medical child abuse. Schreier (2002) points out that the mother who falsifies symptoms in her child to get help for herself or her child, or because she has a delusional belief that her child is ill, will pose much different risks for the child from a mother whose motivation might be a compulsive need to fool her doctor and/or garner attention for herself as an ideal parent.

As for rarity, Fish and colleagues (2005) quote an estimate from an Australian study of an annual rate of between 15.2 and 24.5 cases (Tait et al., 2004). They conclude from these and other available international statistics that the condition is rare compared with other child maltreatment subtypes. However Schreier (2002) concludes that MSbP is 'unfortunately not an uncommon disorder'; Boros et al. (1995) agree that 'contrary to popular beliefs, this behaviour is not rare and Truman and Ayoub (2002) point to the need to consider the possibility of its involvement in sudden and unexplained child deaths.

Most cases of this condition will come to the attention of doctors and hospitals who will have primary responsibility for detection and intervention. However, child protection caseworkers need to be aware of the different professional perspectives on this condition. Fish et al.'s article contains a list of characteristics in a carer that may be present in those who fabricate FIIC. Characteristics include such things as usually being the primary carer, often presenting initially as 'good' parents and usually being accomplished liars and manipulators. They note legal difficulties involved where cases of FIIC are brought to court and conclude that child protection workers do not need to assess the capacity or intention of parents in order to demonstrate negative child outcomes. Nevertheless, knowledge of FIIC may be useful to guide interventions for parents and strategies for prevention of further harm to the child (Pritchard, 2004).

Obsessive-Compulsive Disorder (OCD)

Chaffin et al. (1996) found an unanticipated association between OCD and child neglect which persisted when substance abuse was controlled. Suggested explanations could be either that obsessional rituals interfere with childrearing responsibilities or that parents with OCD are overly meticulous and self-doubting. Its public health significance seems minimal given its low rate of occurrence (0.4 per cent of the population, Andrews et al., 1999) but it is suggested that mental health professionals treating patients for OCD be aware of their potentially increased risk for neglect. Time spent on obsessional rituals may reduce time spent emotionally engaged with children.

Personality disorder

Personality disorders are estimated to affect 10 per cent to15 per cent of the adult US population (Bienenfeld, undated). In community samples up to four percent and in clinical samples up to 25 per cent meet criteria for borderline personality disorder (American Psychiatric Association 2001). There is disagreement as to whether or not personality disorder is a mental illness, and problems with the current classification of personality disorders have long been recognised by clinicians and researchers (Spitzer et al., 2001). Personality disorders are difficult to treat and often comorbid with other disorders, especially substance misuse. They involve a long-standing and maladaptive pattern of perceiving and responding to other people and to stressful circumstances. Among this group will be found some of the most difficult to manage and dangerous parents who are a severe risk to children's safety (Adshead et al., 2004). Such people will therefore be highly represented among child protection services' most difficult clients. Yet the issue of adults with personality disorder becoming parents has been neglected (Newman & Stevenson, 2005; see also Newman, 2007).

A community-based longitudinal study found that the most consistent association with problems in the home during the childrearing years was with maternal personality disorder (Johnson et al., 2006). Rutter and Quinton (1984) also found personality disorder to be a powerful predictor of negative developmental outcome for children.

4. Vulnerability and resilience: risk and protective factors in the lives of families with parental mental health issues

Resilience refers to variations in individual responses to adversity, shaped by predisposition and environment, such that the likelihood of poor outcomes is reduced and good outcomes enhanced. *Vulnerability* refers to the reverse, that is variations in individual response to adversity such that the likelihood of poor outcomes is increased and good outcomes reduced. Resilience and vulnerability are multidimensional constructs that must be assessed in terms of both positive and negative indicators of individual adaptation. These indicators have come to be labelled as risk and protective factors (Luthar et al., 1993; Tebes & Irish, 2000). *Risk factors* are characteristics of the individual or environment that increase the likelihood of a poor outcome. *Protective factors* are characteristics of the individual or environment that increase the likelihood of good outcomes. The interplay of these forces determines outcome.

Qualities of the individual or the environment that research has found to be significantly associated with parental mental health issues and both positive and negative developmental outcomes for their children are listed below.

4.1 Risk and protective variables directly related to parental mental health issues

Level of insight into effects of illness on self and children

Mullick et al. (2001) found that better insight into mental illness was associated with more sensitive mothering behaviour and lower clinical risk of child maltreatment (see also Nicholson & Blanch, 1994). Conversely, parents with less awareness were at higher risk for maltreatment (Newberger & Cook, 1983).

Almost half of persons diagnosed with bipolar disorder and schizophrenia experience some degree of impaired self-awareness (Francell, 2001). Inability to recognise one's mental illness impedes willingness to seek treatment (Amador et al., 1994). With appropriate diagnosis, support, treatment and medication, most seriously mentally ill parents improve greatly, for example approximately 60 per cent of people with schizophrenia improve significantly with treatment, with about 25 per cent returning to high functioning (Nathan et al., 1999; Risley-Curtiss et al., 2004). Given this evidence, the fact that less than 40 per cent of people with mental disorders receive any mental health care in a 12 month period (Hickie et al., 2005) must be a matter for concern. But even among those who are receiving care, many have difficulty sticking to treatment, and the side-effects of drugs (including weight gain, involuntary bodily movements, organ infections, epilepsy) are often debilitating, leading to non-compliance with treatment and lack of motivation to parent (Risley-Curtiss et al., 2004: Maybery et al., 2006; Allison et al., 1999; Phillips, 2000; Thomas and Kalucy, 2003).

Severity, chronicity and category of diagnosis of parental mental disorder

Children of parents with severe mental illness are at significantly greater risk of involvement with child protection agencies or of being in out-of-home care or in the care of relatives, than children of parents whose illness is less severe. They are also at significantly greater risk of other adverse outcomes such as impaired attachment and less competent parenting than children whose parents have a milder form of disorder (Frankel & Harmon, 1996; Harnish et al., 1995; Hollingsworth, 2004; Min Park et al., 2006; Nolen-Hoeksema et al., 1993; Rogosch et al., 1992; Salmon et al., 2004; Sameroff et al., 1983; Teti et al., 1995).

Severity predicted poorer outcomes than diagnosis or chronicity (Ackerman, 2003; Hammen & Brennan, 2003); however, there were disturbing findings concerning chronicity and duration in a study of a large sample of caregivers of relatives with major depression. Van Wijngaarden et al. (2004) found a higher occurrence of adverse consequences for young children whose parents were in a non-acute outpatient

sample, compared with an inpatient sample. Patients in the non-acute sample had a much longer history of depression, and the authors conclude that long-term exposure to a depressive parent seems to have led to considerable and probably chronic consequences (see also Rogosch et al., 1992; Campbell et al., 1995).

Mowbray et al. (2002) and Salmon et al. (2004) found a diagnosis of schizophrenia had a significant negative effect, but also that specific mental illness diagnosis is not a useful predictor for parenting problems or strengths. Maybery et al. (2005) concluded that while the significance of severity was clearly established, evidence regarding the impact of parental illness diagnosis *per se* on children was contradictory.

4.2 Variables related to children, parents and families

The following comprises major variables for which there is substantial research evidence that they exacerbate, moderate or protect children from the risk of adverse developmental outcomes associated with parental mental health issues:

Level of state provision of supportive resources

A follow-up of a two year cohort of children of hospitalised mentally ill mothers six to sixteen years later found no significant difference between these children and controls regarding hospital admissions and academic achievement. The authors suggest the reasons for the better outcome in school of these children in Sweden compared with studies from other countries might be related to good access to after-school care, free school health care including contact with a child psychologist and a well-functioning social welfare service (Ruppert & Bagedahl-Strindlund, 2001).

