



Evaluation of a model of best practice for families who have a parent with a mental illness

Darryl Maybery

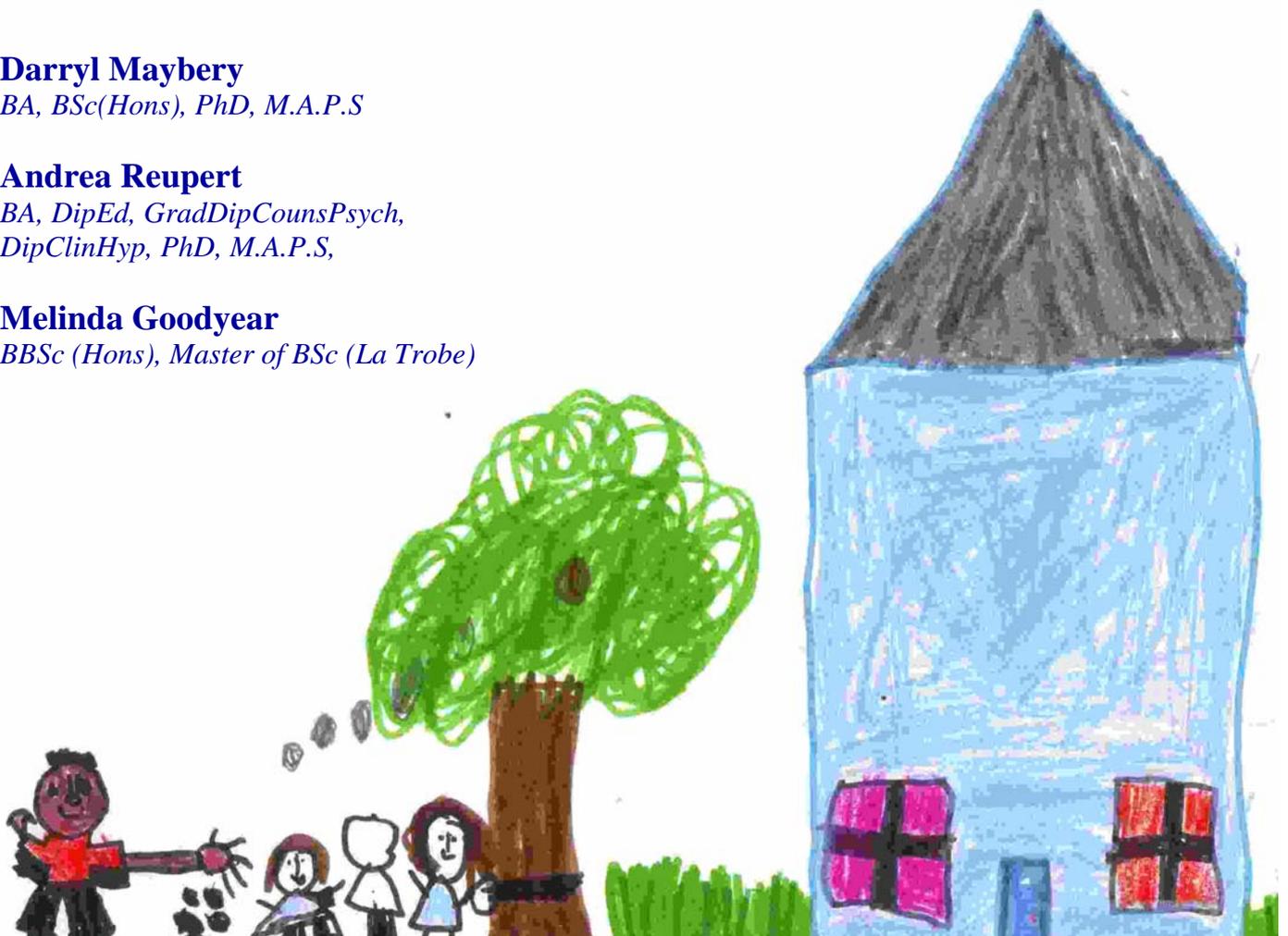
BA, BSc(Hons), PhD, M.A.P.S

Andrea Reupert

*BA, DipEd, GradDipCounsPsych,
DipClinHyp, PhD, M.A.P.S,*

Melinda Goodyear

BBSc (Hons), Master of BSc (La Trobe)



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For further information:

Darryl Maybery PhD
Senior Lecturer in Psychology
Charles Sturt University
Locked Bag 678
Wagga Wagga NSW 2678
AUSTRALIA

Phone (02) 69332777
Email dmaybery@csu.edu.au
<http://www.quantifyingconnections.com/>

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Executive summary: Findings and recommendations

A model of best practice for families affected by parental mental illness is documented in this report. Such information is expected to provide direction to the Government of Victoria and various agencies within the mental health and welfare sectors. It is also hoped that the report will contribute useful information to a larger evidence base, thereby improving future programs for children and families.

At the outset, the executive summary details the context in which the VicChamps project operates. Initially outlined is the prevalence of Victorian and Australian children and families living with a parent with a mental illness. These population estimates are then linked to a key finding from this report that shows that a large proportion of these children, and a significant proportion of the general child population in Australia, is living in family circumstances that pose significant risk to the child's mental well-being. The prevalence of such children establishes a context of the 'problem' but also presents an important role of the evaluation that sought to empirically determine the credentials of the VicChamps approach - a model recognised as one of the best approaches in Australia in assisting families where a parent has a mental illness.

The executive summary then continues with the key findings and recommendations highlighted in relation to the various components of the VicChamps approach, according to chapters found in the larger document. However, before reading further, it is imperative that the reader recognizes the following findings and recommendations need to be considered within the broader context of the data and text of the larger document.

Prevalence according to levels of risk

It has recently been estimated that between 21.73 and 23.52 percent of children living in Victorian and Australian households have at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2005). Table 1 shows the numbers and percentages of Victorian and Australian families and children in such households.

Table 1: Numbers and percentages of Victorian and Australian families and children in households where at least one parent has a mental illness.

Area	Families	Children	Percentage of all children¹
Victoria	142,325	266,657	21.73 to 23.52
Australia	577,507	1,082,402	21.73 to 23.52

This equates to just over a quarter of a million Victorian and one million Australian children, and clearly establishes a large group in the population who might benefit from prevention and early intervention approaches.

¹ See Chapter 2 for a detailed exposition of the methodology.

The need for early intervention

The literature suggests that children whose parents have a mental illness have more problems than those whose parents do not have a mental illness. To specify the types of

problems and issues that such children face, an additional study was undertaken for children in the 8-12 year age group – a central focus of this project. A large community-based study (undertaken by Charles Sturt University) paralleled the current evaluation. This sought to establish normative data in regard to the measures employed (such as the Strengths and Difficulties questionnaire) in the VicChamps evaluation.

As it has been found that 12.5 percent of the adult Australian population has a mental illness (excluding substance abuse, ABS, 1997, p.29) it was expected that such a large community data collection would also include families affected by parental mental illness.

Three groups were identified: 598 children whose parent did not have a mental illness, 101 children whose parent had a mental illness but were part of the general community, and finally 134 VicChamps children (the focal group for this evaluation).

Employing the Strengths and Difficulties questionnaire was important as indicative scores (norms regarding the likelihood of mental health problems) have previously been established. This allowed percentages of the three groups to be classified according to typical, borderline and clinical levels of mental health risk.

From a statistical perspective, the three groups were significantly different to each other. The VicChamps intervention group scored significantly higher (worse) than the other two groups (normative and

normative COPMI). From a clinical perspective, the normative, normative COPMI and VicChamps groups had approximately 20, 40 and 60 percent of children respectively in at risk ranges for total difficulties.