Variables relating to children

Children who have the following characteristics are more vulnerable to the effects of parental mental disorder:

- low birth weight (Sidebotham et al., 2006)
- younger age at onset of parental mental illness (AICAFMHA, 2001; Benjet et al., 2003)
- a high temperamental risk – conversely, children with low temperamental risk were less likely to show disturbance (Rutter & Quinton, 1984)
- no supportive relationships – supportive relationships and good parenting predicted resilient outcomes in children and young people (Brennan et al., 2003:113). Social and emotional connections with others significantly moderated the effects of parental mental disorder (Beardslee et al., 1998)
- poor coping skills – children who use strategies to accept or adapt to the stress of parental mental illness have fewer adjustment problems than those who were unable to disengage (Langrock et al., 2002). Resilient children possessed self-understanding, the ability to view parental illness realistically, and to build the resources necessary to survive despite parental dysfunction (Webb et al., 2005; Tebes et al., 2001). But many children adopted problematic coping styles, withdrawing, avoiding and distancing themselves (Maybery et al., 2002; Beardslee et al., 2003).

It is notable that there is considerably less research evidence relating to children of parents with mental health issues than there is for their parents. Hetherington et al. (2002:182) stated that 'services, in struggling to respond to the needs of the family, focused on the mentally ill person'. They give examples of a lack of attention to children in their research and in mental health texts.

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Psychosocial variables affecting families

There was increased vulnerability and poorer developmental outcomes in families characterised by:

- social isolation versus strong social (including family) support (Sidebotham et al., 2006; Bassett & Johnson 2004; Sheppard, 1997; Maybery et al., 2005; UNICEF, 2003; Benjet et al., 2003)
- family discord or breakdown (including domestic violence) versus family stability, including a good relationship with a supportive spouse (Maybery et al., 2005; Connell & Goodman, 2002; Nicholson et al., 1998; UNICEF, 2003; Beardslee et al., 1998; Rutter & Quinton, 1984; Benjet et al., 2003; Dixon et al., 2005; Sheppard, 1997)
- mental disorder in both parents rather than just one parent (Dierker et al., 1999; Goodman et al., 1993; Reich et al., 1993; Foley et al., 2001)
- low socioeconomic status versus high status (Chaffin et al., 1996; Benjet et al., 2003; *NSW Parenting Program for Mental Health*, 2003; Sidebotham et al., 2006; Tunnard, 2004; UNICEF, 2003; Cowling et al., 2001). Study of this variable also incorporated the number of children in the household as an associated factor. The buffering effects of high socioeconomic status were demonstrated in a study by Abel et al. (2005) where schizophrenic mothers who were of higher social class had good staff-rated parenting outcomes, with only a fifth of them being subject to social services intervention at discharge from joint mother-baby psychiatric care, with less than 10 per cent being separated from their infant
- single parenthood (associated with social isolation and poverty) versus intact families (Menard et al., 2004; Sidebotham et al., 2006; UNICEF, 2003; Chaffin et al., 1996; Maybery et al., 2005; Rutter & Quinton, 1984; Sheehan & Levine, 2005; Sheppard, 1997; Benjet et al., 2003)
- young parenthood (Dixon et al., 2005; Sidebotham et al., 2006; UNICEF, 2003; Chaffin et al., 1996)
- co-occurring substance misuse (Chaffin et al., 1996; Menard et al., 2003 UNICEF, 2003; Harris, 2004).

Multiple stressors, risk and resilience

Except for factors relating specifically to the impact of parental mental health issues, the above list of risk/protective factors is similar to what has been found to apply in the case of other stressors associated with child maltreatment. Evidence that the accumulation of risk factors provides a strong predictor of poor outcome (Hammen, 1990; Rutter, 1990; Simons & Miller, 1987) has led to the construction of measures such as a Child Adversity Index (Beardslee et al., 1996) and an Adverse Childhood Experiences (ACE) score, which comprises a simple count of stressors (Felitti et al., 1998; Dube et al., 2001). However, it is unclear if risk increases as a simple function of the number of stressors, or if some variables or combinations exert stronger influences than others (Menard et al., 2004). Concluding that two variables, severity of parental mental illness and family structure, served as 'shorthand' for level of risk to children, Maybery et al. (2005) utilised the following categories of risk in estimating the number of children affected by parental mental health issues:

- two parent family, illness not severe – low to moderate risk
- one parent family, illness not severe – moderate to high risk
- two parent family, severe illness – moderate to high risk
- one parent family, severe illness – extreme risk.

The very usefulness of the 'at-risk' paradigm and the dominance of a discourse of risk and its management has recently come in for criticism (Benjet et al., 2003; Gillingham, 2006). Musick et al. (1987) emphasise that *risk* is a statistical concept, not a psychological one. Gillingham (2006) points out that the terms 'risk of harm' and actual 'harm' are often used interchangeably in child protection practice. He also notes that the reliability of risk assessment tools is low, rarely exceeding 70 per cent in the UK; and that generalisations about behaviours enshrined in risk assessment tools do not automatically apply in individual cases. Therefore, using them can engender a sense of false security. Gillingham suggests a re-evaluation of the efficacy of risk assessment as a central tenet of child protection practice.

Adopting a more positive approach to the assessment of vulnerability in children, a research review by Logan et al. (2007), has identified the following as key variables associated with positive child outcomes:

- mother's good health
- available health-related services
- positive health-related maternal behaviours (including good practices relating to smoking, drinking and other substance use)
- lack of material hardship
- supportive marriage and other social support
- positive attitudes to pregnancy
- higher levels of social and demographic characteristics (maternal literacy, education, immigration status)
- older age of the child
- later onset of the illness.

5. Early intervention and children of parents with mental illness

Early intervention can be defined as intervening early in the life of a child or intervening early in the pathway of a problem or potential problem.

Where an intervention occurs before problems are actually detected, it can be classified as prevention. In practice, prevention and early intervention overlap.

5.1 Australian and NSW responses

This section begins by summarising developments at national and state level relating to children of parents with mental health issues.

Public awareness of the needs of children of parents with mental health issues, indeed of their very status as a special group, seemed almost non-existent until just over a decade ago. In 1995 the establishment of a national association concerned with child and adolescent mental health was proposed and the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) came into being in 1998.

In 1999, AICAFMHA undertook a national scoping project to identify services available and future plans of services for children of parents with a mental illness. In March 2001 the scoping report was launched and the Australian Government allocated three years of funding. This national initiative included the development of guidelines for services, *Principles and actions for services and people working with children of parents with a mental illness* (AICAFMHA, 2004) together with complementary resource materials for services, parents and young people.[2]

AICAFMHA continues to advocate for what have become known as COPMI (Children Of Parents with a Mental Illness), organising conferences, writing submissions, publishing a newsletter and listing relevant programs on its website. Its interest is in interventions targeted at COPMI, children 'whose risk of developing mental disorders is significantly higher than average' (AICAFMHA report, 2004:5).

In 1997 AUSEINET (The Australian Network for Promotion, Prevention and Early Intervention for Mental Health) was funded by the Australian Department of Health and Ageing to work with governments and organisations to support change in Australia's mental health policy and practice. It develops, collects and disseminates information on:

- Promotion of mental health
- Prevention of mental disorder
- Early Intervention in mental illness (PPEI)
- Suicide prevention.

This network also coordinates a national approach to prevention and early intervention for the mental health of children and young people.

As COPMI moved onto the national agenda, the NSW Health Department's Centre for Mental Health announced its commitment to provide a spectrum of care to parents and children, introducing such prevention and early intervention initiatives as *Families First*, *Integrated Perinatal and Infant Care*, *Health Home Visiting*, *School-Link*, and *Parenting Partnerships* (2003).[3] The latter aims to integrate mental health service parenting initiatives with other community initiatives. Area Mental Health Services have

[2] Available through the AICAFMHA website – www.aicafmha.net.au

[3] Descriptions of these initiatives are contained in Appendix 7 of the NSW Interagency Guidelines (2006). See also *NSW Parenting*

parenting coordinators or contact staff, and COPMI project officers who provide training, consultation and information about factors affecting COPMI.[4]

Williams et al. (2005) state that there is a well-planned and systematic approach to public health in Australia, with an increasing number of prevention and early intervention initiatives, specifically relevant to children and young people. However, some argue that while the framework may be sound there is a lack of substance. Hickie et al. (2005) report little progress in implementing key priorities such as expanded early intervention programs, despite this being at the top of a list of 10 priorities. The *NSW Mental Health Action Plan 2006-2011* proposes expenditure of $938.9 million, but none of this is earmarked for services for children of parents with a mental illness. However, from 1 July 2006 the NSW Government has funded a new model of service delivery known as the *Family and Carer Mental Health Program. Carers NSW*, which incorporates the Young Carer initiative (see later in this Report), is one of the successful NGO tenderers for participation in this program.

5.2 Evidence relating to the effectiveness of early intervention programs for families where there are mental health issues

Research evidence concerning the effectiveness of key early intervention initiatives, in relation to families where there are parental mental health issues, is summarised below. In particular:

- Quality child care
- Parenting programs
- Home visiting

Interpretation of findings is complicated by the increasingly frequent combining of two or even three of the above types of services. For example, Early Head Start combines home visits with child care and in High/Scope classes in the Perry Preschool Project, planned learning was combined with weekly home visits. Nevertheless, an attempt is made here to summarise findings relating to the three types of intervention, plus extra categories the need for which seems to be indicated in light of findings presented in this report.

Quality child care

Studies of the specific effects of child care on children of parents with mental health issues have not been found. However, Nicholson et al. (2001) point out that Head Start's target population, that is children and families in poverty, is similar in many ways to families in which a parent has a mental health issue. Both groups are parenting in compromised circumstances that often include low income, unsafe housing, un- or under-employment and inadequate social networks. While the prevalence of mental health issues among Head Start parents is unknown, one administrator of a Head Start program estimated that a third of the families have a parent with depression. For lack of more specific evidence, therefore, research relating to the effects of child care in disadvantaged populations must be relied upon.

Findings of the positive consequences for children of quality child care, especially for children in at risk sections of the population, continue to accumulate (Love et al., 2005; Temple & Reynolds, 2007). In a review of family factors in child care research, Hungerford & Cox (2006) conclude that evidence generally supports the conclusion that high quality child care experiences are likely to have stronger effects on children who are at risk of poorer outcomes because of less optimal family environments.

[4] NSW programs for COPMI are listed on the COPMI website, mainly located in Area Health Services with COPMI project officers

Parenting programs

In identifying parenting performance as a central process relating to adaptation for children of parents with mental health issues, Tebes et al. (2001) suggest that the focus should be on improving parenting when developing interventions for these families.

This would seem to accord a high priority to the provision of parenting programs for parents with mental health issues. Bunting (2005) concludes from 'the best available evidence' that parenting programs can have a positive effect on a range of outcomes. But the principle that services need to be tailored to a client population seems particularly apposite here (see also Craig, 2004; Tebes et al., 2001). Ackerson (2003) found that parents with mental health issues view typical parenting programs as irrelevant, inappropriate or uncomfortable. Issues such as setting limits, being consistent, responding contingently and positively when a parent is feeling distracted, fatigued or worthless because of mental health issues are not addressed. Parents may stand out from other members of the group and, as a result, they may drop out or fail to receive the desired benefit from these programs. Ackerson refers to several parenting programs designed specifically for mothers being treated for psychiatric illness that are hospital-based or provide in-home visits (Rubovits, 1996; Seeman & Cohen, 1998; Oyserman et al., 1994).

The National Child Protection Clearinghouse reviewed 20 programs designed to prevent child maltreatment that had a parent education component (Holzer, Bromfield & Richardson, 2006). While the majority reported improvement in parenting performance, the outcome of reduction in child maltreatment was rarely directly measured. The authors identified the following as key features of effective programs:

- targeted recruitment
- structured program
- a combination of interventions/strategies
- a strengths-based approach.

A meta-analysis of the effectiveness of parenting programs in improving maternal psychosocial health (Barlow et al., 2002) found a significant reduction in depression and anxiety/stress in the intervention group. Follow-up data, however, was limited and the severity of the mothers' disorder and outcomes for children were unknown (the parenting groups appear to have been set up on the basis of behaviour problems in the subjects' children rather than parental mental health criteria).

Home visiting

Recent research reviews indicate the suitability of home visiting programs for parents with mental health issues. Up to 50 per cent of families in some home visiting programs have some symptoms of clinical depression (Beardslee et al., 1997; Brennan et al., 2003). While domestic violence, maternal mental health issues and parental substance abuse pose especially high risks for parents they are some of the hardest issues for home visitors to recognise or to feel comfortable discussing (Beardslee et al., 1997; Brennan et al., 2003; Tebes et al., 2001). Research on home visiting indicates that it is most beneficial for high-risk mothers, for families where the initial need is greatest, and where parents perceive that their children need the service (Barnet et al., 2004). Ammerman et al. (2006) allude to a growing body of findings suggesting that increased adversity promotes engagement in prevention programs in general, and home visiting in particular. However, functional impairments resulting from depression can undermine the potential benefits of home visitation.

Findings regarding child abuse and neglect are disappointing. Barnet et al. (2004) found no significant overall effect on any malleable parental risk or on the use of community services to address risk. MacMillan et al. (2005) found in a randomised controlled trial that hospital records showed a *higher* recurrence of either abuse or neglect in the intervention group. A meta-analysis (Sweet & Appelbaum, 2004) found no significant reduction in child abuse.

To sum up research findings on home visiting, effect sizes are small, gains modest, and there have been few studies of long-term effects. Gomby (2005) concluded that while home visiting can provide benefits for children and families, it does not always do so. Programs that combine home visiting services with centre-based early childhood education appear to produce larger and more long-lasting results than home visiting on its own. Issues include the intensity of services, the skills of the home visitors and the content of the home visiting curriculum.

One study warrants mention despite its small sample size and lack of a control group because of its relevance and its relationship to the section to follow. This sample of 26 mothers with diagnosed major depression received cognitive-behavioural therapy from a licensed social worker with the usual home visitor as liaison person attending the first and last therapy sessions. Mothers experienced a substantial reduction in depression symptoms and remission from major depression following treatment. The authors concluded that the results warranted replication and expansion in a controlled clinical trial (Ammerman et al., 2005).

Balbernie (undated) states that a guiding principle of early intervention is that services need to be carefully tailored to their client population. Efforts to adapt existing treatments to the unique needs of target populations are increasing (NIMH, 1998). In the light of disturbing findings about the long-term effects of parental mental health issues, particularly maternal depression, presented in this report, the following section looks at programs aimed at improving mother-child interaction in depressed mothers.

Programs focusing on maternal depression and mother-child interactions

Three approaches to ameliorating the harmful effects on children of maternal depression can be discerned.