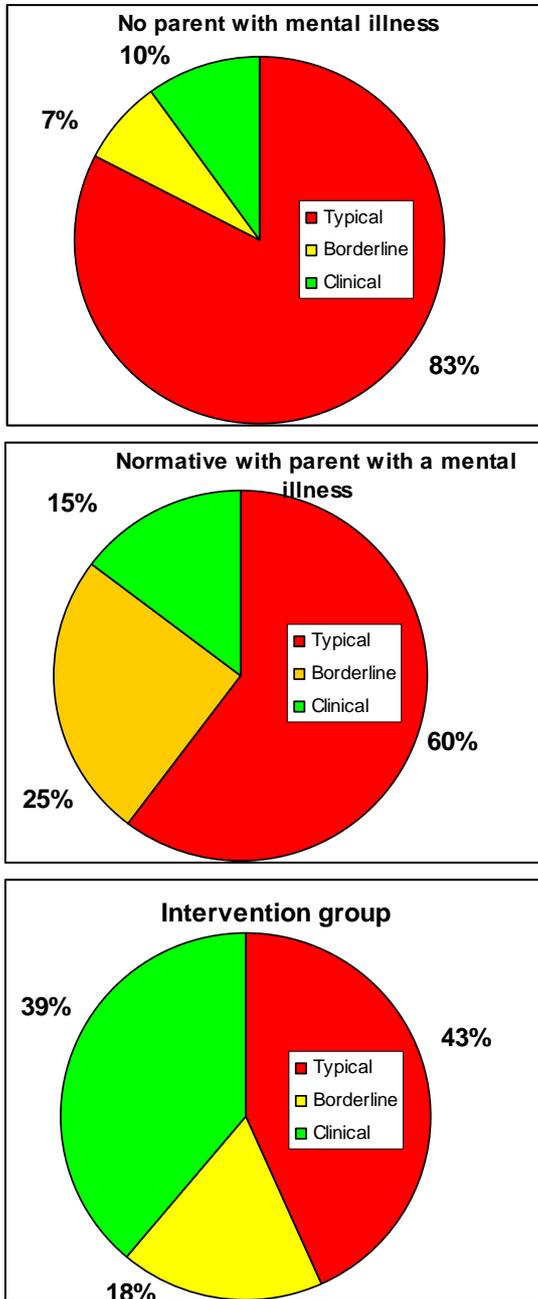


Figure 1: Percentage of children classified as typical, borderline and clinical according to no parent with a mental illness, normative and intervention groups.

With 60 percent of the VicChamps children scoring in the at risk category, the findings clearly establish this group as an important focus for early intervention. However, of considerably greater importance, when viewed in terms of the above prevalence information (Table 1), the findings highlight that 40 to 60 percent of the ¼ of a million Victorian and 40 to 60 percent of one million Australian children have a substantial mental health risk. This equates to approximately 130,000 Victorian and ½ million Australian children. This is a large group of ‘at risk’ Victorian and Australian children who are in need of prevention and early intervention services.

These findings also establish a need to investigate the quality of current prevention and early intervention approaches (such as VicChamps). Additionally, the findings support the focus of the current project by *beyondblue*, the national depression initiative, the Mental Health Branch of the Victorian Department of Human Services and Victorian Health Promotion Foundation (VicHealth) whose common goal is:

...to reduce the significant impact on the quality of life and the health outcomes for children and young people whose parents experience a mental illness. Funding over a three year period will enable the development, implementation and evaluation of models of good practice that includes appropriate responses, across all sectors, to young people, children and families in rural and metropolitan areas of Victoria (Burns & Basinski, 2004, p.2).

Having established the need for an intervention with this group of children, the literature is then reviewed in Chapter 2 in an effort to provide an overview of the range of interventions that might be potentially useful for practitioners working with such families, as well as providing a resource bank for systematic evaluation and research. It is contended that the issues for families affected by parental mental illness are multifaceted and have implications for many, including the child/ren, the parent/s, extended family members and the various organisations that come into contact with family members.

Chapter 3: Programs for 8-12 year old children

Chapter 3 aims to establish what changes occurred in the mental health and well-being of children as a result of their involvement in the VicChamps programs. Data are analyzed according to program type (holiday and after school) and location (Eastern and North Eastern) at pre to post intervention points. Such an analysis seeks to establish the impact of the programs on the children.

VicChamps ran 37 programs, including 15 holiday programs with 118 children and 31 after school programs with 121 different children, during the 2003 to 2005 period. As indicated above, the VicChamps children scored significantly lower than others (normative including COPMI) on a range of well-being variables from their own and their parents’ perspectives.

In general, the well-being of children increased as a result of the program, with reduced emotional difficulties, hyperactivity, and problems with others, and a corresponding increase in connections and self-esteem.

Both parents and children indicated positive changes in child well-being as a result of the school holiday program. Participants in this program improved in terms of total

difficulties, particularly in terms of emotional symptoms. Participants in school holiday programs showed greater improvements compared to after school programs.

Changes in total difficulties scores were dependent upon the site and type of program. Overall, improvements were found as a result of the Eastern region's after school program, and the North East's school holiday program.

A surprising finding was that total difficulties increased after the North East school holiday program. However, the intake score of these children was in the high indicative range, suggesting that the effect of these programs may be reliant upon the child's initial well-being.

While the North East school holiday program had a large increase in connections outside the family, total problems increased. In contrast, total problems decreased in the Eastern school holiday program. Neither school holiday programs produced changes in coping activities.

Improvements in child well-being were found in the Eastern region After School and School holiday programs, and in the North East School Holiday programs. There was a large improvement in participant self-esteem in both Eastern region programs, and in the North East school holiday program.

Finally there was a reduction in several aspects of child well-being. This included an increase in conduct problems and reduced prosocial behaviour. However, this was balanced with a general increase in participant self-esteem. One explanation for this finding is that the interventions are helping children to improve their self-esteem and confidence, which is then leading them to be more critical of others. Future programs should recognize that changing children's confidence and skills might have a long-term influence on the dynamics within their families.

The following recommendations emerged in relation to the programs for 8-12 year old children.

Recommendation: Interagency partnerships are central to the development and running of programs.

Recommendation: Agency partners involved in developing and running programs should have clearly articulated roles and responsibilities.

Recommendation: School holiday programs are recommended as intervention programs for 8-12 year old children.

Recommendation: School holiday programs are recommended as intervention programs for 8-12 year old children.

Recommendation: After school programs are recommended intervention programs for 8-12 year old children in urban or larger regional settings.

Recommendation: After school programs need to consider distance, transport and associated funding issues, particularly for children from rural or remote locations.

Recommendation: It is essential to have clear referral and selection criteria (specifically in regard to children's mental well-being) prior to program entry.

Recommendation: Programs should have clear behaviour management guidelines for group facilitators to adhere to (and the guidelines need to be included in program manuals).

Recommendation: Program facilitators must make the mode of program delivery responsive and flexible to the needs and circumstances of the children.

Recommendation: Clear information should be supplied to parents about possible changes in their children (e.g. increased self-esteem, lowered prosocial behaviour, greater conduct problems) resulting from programs. If necessary, support to families should be provided following programs, including linking parents to parent support programs.

Recommendation: Ongoing evaluations should be undertaken by future programs with standardized measures (e.g. SDQ) to allow comparisons with other programs or groups, and to develop further research knowledge regarding families with a parent with a mental illness.

Recommendation: A body or organization should be established as the repository for the ongoing collection and entry of evaluation and research data from families where a parent has a mental illness. Such a body would undertake analyses of various aspects of that data, including making the data available to other researchers and evaluators in the community.

Recommendation: A 'Graduates' group or program for children and their families to attend at completion of an after school program needs to be established, to offers ongoing social and peer support.

Chapter 4: Interventions for five to seven year olds

As children in the five to seven age group differ physically, intellectually and psychologically from those in the eight to twelve group, different programs and evaluation tools were developed for the two age groups of children. Additionally, the two regions employed two different approaches in addressing the needs of children aged 5-7.

In Eastern Melbourne, concurrent parent and children YoungChamps groups were run. The objectives of both programs were to strengthen relationships within families, facilitate family access to community supports, provide education and support to parents and their children and finally, to develop and establish a strong collaborative role for

health professional and family workers. However, due to child care, transport and timing, there were difficulties attracting participants for both programs, with three children and three parents attending the one program. The children who attended the YoungChamps program report having fun and making new friends, while parents reported increased ability to discuss their parenting concerns with others, and increased access to parenting support and information.

In the North East, children and their families preferred to stay in family groupings, rather than attend age-specific programs, which meant that children aged 5-7 attended the 8-12 year old program with their older siblings. However, this approach is perhaps only appropriate if children are developmentally more advanced and/or have older siblings attending the 8-12 year old program. Conversely, while such an approach may be appropriate for these younger children, it might impact on older children. It also remains to be seen how younger children, who do not have an older sibling, might be best supported.

Thus, while two support strategies were trialed, namely age specific programs and sibling groups, the most effective strategy for attracting and supporting children aged 5-7 is unclear.

Recommendation: It is recommended that programs be developed, trialed and evaluated with children aged 5-7 to provide evidence for program effectiveness.

Recommendation: It is recommended that different methods of attracting 5-7 year old children to programs be determined and trialed. Including younger children with their older siblings in 8-12 year old program has been one successful strategy in attracting children to VicChamps programs.