Preventive interventions

A meta-analysis of preventive intervention trials involving 7,697 expectant mothers (Dennis & Cready, 2004) found the following:

- The only intervention to have a clear preventive effect was intensive postpartum support by a health professional.
- Identifying women at risk helped in the prevention of postnatal depression (see also Nylen et al., 2006).
- Postnatal-only interventions were more beneficial than those that incorporated an antenatal component.
- Individually-based interventions were more effective.

Alleviation of depression

Evidence is emerging that targeting maternal depressive symptoms is insufficient to protect against negative child outcomes (Murray et al., 2003; Forman et al., 2005; Austin & Priest, 2005).

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Interventions to improve the mother-child relationship, typically as early in the child's life as possible.

A variety of types of mother-child interventions with some promising results have been reported. Approaches studied can be grouped as follows:

Mother-infant psychotherapies

Psychotherapy is based on several theoretical orientations and therapeutic approaches including attachment theory and family systems theory. A number of studies showed positive outcomes from group therapy sessions with mothers and their infants or toddlers. Cicchetti, Rogosch and Toth (1999; 2000) found significantly improved attachment and cognitive gains in toddlers, which were sustained even where mothers had a subsequent depressive episode. After mother-infant psychotherapy, Robert-Tissot et al. (1996) found mothers became less intrusive, maternal sensitivity increased and infants became more cooperative.

Newman and Stevenson (2005) also report favourably on clinical results from mother-infant psychotherapy, and on Interaction Guidance and Watch Wait and Wonder (WWW – see below) in working with parents with personality disorders.

Interaction guidance

This approach does not rely on insights gained through therapy, but uses video feedback to encourage positive aspects of caregiver-infant interaction, helping parents to gain enjoyment from their child through interactive play experience (McDonough, 1993). This form of treatment was specifically tailored to reach multiple-risk families, to improve maternal sensitivity (Beebe, 2003). In the UK, health visitors were trained in the use of Patricia Crittenden's 'Care Index' and taught how to apply this to brief video recordings of mother-baby play (Balbernie, undated).

Watch, Wait and Wonder (WWW)

In this intervention the parent is encouraged to be more directly involved with the child by engaging in playful interaction initiated by the child. The parent is then invited to explore feelings and thoughts evoked by what they observed and experienced in the play session. Infants in this group show greater capacity for emotional self-regulation and an increase in cognitive ability, with mothers reporting more satisfaction with parenting than those in a traditional parent-infant psychotherapy group. But at six month follow-up, results for parent-infant psychotherapy and WWW were similar (Cohen et al., 1999).

Baby massage

A variety of home-based interventions involving mothers and their infants designed to counteract the effects of maternal depression on children is described in Nylen et al. (2006:335-339). Some positive results are reported, including findings regarding infant massage as a preventive intervention (Field et al., 1996, 2000).

Cognitive-behavioural therapy

The use of cognitive behavioural therapy (CBT) with depressed mothers has had mixed outcomes (Dennis & Cready, 2004; Lumley et al., 2004). However, a recent large randomised controlled Australian study has shown longer-term improvement in maternal mood and maternal-infant relationship indicators at a one year follow-up using a tailored group CBT program (Milgrom et al., 2005).

Positive results from intervention early in life may be related to evidence that attachment is often impaired or disorganised in depressed mother-infant dyads, and Bakermans-Kranenburg's (2005) meta-analytic finding that disorganised attachments may change as a result of sensitivity-focused interventions.

5.3 Family-focused services and issues of family structure

Another way of classifying services is according to whether they are provided for individuals (parent or child) or the whole family. Beardslee et al. (2003) developed two family-based psychoeducational programs for the prevention of depressive symptoms in children with depressed parents, both of which achieved a significant reduction in risk factors and an increase in protective factors that were maintained at a two and a half year follow-up. Results provided support for a family-based approach to preventive intervention. Data presented in Hinden et al. (2002) similarly indicated that family-centred, strengths-based values and practices may be a key to program success and improved outcomes for parents and children. The research group in an international comparison of child welfare agencies identified the development of a 'whole family' approach as one of the main factors associated with good outcomes for families where there are issues with parental mental health (Hetherington et al., 2002).

A review of family-based services in children's health and mental health research since 1980 (Hoagwood, 2005) looked at 4,000 studies with 41 meeting stringent methodological criteria. While not directly relevant, the topic of the review is sufficiently related for its findings to have some applicability. There were too few well-conducted scientifically rigorous studies to conclude that family-based services decisively improve outcomes, but there were unequivocal improvements in outcomes including retention in services, knowledge about mental health issues, self-efficacy and improved family interactions.

Psychiatric patients were found to want family focused interventions, rather than focusing solely on themselves as the identified parent (Wang & Goldschmidt, 1996). Similarly, the main recommendation from 78 interviews with parents with mental health issues, their partners, children and support workers were for a whole-family intervention procedure (Davis et al., 1997). Falkov (2007) also sees the family as the key target for early intervention, pointing out that the child's impact on the parent as well as vice versa needs to be considered and that a family operates as a system, not a collection of individuals.

Yet Aldridge (2006) found that assistance for such families rarely included interventions aimed at families. Studies consulted for this report overwhelmingly focus on mothers and to a lesser extent their children as subjects. As is so often the case in the study of developmental psychopathology, the influence of fathers is 'dramatically overlooked' (Connell & Goodman, 2002: 746). In a meta-analysis of the link between paternal psychopathology and behaviour problems in children, Connell and Goodman list the following methodological factors making the study of mothers easier than that of fathers:

- The assumption that fathers are less willing to participate in research
- The idea that certain adult mental health disorders are more common in women
- The large number of children living with single mothers with mental health issues
- The fact that women receiving pre-and post-natal care as well as when they are hospitalised for the birth of a child are an easily accessible research sample.

Perhaps more significantly, sociocultural norms and theories of child development have placed primary emphasis on maternal influence, with consequent 'mother-blaming' where outcomes are adverse.

Connell & Goodman (2002) found that paternal psychopathology was more closely associated with emotional and behavioural problems in samples examining older children, whereas maternal psychopathology, especially depression, was more significant for emotional and behavioural problems in younger children, and that this may indicate that psychopathology in fathers becomes more salient for children as they get older. The spouses of parents with mental health issues often have mental disorders themselves (Nicholson et al., 1998; Tomison, 1996; Connell & Goodman, 2002; Beardslee et al., 2003). Increased risk associated with the presence of mental disorder in both parents has already been noted.

Harnessing the support of fathers

By way of contrast, there is little information on the role of fathers in relation to the promotion of resilience in children. Logan and colleagues (2007) noted the lack of research data concerning fathers' attitudes and behaviours. Emphasis on fathers as risk rather than resource pervades discussion of child protection issues. Thus Gillingham states that 'child protection agencies have failed to address the real problem of the relationships between men and children.' Yet the presence of a healthy partner may moderate risk to children, such that Maybery et al. (2005) classify children in two parent families as being at significantly lower level of risk than those who are living with a single parent. Problem behaviours in children of parents with a mental illness where there is minimal marital discord have been shown to be equivalent to children whose parents do not have a mental illness (Emery et al., 1982). In such cases, interventions may not be needed, or spousal engagement in interventions may increase their effectiveness. An antenatal parent education program for women at risk of postnatal depression that included fathers improved parental relationships postpartum and impacted positively on maternal mood (Nylen et al., 2006). The prevalence of poor parenting outcomes in schizophrenic mothers was much lower where there was a supportive, mentally well partner (Abel et al., 2005).