Chapter 5: Workforce development

Human service agencies traditionally take a categorical approach to their clients with a tendency to focus on either the child (in terms of child protection) *or* the adult (for his or her mental health needs). Such an approach leads to major difficulties for children of parents with a mental illness, as they are not able to become clients of adult mental health services. Adult mental health workers do not routinely engage with children under 18 years of age, nor do they characteristically focus their clinical interventions upon children of their clients. These children only become a focus of attention (or client) if they have a diagnosable problem and/or are case identified. A preventative stance is often not assumed.

An important component of the VicChamps project was to enhance the capacity of mental health services' to respond to families in which a parent has a mental illness. In addition, the program also sought to raise the capacity of mental health and welfare professionals generally, and to enhance the awareness of, and responsibility for, such children and their families. The evaluation sought to measure changes in mental health and welfare staff across the regions according to the following variables:

- referral skills and/or processes undertaken,

- levels of responsibility and activity undertaken for such children by workers,
- any systemic organizational change to accommodate children in such circumstances.

Additionally, a gap was identified regarding the barriers for mental health and welfare workers in working with their adult clients as parents. A number of obstacles were identified for practitioners working with families affected by parental mental illness, including barriers associated with the level of functioning of the ill parent, the level of access to children, the risk of disrupting the worker-client relationship and inadequate worker resources, including time. The greatest barriers for workers were where the client denied having a mental illness or the client did not acknowledge his or her mental illness might be a problem for children.

It was also highlighted that adult mental health workers are not adequately resourced (including time) to involve children in the daily course of their work. In addition, they indicated that they did not have the same level of skills as other mental health professionals for working with children and lacked the skills and knowledge to help their clients on parenting and other child related issues.

The means by which regional workers obtained information about parental mental illness were through training programs and self directed learning. In addition, the Getting There Together program served to be an important approach to improving the knowledge of participants, and led to an increase in support, education and referrals regarding COPMI compared to non-attendees. Participants reported that the presenters of the Getting There Together program were good and that it was useful to listen to the personal experiences and stories of parents/carers.

In addition, changes in workforce activities resulted from the VicChamps programs operating in the East and North East regions. Over time, all regional workers consulted more often with VicChamps personnel, and all workers surveyed considered the VicChamps program to have 'some' to approaching 'a lot' of benefit.

Recommendation: The GTT program is recommended as a vehicle to develop knowledge and introduce practice changes in mental health, general health and welfare workforces.

Recommendation: That GTT type programs be implemented in regions in order to engender culture as well as systemic change with regional workforces.

Recommendation: That other awareness raising media be implemented to improve workers' knowledge about families affected by parental mental illness and that information be provided to new workers as a part of their induction/orientation to positions.

Recommendation: That mental health workforce competency standards include principles in relation to knowledge and skills regarding working with families affected by parental mental illness.

Recommendation: That universities and TAFE colleges provide knowledge and training to mental health and welfare students (e.g. psychologists, social workers, occupational therapists) as part of their undergraduate and post graduate degrees.

Recommendation: Mental health and welfare workers receive skills training regarding the management of clients who are resistant and/or reluctant to discuss parenting issues and/or the impact of their mental illness on their children.

Recommendation: Adult mental health workers identify clients who are parents on entry to the service, and plan their treatment with that in mind.

Recommendation: Adult mental health workers receive skill and knowledge training regarding the impact of parental mental illness on children (developmentally) and in how to work with children.

Recommendation: Adult mental health workers receive training regarding working with clients on family-related issues (e.g., parenting).

Recommendation: Adult mental health services be provided with additional resources including time, to allow workers to work with their mentally ill clients regarding family-related issues.

Recommendation: That the above four recommendations constitute a core component of the role of Adult Mental Health Workers.

Recommendation: Future research be undertaken to examine the barriers faced by other Department of Human Services personnel (e.g. child protection) and General Practitioners when working with their mentally ill clients regarding family-related issues.

Chapter 6: Program facilitator networks and network development

Networking activities implemented by the VicChamps staff aimed to facilitate a cohesive and coordinated approach across different sectors, agencies and community groups when responding to COPMI issues. Key networking activities undertaken by VicChamps staff included (i) attending and organizing network meetings, (ii) joint program facilitation, (iii) using other organisations' venues for VicChamps activities, (iv) providing educational activities, (v) media presentations, (vi) distribution of brochures, flyers, posters and (vii) secondary consultations.

VicChamps facilitators found it important to access support from all levels of an organization, when facilitating organisational change. Upper management support is important to drive policy development. The support of key workers on the ground is needed to implement changes to daily practices. However, the most important avenue of support is from middle management, as it is often their responsibility to mandate and embed policy changes for key workers.

Secondary consultations, defined as requests from individuals, community groups or agencies (either in person, telephone or email) to facilitators regarding COPMI issues, as well as program enquiries, formed a significant component of the VicChamps facilitators' workload. Secondary consultations appear to be reasonably constant over the three year period; Eastern Melbourne consultations ranged between 24 and 50, while North East consultations ranged between three and 16, both across a two week period every three months, over the three years.

Key stakeholder interviews were held with consumers, agency workers and managers, which highlighted high levels of satisfaction with VicChamps in addressing the needs of children, parents, families and agencies. These interviews also reported the need for an ongoing, specialised child-centred service to best address the needs of children whose parents have a mental illness. At the same time, stakeholders suggest that there is a need for a multilevel engagement for families affected by parental mental illness, some of which is answered by VicChamps.

Since the conception of VicChamps there have been systemic changes in how organisations respond to children whose parents have a mental illness. For example, Kerferd Unit (North East) includes parenting status as part of their intake interview, and there are now formal policy holders in upper management levels (Eastern Mental Health). Other agencies are now working on the issues for families affected by parental mental illness, for example through joint facilitation of VicChamps programs (both regions), by initiating and implementing parenting programs (Unfogging the Future, North East), and through the 'Train the Trainer' program (Eastern Melbourne).

Recommendation: Substantial effort should focus on developing individual and agency networks to increase workforce awareness of families where a parent has a mental illness.

Recommendation: It is recommended that some of the networking activities for workers of future programs include attendance and establishment of network forums, providing secondary consultation, joint program facilitation, and implementing 'train the trainer' programs.

Recommendation: Secondary consultations are an important need/task that arises from providing specialized programs that address the needs of children with a parent with a mental illness.

Recommendation: Organisational change is essential for delivering services to this target group. All levels of a mental health or welfare organization should be targeted including upper management to drive policy change, middle management to implement policy, and key workers to put policy into practice.

Chapter 7: Family care plans

Working from existing crisis plans, workers in the North East invited parents and their children to develop plans that would work for families such as their own. As a result of these consultations, the concept of family care plans was established, which incorporated

both a crisis plan (ie planning for the parent being hospitalized or very ill) as well as a care plan, in which short and long term family goals were identified. Subsequently family care plans were undertaken with five families in the North East. All stakeholders including the parent/s, extended family members, children and key agency workers took an active role in the development and implementation of these family care plans.

In times of crisis, benefits of plans include the coordination of care, minimizing disruption to the family unit, and enhancing personal control of family members. Plans needed to include a crisis component, particularly if the parent has severe, recurrent symptoms, and there is a likelihood of hospitalization. The care component was important to identify what was important for all members of the family, both in the short and longer term.

The process of implementing family care plans had incidental benefits including improving family knowledge about mental illness, providing an opportunity to talk and discuss needs, providing an opportunity for the parent to develop new skills, as well as improving external supports to the family, both formal and informal. Overall plans were considered an important way for children's needs to be acknowledged and addressed more generally, and not just in crisis times.

Some discussion is provided in the chapter as to which agency might be best placed to facilitate family care plans in the future. As many of their clients are also parents, it was argued that adult mental health agencies are best placed to implement family care plans, if provided with adequate training, resources and time.

Recommendation: The model of family care plans illustrated here needs to be more extensively trialed and evaluated.

Recommendation: If provided with appropriate training and resources, adult mental health agencies are seen as the most appropriate agency to assume responsibility for the implementation of family care plans.

Recommendation: Family care plans incorporate a plan for managing potential crises, as well as identifying short and long term goals for family members.

Recommendation: Further development and evaluation should be undertaken before substantive claims are made regarding the efficacy of family care plans.

Chapter 8: Community education: SKIPS, pamphlets and website

A considerable amount of advertising and education of the general public and target groups (e.g. COPMI) was undertaken by way of the VicChamps website, and through promotional and educational pamphlets during the 2003 to 2005 period. In addition, a central focus of community education was SKIPS (Supporting Kids in Primary Schools), which had two main objectives:

1. addressing the roles of schools and teachers in supporting children and families affected by the mental illness of a parent; and
2. reducing stigma through classroom education about mental illness.

Previous published research on SKIPS shows that the program reduces prejudice and supports students and families affected by mental illness in primary schools.