There may be a need for interventions that assist spouses who are generally supportive but under stress. In a study of carers (van Wijngaarden et al., 2004), the majority were the partners of the parent with a mental health issue. Carers NSW (2006) reports that men comprise 46 per cent of all carers in NSW. There is no breakdown of carer numbers according to category of need but Carers NSW estimates that 10 per cent of carers are caring for mentally ill people. Carers of mentally ill spouses reported feeling worried, burdened and stressed (van Wijngaarden et al., 2004; Nankervis et al., 1997). Those who did not get social support from others were worse off. The buffering effects of the other parent as supportive partner and promoter of resilience in their children will be undermined if caregiving is burdensome and unsupported. Therefore the availability of carer support when needed, and inclusion of both parents in family-focused interventions if such be judged to be useful, is indicated.

Although the extended family may contribute both positively and negatively to support of the parent with mental health issues (Nicholson et al., 1998), in general the presence and strength of current supportive networks of family, friends or church predict adaptive parenting attitudes (Rogosch et al., 1992; Ackerson, 2003). Services need the capacity to support and augment families' informal care structures (Darlington et al., 2006). Homel (2006) commends the (at the time considered 'preposterous') proposal enunciated by the American psychologist Urie Bronfenbrenner 25 years ago that suggests formal support systems should aim to generate and strengthen informal support systems, which in turn will reduce the need for formal systems. This proposal has been adopted as a principle in the *Pathways to Prevention* program.

Enhancing support for children of a parent with mental illness during hospitalisation and crises

Support of the extended family may be particularly useful during crises of hospitalisation in episodic mental illness. Family may be involved in contingency planning for such episodes. Family case conferences for this and related purposes were evaluated over two years and found that hospital admissions were avoided because services were accessed early and support provided by agencies and families (Mutter et al., 2002; see also Handley et al., 2001). The participation of extended family members in the development of strategies may help to ensure children's safety while preserving family relationships (Risley-Curtiss et al., 2004). A model **Family Care Plan** is available from the COMIC website (Appendix C). Children consulted thought such plans a good idea, but some were happy with an informal plan currently in place within the family (Fudge & Mason, 2004). There is also the suggestion that a mother could arrange a standby guardianship in which the legal custody of her children would automatically but temporarily revert to someone else in the event of relapse and revert to her when she was well (Jacobsen & Miller, 1998).

5.4 Child-focused interventions

When asked what they need most, children of parents with a mental illness have identified the following:

- more information about their parent's illness (Maybery et al., 2006; Handley et al., 2001; Fudge and Mason, 2004; Delvin and O'Brien, 1999; Barlow et al., 2001; Falkov, 2007)
- to be informed and consulted by professionals who often focus exclusively on the parent's needs (Aldridge & Becker, 2003; Stallard et al., 2002; Cooklin, 2006; Aldridge, 2006)
- someone to talk to (Fudge & Mason, 2004; Handley et al., 2001; Maybery et al., 2005b)
- help with practical issues around parent hospitalisation and respite (Maybery et al., 2005b).

Parents also identified least disruption to home and school, explanation of illness, someone to talk to and peer support as key needs for their children (Cowling, 1996). Falkov (2004) states that young children can be told simply what mental illness is and what to do when mummy is unwell.

Apart from a few scattered programs for younger children listed on the COPMI website, interventions for these children have typically focused on alleviating caring responsibilities by the child for an ill parent. A variety of young carer support programs exist. Information about them and other features useful for children of mentally ill parents in general, can be found on the following websites (see Appendix E):

- COPMI (Children of Parents with a Mental Illness)
- Young Carers
- AUSEINET (Australian Network for Promotion Prevention and Early Intervention for Mental Health)
- COMIC (Children of Mentally Ill Consumers)

The websites provide information about, and access to, camps, newsletters, telephone and/or face-to-face counselling, telephone support/information/ referrals, chat rooms and other forms of link-up for young carers, information on resources and on parental illness at levels accessible to children at different stages of development. Thus access to the internet has greatly assisted communication, the provision of support and information to literate children and young people for whom these forms of assistance would not otherwise be accessible.

Similar services operate in Victoria, where comprehensive evaluations have recently been completed on two VicChamps school holiday and after-school activity programs operating in Melbourne and north-east Victoria (Maybery et al., 2006) and on PATS (Paying Attention To Self), a peer support program for children and young people aged 13 to18 years (Hargreaves et al., 2005). Both reported positive findings; however, the existence of this and similar programs is merely noted here, as they appear to be less appropriate and effective for younger children. Maybery et al. (2006) arranged a program for five to seven year olds but had difficulty attracting participants because of problems with child care, transport, timing, and children's preference to stay in family groupings with older siblings in the programs for older children. They recommended that different methods of attracting five to seven year olds be devised and trialled.

There are also targeted and universal (often school-based) programs aimed at improving mental health, lessening prejudice against mental illness, improving teachers' capacity to identify and assist children and young people at risk of mental health problems, and preventing the onset of, or alleviating, depressive symptoms (Joyce et al., 2003; Spence et al., 2003; Barrett et al., 2006; Horowitz & Garber, 2006). Early results of some programs are promising, and details of Australian initiatives can most readily be found in AUSEINET newsletters, available electronically.[3] Again, however, these are simply noted, as they are more suitable for older children.

6. Indigenous and CALD families with parental mental health issues

6.1 Indigenous communities

Evidence regarding the high level of stressors associated with mental illness in Indigenous communities is so substantial that it barely needs re-stating here. Zubrick et al. (2005) note that for many Aboriginal and Torres Strait Islander communities the occurrence of risks such as early mortality and chronic disease is almost universal and that in such communities the consequent increased risk for mental health issues is more or less pervasive. The impact of historical and continuing trauma and loss operates intergenerationally through effects on child rearing practices, the passing on of culture and the lack of role models. Past practices of forced removal of Indigenous children from their mothers could be regarded as a kind of 'natural' experiment demonstrating the adverse consequences of disrupted attachment.

In recognition of the complex and severe health problems affecting many Indigenous people, and in accordance with principles of self-determination, the National Aboriginal Community Controlled Health Organisation (NACCHO) has been established, with 130 affiliated Aboriginal Controlled Health Services (ACCHS) operating across Australia. Services form a network but are autonomous and independent of one another and of government.

In a position paper on child abuse/family violence in Aboriginal communities prepared for NACCHO, Thiele (2006) emphasises that consideration of social/emotional health and psychiatric disorders must encompass oppression, racism, environmental circumstances, economic factors, stress, trauma, grief, cultural genocide, psychological processes and ill health. There is a delicate balance here as professionals operating within a western biomedical model may fail to understand or recognise the contribution of trauma, racism and continuing oppression to problems with mental health. On the other hand, Hunter warns that 'denying or minimising disorder or disease in a cross-cultural context is disarmingly easy and dangerous' (Zubrick et al., 2005, xxi).

In 2003 NACCHO undertook consultations with ACCHSs to inform the development of the *National Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing (SEWB) Framework 2004-2009*. Key outcomes were calls for:

- the prioritising of children and young people
- working within a holistic health care model with the development of culturally appropriate programs
- outreach to judicial/corrective services systems
- increased access to information on mainstream services, their accessibility for Aboriginal people and their effectiveness
- the development of strong links between national and state Aboriginal mental health policy frameworks
- support for health workers
- maternal health programs to be viewed in a family-life continuum context
- links with relevant corrective services, community and family services and substance misuse agencies are seen as critical. To this end, there needs to be service agreements, partnerships and MOUs with mainstream agencies.