Evaluation of a train the trainer program was undertaken here, which showed that participants rated the presenters of SKIPS Train the Trainer program as clear and easy to follow, and the manual to be clear, logical and easy to use. Two-third of SKIPS Train the Trainer participants considered themselves ready to run a SKIPS program at the end of training. The train the trainer program improved participants' knowledge of the problems of children whose parent had a mental illness, and enhanced their enthusiasm to get started. The central barrier for participants running SKIPS programs in future was gaining access (including time) to schools.

Recommendation: Pamphlets, flyers and websites should be regularly employed to advertise and educate about the range of issues regarding families with a parental mental illness.

Recommendation: The SKIPs should be made readily available to organizations across the state, with accompanying training to run the program.

Chapter 1: The problem, the programs and the evaluation: Building an evidence base for practice

Policy makers and funding bodies now demand evidence to support programs, including mental health interventions. Evaluation is therefore an essential part of any program and is defined in the following way:

Evaluation is a systematic process for an organization to obtain information on its activities, its impacts, and the effectiveness of its work, so that it can improve its activities and describe its accomplishments (Mattessisch, 2003, p.56).

Effective evaluation strategies assist in identifying what components of programs achieve pre-established objectives, as well as areas that might require further refinement. By systematically gathering, compiling and reviewing information over time, evaluation allows us to develop a sound understanding of how the targeted intervention group is changing, and what issues and needs remain (Matterssisch, 2003). Effective evaluation also permits an improved allocation of resources, so that more resources might be directed to more effective activities and, conversely, fewer resources are directed to less effective activities.

The evaluation of programs is not only based on the systematic gathering of evidence. Good evaluations also focus on the clarity of the concern at hand, and the key objectives and components of a program. Effective evaluations are informed by responses to the following questions:

- What is the problem?
- Where might interventions occur in relation to this problem?
- What aspect of the problem is this aspect of the program trying to solve?
- What is the program?
- How do the goals and strategies of the program aim to solve the problem?
- What evidence is there for how well this program solves the theorised problem?
- What is the quality of the evidence?

These are best summarised as the problem, the program and the evidence. The significance of these factors in evaluating programs are outlined below and, most importantly, applied to issues for children living in families with a parental mental illness. In doing so, an outline of the structure of the chapters that follow is also highlighted.

The problem

The prevalence and problems for children of parents with a mental illness (COPMI) are summarized in a brief literature review in Chapter 2. The literature highlights the issues and possible intervention points for the children, the parent with the mental illness, other family members and the various organisations and workers engaged with such families. While the VicChamps programs focus most prominently upon programs for children, as well as workforce change, the literature is outlined in Chapter 2 to contextualize the issues for such families. In addition, at the commencement of each chapter there is a brief synopsis of any distinctive feature or issue as drawn from the literature.

The programs

Effective program evaluation strategies require, in the first instance, clearly defined goals expressed in simple, measurable terms. This allows specific measurement tools to be selected that are clearly linked to each goal. Thus, in each chapter that follows, there is a detailed, though succinct description of each of the intervention programs undertaken by the VicChamp facilitators, highlighting in particular the goals and expected outcomes of each of the interventions. Each chapter commences with an introduction to the theoretical and research base underlying the issues for the target group, following which is an overview of the intervention program for this group, along with specific objectives. Also outlined at this point are the activities (e.g. number of After School programs) undertaken as part of the project during the 2003 to 2005 course of the project.

Chapter 3 highlights the After School and School Holiday programs for 8-12 year old children, while the programs for 5-7 year olds are outlined in Chapter 4. Chapter 5 then details workforce development activities such as the Getting There Together program that aims to enhance the capacity of mental health and welfare services' to respond to families in which a parent has a mental illness. The development of sustainable practices within regions was a central aim of Chapter 6, with a focus on developing and improving agency and community networks. Chapter 7 outlines efforts to develop family care plans to manage the circumstances of a parent being hospitalized, or otherwise in crisis, due to their mental illness. The final chapter (Chapter 8) focuses on community education, detailing the Supporting Kids in Primary Schools (SKIPS) program for educating and reducing stigma in primary schools, the VicChamps website, and promotional and educational pamphlets distributed throughout the period. While specific components of the VicChamps program are detailed in the chapters that follow, the subsequent section details the background and key components of the VicChamps approach.

Background to and key components of the VicChamps approach

VicChamps is a program of activities, which have been developed over the last decade, aimed at addressing the needs of families with a parent with a mental illness. VicChamps aims to increase the resilience and social connectedness of children with a parent with a mental illness, to reduce stigma associated with mental illness, and to enhance community capacity to assist these families through inter-sectoral peer support program provision, work force development and whole of community education.

The components of the VicChamps approach are designed to meet a number of policy and philosophically based objectives. The principle of inclusion and including both low and high prevalence mental health issues (for example, psychosis, depression, anxiety and so on) is an important component. The model utilized by VicChamps closely reflects the ethos of the Second National Mental Health Strategy in terms of the initiatives directed towards mental health promotion, prevention of poor mental health, and early intervention.

Eastern (metropolitan) and North Eastern (rural) partnership

The VicChamps approach is a partnership between metropolitan and rural programs that have a firm commitment to families in which a parent has a mental illness. Historically, the Eastern and North Eastern regions of Victoria have committed significant worker time and infrastructure to promoting the emotional well-being and resilience of this vulnerable group. These partners include the Parents in Partnerships Project at Eastern Health Mental Health Program (Eastern Metropolitan Region) and the Supporting Kids Project at Eastern Hume Region (North East).

Eastern Health Mental Health Program is a component of Eastern Health, and is funded through the Mental Health Branch of the Department of Human Services. It is a clinical mental health service which assists people across the whole of life age span. Much of the core business is the assessment and treatment of people with mental health problems. The Eastern Health Mental Health Program covers the local government areas of Maroondah, Monash, Yarra Ranges, Knox, Whitehorse and Manningham.

In the North East, the *Supporting Kids Project* is a community initiative aiming to improve services to children with parents who have a mental illness. It covers the cities of Benalla, Wangaratta and Wodonga, and the Shires of Alpine, Delatite, Indigo and Towong. The project evolved as a response to a distinct service gap and deficit in the resources available within this area of practice. Interagency collaboration from both mental health and non-mental health services was deemed to be essential to enable any program to be sustainable and successful in identifying and meeting the needs of this group of children. The project is a collaboration of mental health services, community agencies and consumers who are parents. The agency partners are:

- Upper Murray Family Care
- Trinity Community Support Association, a Psychiatric Disability Support Service in Wangaratta
- Wangaratta Community Psychiatric Service
- Mental Illness Fellowship (MIF – formerly the Schizophrenia Fellowship of Victoria).
- Upper Hume Community Health Service, Get Together House, Psycho-Social Rehabilitation program.
- North East Child and Adolescent Mental Health Service
- Department of Human Services
- Parent representatives
- Wodonga Adult Mental Health Service
- Charles Sturt University

The North East component of the program sought to provide a rural perspective to all the key program components, and to explore their transferability to other rural communities.

The following figure outlines the organisational relationships of project partners.