Thiele (2006) recommends consultation of the *SEWB Framework 2004-09*, developed and endorsed by the National Aboriginal and Torres Strait Islander Health Council; the National Mental Health Working Group and the Australian Health Ministers' Advisory Council. It spells out roles for all levels of government and other key stakeholders, and sets out how the framework should be implemented, monitored and

evaluated. Action Areas from the *SEWB Framework* listed in Thiele's paper and directly relevant to statutory child protection concerns are:

- Develop, support and implement age appropriate assessment and intervention strategies for children and young people at risk of mental health and related problems.
- Establish cross-agency forums at the state/territory level to examine regulatory issues and policy and practice relating to family violence, child abuse and child protection.

'Child protection services' is listed among agencies with responsibility for the second of these action areas. Barriers to collaboration include lack of trust in a 'white' child welfare system that 'has been implicated in the ongoing generation of profound social and cultural trauma for Indigenous Australians' (Litwin, 1997: 334) and fear and anxiety on the part of parents at the thought of needing to seek help for children (Stanley et al., 2003).

6.2 Culturally and linguistically diverse communities (CALD) including refugees

Thiele (2006: 4) states that 'In studies of non-Aboriginal communities, the extent of such traumatic separations, losses, abuse, dislocation and dehumanisation can only be found in populations subjected to systematic torture, genocide, concentration camps or urban or family violence.' Such populations are to be found among refugees coming to Australia who have been exposed to torture and trauma. The NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides a holistic range of services to this population, and in 1998 established an Early Intervention Program to ensure refugees are connected to appropriate services to address their needs. The STARTTS website holds papers providing useful information to those in other services working with refugee women and their children (Lamb, 2002; Mehraby, 2000), develops partnerships and provides training to other agencies (www.swsahs.nsw.gov.au/areaser/startts).

Refugees are a small sub-group of the culturally and linguistically diverse (CALD) section of the Australian population. Language and cultural barriers present significant obstacles for CALD people in gaining access to mental health services (Department of Health & Ageing, 2003; Var, 2004). To improve access to services for CALD clients, the Diversity Health Institute, based in the Western Sydney Area Health Service has been established. It consists of a number of services brought together for greater efficiency. These include a Transcultural Mental Health Centre, a statewide organisation funded by the NSW Centre for Mental Health. The Transcultural Mental Health Service seeks to assist CALD people through what is virtually a mental health service parallel to the mainstream and utilising health professionals at all levels. Workers collaborate with other services including the Carer Respite Centre, School-Link programs and local Area Health Service in engaging children from refugee, Indigenous and NESB backgrounds in programs such as Young Carer camps, and parents with mental illness in parenting and other programs. An information sheet, 'My Family Doesn't Speak English' directed at young carers of NESB mentally ill parents, is available on the Young Carers website.[6]

In her review of research on home visiting programs, Gomby (2005) notes that parenting practices are strongly bound by culture and that some parenting practices can yield different results for children from different cultures. Home visiting programs are likely to be less effective with some families if advice is not consonant with families' beliefs about parenting, especially where mothers live with their mothers or extended family.

Recognition of Diversity forms part of the Rationale underlying principles and actions guiding those working with COPMI (AICAFMHA, 2004). Appendix C – Special Needs Groups in the Draft *Personal Helpers and Mentors Programme Guidelines* (2007) also contains guidance for workers in this new program who will be working with Indigenous people and CALD clients.

7. Implications and conclusions

7.1 Issues relating to diagnosis and treatment

There are unique challenges for statutory child protection agencies' policy and practice relating to families where there is a parental mental health issue. These differ according to three conditions which may pertain to parents with mental health issues, namely:

- where the parental status of a client is not known to, or is not considered as relevant by, mental health professionals
- where a parent is diagnosed and being treated by a mental health professional or professionals, and is referred to a child protection agency by that professional or by family members
- where a parent has a mental health illness or disorder but has not been diagnosed or treated for that illness or disorder.

Diagnosis and treatment but non-recognition of parental status

The implication of this condition is that a child or children may be at significant risk of adverse consequences from parental mental illness but not referred to a child protection agency or to any other agency that might be able to provide support or assistance.

Diagnosis, treatment and referral

Research shows that diagnosis, severity and chronicity of the mental illness and compliance with treatment all significantly affect the level of vulnerability of children. Where information regarding such variables is held by those notifying a child protection agency that they have concerns about a child or children, it would help caseworkers trying to assess the level of risk if they had access to such information. However, patient confidentiality is a principle that is firmly upheld by health professionals, partly due to a justified fear of litigation where a case can be made that such confidentiality has been breached. Even where family members live with mentally ill relatives and bear the whole burden of their care and management, they may not be privy to health-related information that could help them.

Non-diagnosis of mental illness

If, as research referred to above has indicated, most of those suffering a mental illness or disorder are undiagnosed or untreated, then it probably follows that many parents notified to a child protection agency who are mentally ill or disordered are not identified as such. They may be reported because of other causes or concerns, or because their behaviour has led the reporting person to judge that they may be mentally ill (e.g. in the case of suicide attempts), even if they have not previously been labelled in this way.

7.2 Generic or tailored intervention programs?

With respect to the generic forms of early intervention, that is quality child care, parenting education and home visiting, there is little specific evidence relating to the effectiveness of such programs for children of parents with mental health issues. In the case of quality child care, this may be of little consequence as such programs have been found to be more effective with children from disadvantaged families and these children may well fall within that category. With parenting programs, there is evidence that caution is needed in considering whether or not to integrate parents with moderate to severe mental illness into general parent education programs. In the case of home visiting, there is some evidence that mental health issues need to be recognised and addressed by home visitors if they are to be effective. It would therefore seem advisable to assess the relevant competence of those working in these programs and to provide extra training if necessary.

This raises the issue of whether it is possible to tailor programs to meet the special needs of mentally ill parents, and the cost-effectiveness of such efforts where there may be very small numbers involved. However, the evidence regarding the adverse consequences of perinatal mental illness is especially disturbing. It suggests that more intensive study of interventions specifically designed to improve mother-child interactions and which have demonstrated positive outcomes might be warranted, in order to determine the feasibility of adapting them to or adopting them as part of an intervention.

7.3 Family-centred and child-centred approaches to early intervention

Research pointing to the positive aspects of a family-centred approach to family support poses another challenge. Since social isolation or lack of support so often accompanies and exacerbates parental mental illness and problems, building up and strengthening family and other forms of support where these exist would seem to be an important strategy.

Given the evidence that combining different types of intervention, for example child care and parent education achieves more positive results than a single intervention on its own, more flexibility in combining and adapting programs is now considered both desirable and achievable. Programs or strategies that involve both parents, where this is possible and extended family members and/or friends to the extent that this is appropriate, might start to shift the focus from the individual parent (most often the mother).

As for child-focused programs, most of those noted above are for older children. It is also worth noting that some professionals argue against interventions directed primarily at children as they fear this labels the child as *the problem* and enables parents to avoid acknowledging their difficulties (Hetherington et al., 2002). But the advantages of quality child care, both as respite for parents and for a richer set of experiences for children of parents who have mental health issues and are socially isolated, seem to be well established.

7.4 Future research directions

Research into the effects of perinatal depression, and interventions aimed at mitigating adverse outcomes for the children of depressed mothers, is particularly active. Universal mental health promotional and preventive initiatives are also being more widely trialled and implemented, although at this stage evidence of long-term positive outcomes is lacking. The success of these programs would eventually lead to a reduction in the number of families coming to the attention of child protection agencies on the basis of mental health concerns. Under the COAG National Action Plan for Mental Health 2006-2011 the NSW Government committed $10 million for mental health research to the Brain and Mind Research Institute and the University of NSW. In the case of the latter this is for research on schizophrenia, depression, and anxiety disorders. It is to be hoped that future research findings will be of value to services seeing to assist families affected by these disorders.

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Appendix A
Classification of mental illness or disorder

Research reports describing measures used to assess whether or not subjects have a mental disorder sometimes refer to ICD-10, DSM (III or IV or IV-TR) psychiatric disorders or DSM diagnostic criteria. They may also allude to Axis I and Axis II disorders.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) was first published by the American Psychiatric Association in 1952, and is now in its fourth edition. The criteria and classification system of the DSM are based on a process of consultation involving primarily psychiatrists. The DSM sets out checklists of symptoms, and clusters of symptoms, that are labeled using terms that psychiatrists with different theoretical orientations agree to use. It has consequently facilitated communication between clinicians and researchers and is typically considered 'the bible' for professionals who make psychiatric diagnoses in the United States and in many other countries. There is also a European ICD-10 (*International Statistical Classification of Diseases and Related Health Problem*) classification of mental illness and behavioural disorders endorsed by the World Health Organization in 1992 and updated to 2006. Both are used in Australia, although use of DSM is very much the dominant classification. Much of DSM IV has been incorporated into ICD-10 in an effort to achieve more consistency between the two systems.

The DSM I listed about 106 different disorders; the categories and numbers of disorders listed has grown with each edition. Diagnosis is now systematised in five axes:

Axis I: major mental disorders, clinical disorders

Axis II: underlying pervasive or personality conditions, developmental disorders and learning disabilities, as well as mental retardation

Axis III: medical conditions contributing to the disorder

Axis IV: psychosocial and environmental factors contributing to the disorder

Axis V: global assessment of functioning (scale from 100 to 0).

The ICD-10 lists 22 Chapters of separate categories of health problems. Chapter V – *Mental and Behavioural Disorders* – comprises 11 categories of disorder numbered F00-F99.

The publication of the DSM marked a significant advance in the development of psychiatry as a science. But it has been pointed out that its atheoretical approach, eschewing explanations of cause or considerations of aetiology, has led to the emergence of a descriptive, nondynamic, nondevelopmental psychiatry. A disease model predominates, tending to reify diagnoses as diseases: for example 'the boy has got ODD [oppositional defiant disorder]', with consequent emphasis on medication (Josephson, 2006). The same comments could be applied to the ICD-10.

(This brief description of the DSM and the ICD has been compiled from the DSM-IV-TR Official website – the American Psychiatric Association; the website of the DSM-V Prelude Project; Josephson (2006 – listed in Report references); and the World Health Organisation's website).

Appendix B
Definitions of mental illnesses and disorders

Dual Diagnosis Manual for Caseworkers

Common anxiety disorders

There are a number of anxiety disorder subtypes:

Panic disorder

People suffering from panic attacks may find it hard to breathe, have a rapid heartbeat and become distressed and not want to leave the house.

Obsessive-compulsive disorder

The person has constant unwanted thoughts and feels compelled to conduct elaborate rituals (eg. repetitive washing of their hands) as a way to banish or control these thoughts.

Social phobia

The person fears being judged in a negative way, particularly when in the presence of unfamiliar people or under specific scrutiny.

Post-traumatic stress disorder

A person experiences flashbacks, intrusive thoughts or nightmares following major traumas, like assault, war, torture, rape, accidents and fires. It is quite common for people with an anxiety disorder to also suffer from depression.

Symptoms of depression

Some common ongoing symptoms of depression are:

- depressed mood – for example, the person may report feeling sad or 'empty' or appear tearful
- significantly reduced interest or pleasure in usual activities, significant weight loss or gain or change in appetite
- sleep disturbances, including insomnia or excessive tiredness
- physical agitation, such as pacing, or a 'slowing down' of movement
- fatigue and loss of energy
- feelings of worthlessness and excessive or inappropriate guilt
- diminished ability to think or concentrate, and indecisiveness
- recurrent thoughts of death, recurrent suicidal ideation, plans or suicide attempts.

A person who suffers from major depression usually has a depressed mood or loss of interest or pleasure in their usual activities consistently for about two weeks. In many cases the symptoms of depression are present for some time before the problem is recognised. The person's mood usually affects their ability to work or study and engage in social and other activities.

Different types of psychoses

Schizophrenia

Schizophrenia is generally an ongoing illness. Common symptoms include:

- false ideas or beliefs about reality – known as delusions
- false perceptions of reality – known as hallucinations. These include seeing and hearing things that are not there, as well as smelling, tasting and even feeling things that have no basis in reality
- thought disorder – jumbled or disjointed thoughts and speech. Includes going off on tangents or making loose associations between words and thoughts.

Other symptoms can include loss of motivation, social withdrawal, concentration problems and blunted or inappropriate emotions.

The most effective treatment for schizophrenia involves medication, counselling and support in managing its impact on everyday life. Treatment is commonly provided through psychiatrists and mental health services in the community. In some cases, hospital care may be required.

Medications work by correcting the neuro-chemical imbalance associated with the illness. Some people may need to take medication indefinitely to prevent relapse and keep symptoms under control.

Bipolar mood disorder

Bipolar mood disorder used to be called 'manic-depression'. People with bipolar mood disorder experience extreme mood swings from the lows of depression to elation and excitement, known as 'mania'.

Common symptoms of mania include:

- elevated mood
- increased energy and activity
- irritability and rapid thinking or speech
- lack of inhibition
- grandiose plans or beliefs and lack of insight.

When depressed, the person withdraws and loses interest in their usual activities. They commonly have disturbed sleep, appetite and concentration. They may experience overwhelming sadness and hopelessness and can become suicidal. They can also experience psychotic symptoms such as delusions. Most people with bipolar disorder experience normal moods in between and can generally manage their household or work commitments between episodes.

Medication is commonly used to manage bipolar disorder. Anti-depressant medications are used during depressive phases while, during the manic phase, several different medications are used to stabilise mood and calm excitement.

Preventive medications like lithium and anticonvulsant medications are also used to help control mood swings. Psychotherapy and counselling can also help a person understand the illness and better manage its effects on their life.

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Drug-induced psychosis

A psychosis can also be drug induced.

Drug-induced psychosis is treated in much the same way as schizophrenia, and will often resolve more quickly than other psychotic illnesses, particularly once substance use stops. Some people recover completely, though once a person has had one drug-induced psychosis they are more likely to have further episodes. A small number of people will also continue to have these symptoms even after they stop using drugs altogether.

Personality disorder

Types of personality disorders include: antisocial, borderline, paranoid, schizoid, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive.

Borderline personality disorder is one of the more common personality disorders. It is often linked to childhood trauma or sexual abuse. Symptoms include:

- inappropriate, intense anger
- difficulty regulating emotions
- impulsive behaviours – such as erratic spending or driving, engaging in substance misuse, being sexually disinhibited or self-harming
- difficulties in relationships and problems with self-image
- poor social skills.

Appendix C
Example of a Family Care Plan

(from the 'supporting our family' kit, COMIC website)

My name: ..... **My birth date:** .....

My parents/caregiver's names: .....

My brothers and sisters names and ages: .....

If my parent suddenly has to go into hospital I can call these people:

Name	Phone Number
1)	.....
2)	.....
3)	.....

Whilst my parent is in hospital I would like to stay with either:

Name	Their relationship to me	Home Phone No.	Work/Mobile Phone No.
1)			
2)			
3)			

☐ Please tick this box to show that this has been discussed with the people listed.

I would like to be (tick one)

☐ Picked up by the people I am staying with

☐ Dropped off at their home by a FAYS or a Mental Health Worker.

☐ Other .....

My parent/s will be staying at: .....

I can phone them on: ..... or visit them at: .....