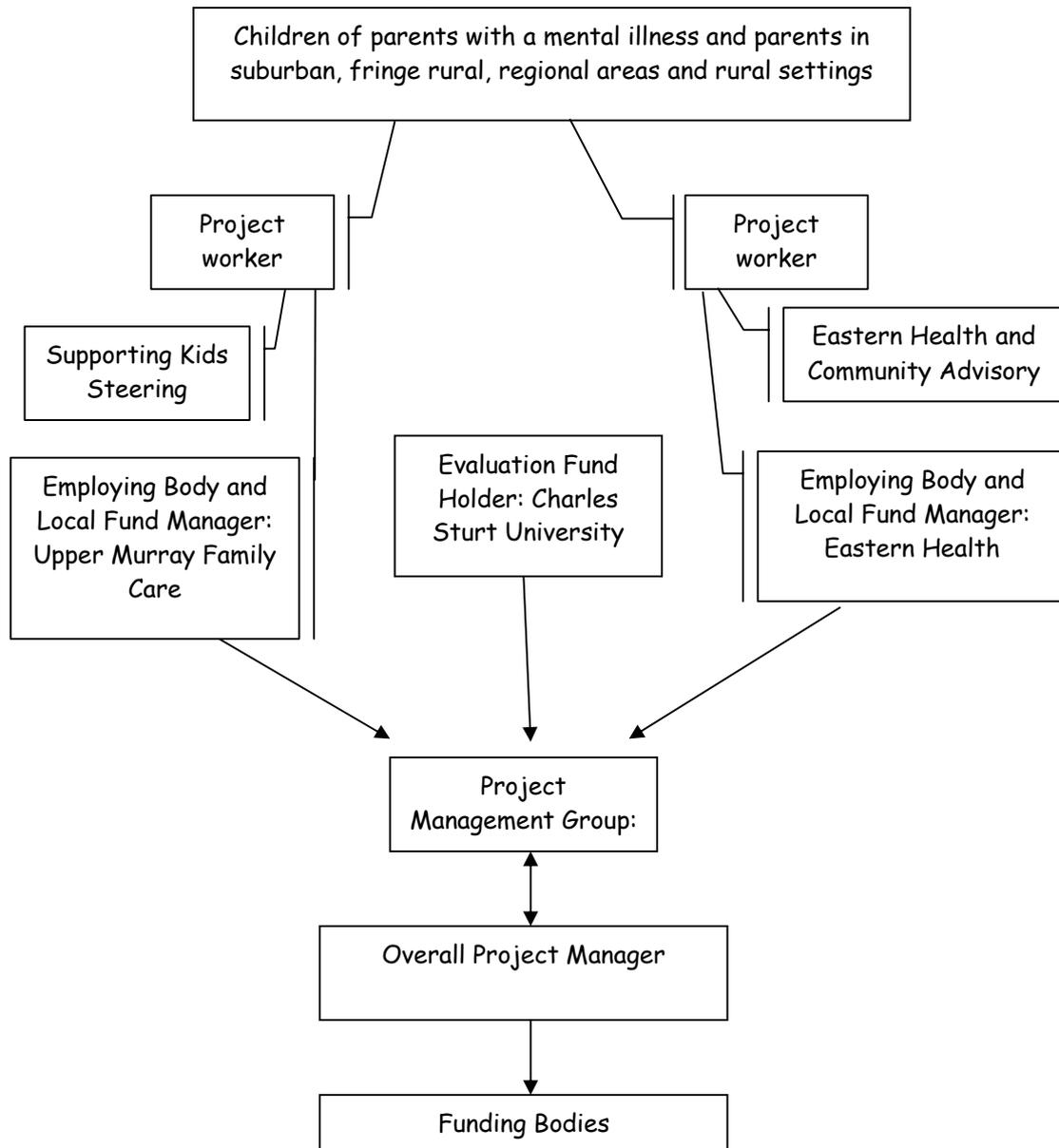


Figure 1.1: VicChamps project – Eastern Health and North East organisational relationships

The evaluation

Each chapter commences with an outline of the problem for a particular target group and the subsequent VicChamps intervention programs. The evaluation strategies for that component of the program then follow. Central to evaluation is the measurement of program activity and changes to problems as a result of intervention. Effective measurement tools are characterized by various attributes, namely, relevance, validity, reliability, sensitivity, timeliness, and the potential for comparison (Matterssich, 2003). *Relevance* ensures that the measurement tool will result in information related to the organisation’s needs and, in particular, to a particular program goal. A measure is *valid* if it measures what it purports to measure. A *reliable* measure is one that provides a

consistent rating, not susceptible to a great deal of error, while *sensitivity* refers to the ability of a measure to provide fine enough details to then plan an appropriate course of action. *Timeliness* refers to working within specific and timely deadlines. Finally, for findings of evaluation reports to be credible, *comparisons* between the target group and another at risk group, and/or other normative data, can provide the strongest evidence of cause and effect. These were the principles used to select the appropriate measurement tools for the VicChamps evaluation.

Overall, the key aspects of any evaluation plan include:

- (i) the questions that the evaluation is to answer, as linked to both past research in this area and the program goals; and
- (ii) the methods and procedures to be used in answering those questions (Rossi, Lipsey & Freeman, 2003).

Accordingly, the evaluation section of each chapter is written in the following manner:

- (i) Methodology - describes the design, procedures and measurement tools.
- (ii) Results – detailing the results of the methodology.
- (iii) Issues for Discussion – ending each chapter is a brief discussion of chapter findings that aims to be instructive to policy makers and programmers about the design and delivery of such programs in future.
- (iv) Key Findings – key results are highlighted in text boxes throughout the chapters. These findings are also outlined as part of the executive summary.

Chapter 2: Issues for families affected by parental mental illness

Families affected by parental mental illness are among the most vulnerable in our community. Such families are more likely to experience social isolation, financial hardship and marital discord, with increased risks for children, genetically, psychologically and environmentally (Beardslee, Versage & Gladstone, 1998). In this chapter, prevalence information is highlighted followed by issues and intervention points for such families. The aim of this introductory chapter is to offer a bigger picture perspective on the problems for children of having a parent with a mental illness.

Prevalence of children living in families with a parental mental illness

Mental illness refers to a wide range of psychiatric symptoms that persist over time and are functionally disabling in living skills, social interactions, family relationships, jobs and/or education (Johnson, 1997). The children involved in the VicChamp programs included parent/s with disorders such as schizophrenia, major depression and anxiety, and bipolar disorder.

As the VicChamps project progressed, VicHealth invited the evaluation team, along with several colleagues, to estimate the number of children living within families with a parental mental illness. While not the focus of the VicChamps project per se, the evaluation team estimated the number of children and families affected by parental mental illness according to various levels of parental disability, home living circumstances and associated risk. In 2005, a paper² was completed from which the following verbatim extract is drawn.

Table 2.1 reports data from two sources [Australian Bureau of Statistics (ABS) and Mental Health Branch (MHB) in Victoria] estimating numbers of families and children, according to single and two parent families and the level of disability conferred by the parent's mental illness.

Building on data in Table 2.1 the percentage of children whose parent has a mental illness (COPMI) in the total child population was estimated as well as the number of COPMI according to family status and the level of parental mental illness. Hypothesised levels of risk to children (low to extreme) for these types of living circumstances (see Table 2.2) were then outlined. Finally, some implications for intervention, once again according to each living circumstance, were shown.

² Details of this work are published in Maybery, D.J., & Reupert, A.E., Patrick, K., Goodyear, M. & Crase, L. (2005). VicHealth research report on children at risk in families affected by parental mental illness. Victorian Health Promotion Foundation, Melbourne. It is available on the www.vichealth.vic.gov.au website.

Table 2.1: Estimated (ABS) and actual (Mental Health Branch) numbers of children and families living with one and two parents in Australia and Victoria, according to illness severity.

Region	Level of Disability	Two Parent		One Parent		Total		Data Source
		Families	Children	Families	Children	Families	Children	
Victoria	Severe	5,862	11,138	1,967	3,265	7,829	14,403	VMH actual
	Severe	16,458	31,272	2,044	3,394	18,502	34,666	Estimate based on ABS data
	Not severe	110,142	209,281	13,681	22,710	123,823	231,991	Estimate based on ABS data
	Total	126,600	240,553	15,725	26,104	142,325	266,657	Estimate based on ABS data
Australia	Severe	23,499	44,705	8,755	14,620	32,254	59,325	Estimate ³ based on VMH actual data
	Severe	65,977	125,516	9,099	15,196	75,076	140,712	Estimate based on ABS data
	Not severe	441,535	839,994	60,896	101,696	502,431	941,690	Estimate based on ABS data
	Total	507,512	965,510	69,995	116,892	577,507	1,082,402	Estimate based on ABS data

³The ABS ratio of children to family was used to calculate the number of children for the VMH estimate.

Table 2.2: Percentage of children (children whose parent has a mental illness, COPMI and all children in Australia), living in single and two parent families, level of parental mental illness, estimate of risk and implication for future interventions.

Family structure and level of illness	% of all children	% of COPMI	Est. of Risk	Implications for Intervention
Two Parent Illness Not Severe	18.46	78.48	Low to Moderate	<p>Ensure that appropriate systems are in place for the identification, assessment, referral and/or intervention for families from community settings such as General Practitioners, community mental health/welfare settings. Involve the other parent (attachment figure) in intervention.</p> <p>Educate both parents regarding attachment and connectedness, and the impact of mental illness on children and parenting behaviours.</p> <p>Provide support and education to the other parent (without the mental illness), and enhance relationship between the two parents.</p> <p>Develop a plan to manage the circumstance of the hospitalization of the ill parent.</p> <p>Encourage open and age appropriate discussion and education about parental mental illness.</p>
One Parent Illness Not Severe	2.00	8.52	Moderate to High	<p>Develop and maintain attachments and connections within and out of the family unit for both parents and children (e.g. with mother, siblings, grandparents, friendship groups).</p> <p>Educate the parent about attachment and connectedness, impact of illness on children and parenting behaviours.</p> <p>Develop a plan to manage the possible event of the parent's hospitalization.</p> <p>Encourage open and age appropriate discussion and education about parental mental illness.</p> <p>Ensure adequate family financial circumstances.</p>
Two Parent Illness Severe	0.98 to 2.76	4.18 to 11.73	Moderate to High	<p>As for two parent family, illness not severe.</p> <p>Ensure that there is constant support for the other parent (without the mental illness).</p> <p>Review the plan for parent hospitalization on a regular basis.</p>
One Parent Illness Severe	0.29 to 0.30	1.22 to 1.27	Extreme	<p>As per one parent family, illness not severe.</p> <p>Identification, assessment, referral and/or intervention for families through Adult Mental Health services.</p> <p>Review the plan for parent hospitalization on a regular basis.</p>
Total	21.73 to 23.52	100		

In total, it was estimated that there were between 21.73 and 23.52 percent of children living in Australian and Victorian households, where at least one parent has a mental illness. This means that there are just over one million such children in Australia, and just over a quarter of a million of them in Victoria. These figures add to previous reports that approximately 30% of the Australian Adult Mental Health clients were female with dependent children under the age of 18 (Australian Infant, Child, Adolescent and Family Mental Health Association, 2001), and the life time estimation of Nicholson et al. (2002) that 68 percent of North American women and 54 percent of men with disorders have children. This is a substantial number of children and, considering the higher rates of mental health issues that they are known to experience, compared to other children (Beardslee et al., 1998; Brotman Band & Weisz, 1988; Cicchetti et al., 1998; Klimes-Dougan et al., 1999), it highlights an important target group for preventive programs.

The current data also add important information about sub groups of COPMI children at different levels of mental health risk. Four categories are highlighted according to mental illness severity and the level of family support, which show variable risks within the population of COPMI. Table 2.2 highlights that just over three-quarters of COPMI (18.46 percent of all children) are in two parent families, where the level of mental illness is not severe. It was suggested that these children are at risk, but in the low to moderate category. In addition, it was also estimated that just over eight percent of COPMI, who live in single parent families where the mental illness is not severe, were at a moderate to high risk of developing future mental health problems. Within the former risk category, there were 209,281 children in Victoria and 839,994 in Australia, and in the latter category there were 22,710 and 101,696 children respectively.

While 87 percent of COPMI are accounted for in the above risk categories, the numbers of children in the most profound, including extreme risk categories, are not significant. Employing the dual approximation methodology, it is estimated that between just over four percent (Victorian Mental Health Branch data), and just fewer than 12 percent (estimates based upon ABS data) of COPMI live in two parent families, where one parent has a severe mental health problem. This accounts for between 0.98 and 2.76 percent of all children. It is calculated that between 11,138 and 31,272 children in Victoria, and 44,705 and 125,516 in Australia live in such circumstances and that these children are at moderate to high risk to their mental well-being.

The final category of single parents with a severe mental illness contains the smallest number of children, but includes those, who it could be argued, are at extreme levels of risk for future mental health issues. It is estimated that this group accounts for 1.22 to 1.27 percent of COPMI, and includes approximately three in every one thousand Australian children. In Victoria, it was estimated that there are 3,265 to 3,394 children, and in Australia 14,620 to 15,196 children who live in these circumstances. While relatively small numbers, this is nonetheless a significant number of children who face compounding, risk variables. Without some form of intervention, these children potentially face considerable risks and corresponding needs in terms of their future mental health.

To this end, it was then thought important to identify from the literature the range of issues and subsequent possible interventions for such families. Table 2.3 below highlights possible target groups, needs and subsequent interventions.

Table 2.3: Target groups, needs and subsequent interventions

Target group	Issues	Intervention strategies
Child	Attachment problems leading to relationship issues in child and adulthood.	Provide children with ongoing opportunities to relate closely to consistent, healthy and supportive others, from within the family (i.e. siblings, the partner of the mentally ill parent, extended family members) as well as outside the family (e.g. friends of the family, peers, teachers, sport and hobby personnel).
	Transport, accommodation and domestic issues when parent is unwell or hospitalised.	Family-friendly hospital facilities, practical support for transport and various domestic issues, alternative or assisted stay at home accommodation.
	Problematic coping styles.	Provide opportunities to learn and practice adaptive problem solving strategies.
	Misconceptions about parent's mental illness	Provide ongoing opportunities for children to express their feelings and thoughts about their parent's illness. Provide age appropriate education about parental mental illness and mental illness generally.
Parent with mental illness	Managing the parent's mental illness.	Appropriate, sensitive and timely assessment, intervention and rehabilitation. Ensure that rehabilitation acknowledges and includes children and parenting role. Supportive communities that help reduce the stigma associated with mental illness and social isolation.
	Assuming parental responsibilities.	Provide appropriate parental role models, education about attachment, connectedness and specific and individualised parenting topics. Ensure that practical support is available, for instance, for looking after children when the parent is very unwell or hospitalised.
	Identifying and accessing emotional and social support.	Ensure that rehabilitation incorporates and develops a client's community and family support system/s.
Families	Crisis times such as the hospitalization of a parent	Initiate and develop critical incident or care plans involving all family members and key agency workers.
Human Service and Mental Health agencies	Fragmented and uncoordinated services	Organisational commitment to share information within and across services. Agencies develop policy responses that consider the family context of clients.
	Inadequate worker skills regarding families affected by parental mental illness. Workers' knowledge is often negative, reactive and/or deficit based.	Further training and education regarding the issues of families affected by mental illness.

The needs of children whose parents have a mental illness

While all children require nurturance and physical care, the child of a parent with a mental illness will experience a home environment different from many other children. Falkov (2004, p.55) summarises this environment when he writes that 'children whose parents are mentally ill live with the symptoms, behaviours and expressions of mental illness. They see it and feel it...'. The environment of children with a mentally ill parent might at times, be chaotic and threatening, particularly if the child is included in the parental delusional behaviour (Jacobsen & Miller, 1998), while depressed parents might be physically but not emotionally available to their children (Oyserman, Mowbray, Allen-Meares & Firminger, 2000).

Parental mental health places children at a significantly greater risk of having lower social, psychological and physical health than children in families not affected by mental illness. Current research consistently shows a higher rate of behavioural, developmental and emotional problems in such children compared with those in the general community (Beardslee, Versage & Gladstone, 1998; Brotman Band & Weisz, 1988; Cicchetti, Rogosch & Toth, 1998; Klimes-Dougan, et al., 1999; Oyserman, et al., 2000), with long term effects including social and occupational dysfunction (Shiner & Marmorstein, 1998). In addition, several studies report increased rates of psychiatric disorders in children from homes with affectively ill parents, compared to children with non-ill parents, on both genetic and environmental grounds (Beardslee, Keller, & Seifer, 1996; Hammen, 1991; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997).

An important issue often discussed in association with parental mental illness is that of the *attachment bond* between parent and child. Attachment theory is based on the premise that an infant's first attachment experience (usually his or her mother) profoundly shapes the child's cognitive and emotional development (Bowlby, 1969; 1988), as well as present and future relationships (Karen, 1998). Bowlby (1977) conceptualised attachment as the 'propensity of human beings to make strong affectional bonds to particular others' (p.201). According to Bowlby (1980), the attachment relationship has evolutionary value, as it promotes the maintenance of close contact between the infant and caregiver, which in turn increases the chances of infant survival. The nature of the attachment relationship is known to be influential to a child's psychological well-being in the short and long term (Bowlby, 1977; Carmen & Huffman, 1996).

A parent, who responds sensitively and consistently to a child's needs, sends messages that build an ultimate sense of security and self-identity (Howes, 1999). Sometimes, however, because of a parent's mental illness (or for other reasons, including addiction or death), instead of sensitive, responsive nurturing, an infant may face inconsistency and/or neglect. Attachment difficulties have been linked with disturbances in personality development, low self-esteem and poor social skills, which all have the potential to influence long-term psychological functioning (Bowlby, 1977), as well as attachment problems in adult relationships (Karen, 1998; Mickelson, Kessler & Shaver, 1997).

Closely related to the concept of attachment is the broader and more inclusive term, 'connectedness', which according to Lee, Draper and Lee (2001) encompasses an individual's various caring and supportive relationships. Masten and colleagues (1988) found that social and emotional connections with others were a significant moderator on the effects of a variety of disadvantages, including parental mental illness. For instance,

Rutter (1979) showed that a positive relationship with at least one parent, especially during infancy and early childhood, is a protective factor for children's psychological health. Howes (1999) argues that children have the potential to form many different kinds of relationships, while Harrison (2003) emphasizes the role of child care workers and teachers in a child's social network. As well, siblings within families which experience disadvantage also have the potential to provide support to each other (Widmer & Weiss, 2000). In a series of interviews with young people, Fudge and Mason (2004) found that positive peer relations, and having someone to talk to on a regular basis was an important coping mechanism. Overall, such research indicates that if or when the primary adult is not able to appropriately support the child (for example if the parent is severely ill), meaningful social and emotional connections, from within (for example siblings) and outside of the family (for example teachers), might be effectively made elsewhere.