My school is: .....

I can tell these people at school what is going on: .....

.....

These are the people I need to tell that my home situation has temporarily changed: .....

.....

.....

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My Doctor's name and phone number is: .....

My Medicare Number is: .....

Current medicines I use are: .....

When I stay with people it's important that I take with me: (include favourite toys, clothes, and any medication) .....

.....

.....

.....

I will get my pocket money from: .....

.....

My pets are:

Name	Animal type	tems to be taken with them (food etc)
1)		
2)		
3)		

They will be cared for by: .....

If there were something worrying me I would deal with it by: .....

.....

.....

I would like to be told what is going on with my parent/s by these people: .....

.....

.....

I can rely on these people when my parent/s are feeling unwell: .....

Other things that I need to remember are: .....

.....

I have agreed to this plan being put into action by .....

when my parent/caregiver becomes unwell.

Signatures Date: ...../...../.....

.....	.....	.....	.....
Child	Parent/Caregiver	Parent/Caregiver	Worker

For the worker to fill out:

Have the children/s needs been met, in particular, has the child been informed about the nature and condition of the parent/caregiver's illness? Yes ☐ No ☐

If not, why not?.....

.....

Has the child had an opportunity to discuss or express their feelings? Yes ☐ No ☐

Are there any protective issues? Yes ☐ No ☐

.....

.....

Are there any custody restrictions? Yes ☐ No ☐

Which agencies/custodial person(s) are involved in the care of this child (include key worker and contact details): .....

.....

Please tick the above boxes when the above agencies/custodial parent(s) have been notified.

I need to let these people know that ..... is unwell:

.....

.....

.....

.....

This is the number of children that can stay at the listed residences: .....

.....

.....

Other notes: .....

.....

.....

.....

.....

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Sample Letter

(from the COMIC website)

This is an example of a letter you could write to the child's school

To The Class Teacher/School Counsellor/ The Principal

I am writing to you to negotiate a school plan for **Child's Name, Class** who has a family member that at times experiences symptoms of mental illness. Generally the person in question functions well within the community and prefers not to be labelled. However, there may be times when the child would benefit from extra support through the school system.

At home I have: – Explained the mental illness to this child

– I have a care plan in place (we could discuss whether the school would like a copy?)

I nominate ..... (relationship eg. husband, grandma)

Telephone number: .....

Address: .....

.....

to advise the class teacher should our family be experiencing a stressful time. Our family would greatly appreciate it if you try to reinforce with the child that mental illness is just another form of illness and not something to be frightened or ashamed of as this is the attitude we try to reinforce within our home.

In the event the primary carer in the family is hospitalised the child will be cared for by:

..... (relationship eg. husband, grandma)

Telephone number: .....

Address: .....

.....

I trust that if you have any further questions about mental illness that I can answer them myself or direct you to someone else or perhaps we could make an appointment. Should you have any concerns about the child's behaviour or learning capacity, please feel free to discuss this with me. I have taken steps to ensure that the impact of the family member's condition on the child is kept to a minimum. The schools cooperation in helping educate and support the child about this important matter is valuable to me.

Yours sincerely

Signature

Appendix D
Some useful references for workforce development

The following references may prove useful in the development of educational and informational materials

1. AICAFMHA (2004). *Principles and actions for services and people working with children of parents with a mental illness*. AICAFMHA.

   This sets out a rationale; guiding principles; and action areas for individual workers and teams, as well as system responses. Much of this material will be relevant for early intervention caseworkers.

2. Gopfert, M., Webster, J. & Seeman, M. V. (Eds) (2004). *Parental Psychiatric Disorder: Distressed Parents and their Families* (2004). , 2nd edition, Cambridge: Cambridge University Press.

   This collection of contributions by experts provides a comprehensive overview of primary research in this area, as well as information on policy and clinical practice developments. It notes the 'relatively little high-quality research addressing aetiology, prevention and treatment from a family perspective' (p.xiv). It also points out that the publication of a completely revised second edition so soon after the first (1996) shows how rapidly the field is changing.

3. Cooklin, A. (2006). *Children of parents with mental illness*. In L. Combrinck-Graham, (Ed.), *Children in family contexts: perspectives on treatment*, 2nd edition, pp.265-291, New York: Guilford Press.

   This chapter combines a review of evidence on the impact of parental mental illness on children with the fruits of extensive clinical experience in a discussion of the needs of children and practical guidelines, particularly on how to talk and how to listen, for those who will work with these children.

4. Cowling, V. (2004). 'The same as they treat everybody else', in M. Gopfert, J. Webster & M. V. Seeman (Eds.), *Parental Psychiatric Disorder: Distressed Parents and their Families* (2004), 2nd edition, pp.87-92, Cambridge: Cambridge University Press.

   This chapter summarises views of parents with mental illness – a perspective that is all too rarely represented in the literature.

5. Hetherington, R., Baistow, K. & Katz, I. et al. (2002). *The Welfare of Children with Mentally Ill Parents: Learning from Inter-Country Comparisons*, New York: John Wiley & Sons.

   This book looks at the range of ways in which social welfare services in a number of countries are delivered to families where there is parental mental illness. Cross-country comparison provides a way of developing a new perspective on the problems that face professionals in mental health and child welfare services.

6. Falkov, A. (Ed.), (1988). *Crossing Bridges: Training resources for working with mentally ill parents and their children*, Reader for Managers, Practitioners and Trainers: Pavilion Publishing for Department of Health.

   Dr Falkov coordinated the UK Department of Health sponsored development of the multi-agency training materials for those working with COPMI and mentally ill parents set out in this book. He is now Acting Director of MH-Kids, which provides policy advice to the Mental Health and Drug & Alcohol Office in NSW and is adapting the *Crossing Bridges* resources for use in Australia.

Parents with mental health issues: Consequences for children and effectiveness of interventions designed to assist children and their families

Appendix E
Some useful websites

The following can be found on the internet through Google or other search engines. They contain information useful for those who wish to keep up to date with initiatives to assist families and children affected by parental mental illness or disorder.

AICAFMHA (Australian Infant Child and Adolescent Mental Health Association Ltd.)
www.aicafmha.net.au

This is a particularly useful site, listing Government and other major reports, giving advance notice of conferences, providing forums for the discussion of mental health issues, newsletter, preparing submissions to government and position papers, listing resources, and providing other relevant information.

AUSEINET (Australian Network for Promotion, prevention and early intervention for mental health)
www.auseinet.com

This network, funded by the Australian Government Department of Health and Aging, develops, collects and disseminates information on the promotion of mental health; prevention of mental disorder; early intervention in mental illness; and suicide prevention. It also establishes and maintains networks of people and organisations committed to this approach. It publishes a newsletter including content relating to a variety of aspects of mental health promotion, prevention, early intervention and suicide prevention across the lifespan, and the *Australian e-Journal for the advancement of mental health*, as well as a list of resources.

COPMI (The Children of Parents with a Mental Illness Resource Centre)
www.copmi.net.au

This website is an initiative of AICAFMHA. It provides information for workers, parents and families, children and young people. It lists a Programs and Services Updates Index on which anyone running a relevant program in any part of Australia can register, as well as resources classified according to age of child or category of worker (including Child Protection). Resources can also be added to the list.

COMIC (Children of Mentally Ill Consumers)
www.howstat.com/comic/

This describes itself as a group of adults who share a common interest for children of parents with mental illness and share a common perception of the past failure of mental health services to acknowledge and support them. It is a lobbying and advocacy group, South Australia-based, and has prepared a Teachers Resource Package, a list of resources (including the 'Supporting our Family' kit). It does not appear to have been updated recently.