In addition to social and emotional support, practical support is also important for such children. The most difficult time for children appears to be when the parent is hospitalised or experiencing an acute phase of their illness (Fudge & Mason, 2004). In focus groups with young people, Maybery, Ling and Szakacs (2002) found that during a parent's hospitalization, the level of risk for children is heightened where there is no other parent or relative to look after the children, particularly in single parent families (where the mentally ill parent is the sole parent). In two focus group based studies (Fudge & Mason, 2004; Maybery et al., 2002), children reported problems accessing transport to go to visit their parent in hospital, limited finances, the separation from their siblings (e.g. whilst in foster care) and the often unfriendly nature of the hospital environment.

Another issue for young people is assuming the domestic and emotional responsibilities for their mentally ill parent and/or younger siblings, particularly in single parent families (Aldridge & Becker, 2003). Care-giving has been associated with limiting young people's recreation, friendships, educational achievement and personal growth (Atkin, 1992). More recently, there is a growing recognition that some degree of caring in childhood is normal and encouraged as a part of 'healthy' child development, that the experience of caring can be positive (for instance in developing closer family ties and encouraging independence) and that the division between caring and being cared for is not always clear, given the reciprocity of support and guidance that occurs between many children and their ill parent (Aldridge & Becker, 1999; Morris, 1993). Nonetheless, because respite care has generally been underdeveloped for people with mental health problems (Atkin, 1992) care-giving can become onerous. Additionally, while young carers may take on substantial care responsibilities within their families, they are rarely consulted by professionals about their parent's needs and their own needs as children and carers (Aldridge & Becker, 2003).

Other problems identified in children whose parents have a mental illness are maladaptive coping strategies. Lazarus and Folkman (1984) define coping as 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person' (p. 141). Thus consideration of coping behaviour relates to attempts to manage stressors that are both successful and non-successful (Compas, 1987). Two types of coping were outlined by Lazarus and Folkman (1984); the first is problem-focused coping which relates to efforts directed towards the stressor in order to change the situation. Emotion-focused coping is the second type of coping, and relates to attempts to alter emotional reactions to the

stressful situation. Examples of emotion-focused coping are avoidance, cognitive reframing and selective attention to non-stressful aspects of the situation (Lazarus & Folkman, 1984). It has been suggested that both problem and emotion-focused coping are important for children to successfully adapt and cope with the presence of stressors (Compas, 1987). Additionally, different situations may require different types of coping strategies, and some situations may require both. Thus, in order for an individual to cope effectively, the methods that they use to cope with stressors must be flexible and adaptive (Compas, 1987).

Brotman Band and Weiss (1988) suggested that different coping strategies emerge at different ages. A subsequent study by Altshuler and Ruble (1989) lent support to this finding, indicating that the developmental age of a child is an influential factor in determining the choice of coping strategy. Dumont and Provost (1999) argue, that in younger children, emotion-focused coping may indeed be useful and adaptive. Conversely, for older children and adolescents, emotion-focused coping has been found to be associated with negative psychological outcomes, such as low self-esteem, depression, and adjustment difficulties (Dumont & Provost, 1999).

More specifically in the target group of children whose parents have a mental illness, Maybery and colleagues (2002) found that many of these children adapted problematic coping styles when their parent was ill, such as withdrawing, avoiding and distancing. Folkman and colleagues (1991) found that the long-term overuse of emotion-focused activities (such as those illustrated above) can be problematic, and they consequently highlighted the need to develop problem-focused activities that aim to change the environment or oneself in relation to it.

Delvin and O'Brien (1999) found that children tend to form misconceptions about their parent's mental illness, and argued that children whose parents have a mental illness require ongoing, age appropriate information. Falkov (2004) suggests that younger children might simply need to learn what a mental illness is, and what to do when mummy is unwell, while Hay (2004) points out that it might be important to present to adolescents the prodromal signs and degree of 'inheritability' of the mental illness. Falkov (2004) continues, suggesting that it is important for children to express themselves and their fears about parental mental illness as part of an ongoing process, rather than a one-off event. In addition, many children reported wanting to hear this information from their parents themselves (Fudge & Mason, 2004), though Falkov (2004) points out that it is everyone's responsibility, including mental health practitioners, to talk about a parent's mental illness.

Based on the issues raised above, there appear to be a number of important intervention strategies when working with children whose parent has a mental illness. In the first instance, children whose parents have a mental illness need, like all children, appropriate physical and emotional care. More specifically, as attachment bonds might be problematic with the mentally ill parent, children require the opportunity to develop and enhance meaningful social and emotional connections, from within and outside of the family. Practical support is important, particularly in times of high need (such as a parent being hospitalised), and include allowing the children to have regular access to the parent in hospital, having a family member (i.e. other parent, grandmother) or trusted friend living in the family home for the duration of hospitalization. Such children also need to

learn and practice effective, problem-focused coping strategies. Children whose parents have a mental illness also need to be provided with age appropriate information and education about their genetic disposition to mental illness, mental illness generally and their parent's mental illness in particular (Falkov, 2004).

The needs of the mentally ill parent

Nicholson and colleagues (2001) point out that the needs of parents affected by mental illness are generic to all parents, as well as specific to their illness. The main issues for mentally ill parents centre on their capacity and motivation for managing their mental illness, and at the same time assuming parenting responsibilities. Risley-Curtiss and colleagues (2004) found that, with appropriate diagnosis, support, treatment and medication, most people with a serious mental illness experience widespread improvement in many areas, including parenting behaviours. However, they also found that many people have difficulty adhering to treatment, the most common reasons being the sometimes 'trial and error' approach of many drug treatments, and the often debilitating effect of many psychotic drugs (such as lethargy and blunting). In addition, the stigma attached to seeking help in the first place and the fear of losing their children, constitutes other barriers for parents in accessing appropriate assessment and treatment (Risley-Curtiss, Stromwall, Hunt, & Teska 2004).

Parents with a mental illness require support, and sometimes guidance, in their parenting behaviours. While it is important to note that the effects of the mental illness are compounded by others factors, such as poverty and social isolation, Oyserman et al. (2000) found that mothers with a serious mental illness have significantly less adequate parenting skills than mothers who do not have a mental illness. For instance, depressed mothers are less likely to be emotionally available and affectionate (Hammen, 1991), and parents with schizophrenia may have unusual or inappropriate affective responses to their children (Jacobsen, Miller & Kirkwood, 1997). However, Rogosch, Mowbray and Bogat (1992) found that not all parents with mental illness evidence the same degree of parenting difficulty, as those with a more severe and chronic disturbance were associated with less sensitive and competence parenting behaviours than parents with less debilitating disturbances. Similarly, Mowbray and colleagues (2002) established that a specific mental illness diagnosis is neither an independent nor useful predictor for parenting problems or strengths. Instead, Mowbray, Oyserman, Bybee and MacFarlane (2002) showed that current symptomatology and community networking were more indicative of parenting capacity, and consequently they stressed the need for quality treatment for clients with a mental illness and the enhancement of existing community supports.

While there are many parenting programs in the community, Ackerson (2003a) argues that these typically fail to address the specific needs of parents with a mental illness. Thomas and Kalucy (2002; 2003) showed that problems with motivation and stigma may impede parents' attendance or, if attendance occurs, a formalized parenting program often does not address a parent's specific needs. Underscoring the importance of providing specific parenting training, Ackerson (2003a) found that most mothers saw themselves as lax or permissive, rather than harsh or punitive. Similarly, Nicholson, Sweeney and Geller (1998a) showed that many parents worry about the impact of their illness on their children and often prioritise their child's needs ahead of their own. Even though some clients might exhibit problematic parenting behaviours, many are open to interventions

that enhance their parenting capacity and sense of maternal self-competence (Oyserman et al., 2000). Generally, mothers are more likely to be effective when given the opportunity to take on responsibilities (Goepfer et al., 1996), and many consider parenting to be just as important as employment (Mowbray, Oyserman & Ross, 1995) and a valued role in their lives (Nicholson et al., 1998a).

While the cyclical nature of mental illness might mean a temporary inability to care for their children, parenting behaviours need not necessarily be the focus of intervention. Ackerson (2003a; 2003b) observed that the literature on mentally ill parents focuses on a parent's pathology, and not on the strengths that parents bring to manage their illness and to care for children, nor their potential parenting capability if their mental illness was properly managed. While a serious mental illness can adversely affect an individual's ability to parent, with adequate resources many individuals with a serious mental illness are able to successfully care for their children. Mullick, Miller and Jacobsen (2001, p.489) suggest, 'Parents within any given diagnostic category can have parenting skills ranging from excellent to maltreating'. Rather than dysfunctional parenting behaviours, Ackerson (2003a) found that many parents with a mental illness regarded the bond between themselves and their children as especially strong and close. While cautioning issues regarding enmeshment, Ackerson (2003a) asserts that many parents with a mental illness had close, mutually interdependent relationships with their children.

Rather than considering parenting as a hindrance, Ackerson's (2003b) found that mentally ill parents are more highly motivated to continue rehabilitation programs than clients who are not parents. White, Nicholson, Fisher and Geller (1995) suggest that the demands and rewards of the caretaking role enhance a mother's motivation to remain in treatment. Similarly, Caton, Cournos and Dominguetz (1999) found that mothers with schizophrenia were more likely to have had better premorbid social adjustment than schizophrenic women who were not mothers. In addition, Wang and Goldschmidt (1996) found that psychiatric patients wanted family focused interventions, rather than focusing solely on themselves as the identified patient. Thus, rather than being a hindrance, assuming parenting responsibilities might significantly assist in the rehabilitation and treatment for the parent with the mental illness, highlighting the importance in incorporating a parent's caretaker responsibilities into his or her treatment plan.

Emotional and social supports are particularly important for parents with a mental illness. Cochran and Brasard (1979, as cited in Rogosch, Mowbray & Bogat, 1992) described how social support networks provide various types of assistance for all parents, such as role modelling, emotional support, companionship and practical assistance. Accordingly, Rogosch and colleagues (1992) demonstrated that the presence and strength of mentally ill mothers' current supportive relationships predicted adaptive parenting attitudes. Ackerson (2003a) found that those parents with a strong social support network, such as family, friends or church, coped better with crises than those who were socially isolated. Such support was especially critical when alternative care was needed, such as when the parent was hospitalized or very unwell (Ackerson, 2003a). In comparison, parents who did not have such support were more likely to have lost custody of their children (Ackerson, 2003a). However, as parents with a mental illness are more likely to be living without partners (White, Nicholson, Fisher & Geller, 1995), and marital discord is more common among families in which a parent has a mental illness (Downey & Coyne, 1990),

the need for parents to find support from his or her extended family and the wider community is further emphasized.

Finally, families affected by parental mental illness are more likely to experience crises, such as the hospitalisation of a parent, or an acute mental illness episode. The exposure to any critical incident has the potential to generate anxiety, stress and hurt to the individuals involved and, while the strain is particularly felt in the time just after the incident occurs, it may endure for a lengthy period (Wilson & Raphael, 1993). As prior planning is the key to optimum management of a critical incident in any setting (Kirkland & Maybery, 2001), it is important for all members of a family to plan for future episodes of hospitalisation or periods of illness. Various crisis plans are available such as that developed by COMIC on <http://www.howstat.com/comic/> as well as VicChamps <http://www.easternhealth.org.au/mental/champs/>. Both plans invite family members to nominate a contact person if a parent is ill or in hospital, who each child might stay with, who needs to be told if the child is staying somewhere else and so on.

Mental health and welfare agencies

Many agencies, which work with families affected by parental mental illness, tend to have a singular and/or negative focus when defining their client base. In addition, many human and health agency workers do not have the training and knowledge to work effectively with such families. In a survey of programs across North America, Nicholson et al. (2001) found that many organisations are often fragmented and uncoordinated, so that they tend to focus only on the client (either the 'child' or 'adult'), and do not consider a client's environment (such as his or her school, or family base) and/or contextual demands (such as parenting responsibilities). Nicholson et al. (2001) point out that program eligibility requirements may limit participation to eligible adults or children but not both, as is generally needed for families affected by parental mental illness. In addition, mental health professionals usually have no legal responsibility to identify adult patients who have a dependent child, even in situations where hospitalisation is necessary (Handley et al., 2001).

Growing recognition of the potential intersection between child abuse and parental mental health has highlighted the importance of collaboration between child protection and adult mental health agencies. Reviewing adult and child services in Europe, Hetherington and Baistow (2001) stressed the importance of informal communication between agencies, though at the same time highlighting time and geographic difficulties in doing so. Fleck-Henderson (2000) uses the term 'seeing double' to describe how workers are being asked to simultaneously recognise and work with the needs of adult clients and of their child/ren, though Cousins (2004) points out that this might not be possible for all workers, for both personal and professional reasons. Mowbray et al. (2000) found that, while parents identified their mental health provider as a source of support, only 20% of parents listed their provider as someone who could provide assistance in being a mother, perhaps because of mothers' concerns about losing custody of their children. The stigma, from providers and family members, associated with parents accessing and participating in mental health treatment is another significant barrier to utilizing services (Nicholson, Sweeney & Geller, 1998a).

Many government departments have consequently recommended that mental health agencies be encouraged to take a leadership role in developing community linkages (e.g.

Commonwealth Department of Health and Aged Care, 2000). Accordingly, collaboration between and within organisations is vital. For example, if child protection workers are called for suspected cases of abuse, they may need to work closely with adult mental health workers in order to best work with the parent. Hetherington and Baistow (2001) suggest that adult mental health services need to, as part of their standard intake practice, record whether patients are parents, the ages of children and who is caring for them. The rationale for this assessment would be for adult mental health services to then offer assistance to parents in their responsibilities as primary caregivers and to identify their needs as a parent with a mental illness (Hetherington & Baistow, 2001). Falkov's (1998) training resource, 'Crossing Bridges', is designed to encourage inter-agency collaboration across specialist areas, by covering information on adult mental health, parenting and the parent-child relationship, legislation and child development.

As well as organisational barriers, many human and health agency workers do not have the skills and knowledge to identify, refer and/or intervene appropriately with different family members. Bibou-Nakou (2004) found that while many teachers in Greece acknowledged that supporting children whose parents had a mental illness were a part of their responsibilities, they did not feel that they had adequate training and knowledge to do this. Similarly, the difficulty for many child protection workers is that they are not adequately trained in the area of mental health. Riskey-Curtiss and colleagues (2004) argue that while research into the assessment and treatment of serious mental illness has expanded and changed in the last ten years, much of this research is published in the mental health literature, and subsequently not readily accessible to child welfare workers.

Maybery and Reupert⁴ (2006) found that the most significant barriers reported by workers to working with such families, were firstly, clients not identifying their illness as a problem for their children and secondly, clients denying that they had a mental health problem. On the other hand however, all workers surveyed reported that it was part of their role to get involved with issues regarding their client's children (Maybery & Reupert, 2006). Suggesting the need for focused professional development, workers reported time and resource limitations, as well as specific skill and knowledge deficits regarding parenting and working with children (Maybery & Reupert, 2006).

Ackerson (2003b) argues that many human and health agency workers often take a problem and deficit focus approach when working with clients, and as Nicholson et al. (2001) note, their services are often only available when parents or children have a diagnosable problem, or after abuse or neglect has been identified. A preventative stance is not often assumed. Ackerson (2003a) suggests that rather than focus on the parents' deficits and their psychiatric disorder, workers need to acknowledge the cyclical nature of mental illness, and an individual's parenting strengths. This might also lessen the stigma often associated with seeking treatment for many parents.

In summary, the issues for families affected by parental mental illness are multifaceted and have implications for many, including the child/ren, the parent/s, extended family members and the various organisations that come into contact with family members.

⁴ These published findings are also included as part of this report – see workforce development chapter for details.

Chapter 3: Programs for eight to twelve year olds

Children who are aged between 8 and 12 years are considered to be in middle childhood. The child here begins to understand more complex ideas, and their ways of thinking become increasingly more sophisticated, abstract and structured. The child in this period becomes more competent in literacy, which means that children might be educated through books and pamphlets about their parent's illness, and program evaluation tools might be paper and pencil-orientated. Nonetheless, these children will also need opportunities to reflect and ask questions in a safe and responsive environment.

Often called a latency period, the 8-12 developmental range often marks the start of puberty with accompanying physical changes. Major hormonal changes occur in girls around eight years of age, and for boys around nine and ten, resulting in physical growth, development and sexual maturation (Bee, 2000). These children are increasingly becoming body conscious and comparing what is normal and what is not, physically as well as psychologically.

Children in this age group have an increasing need for independence. Normal development generally is marked by children beginning to assert their independence from their parents and turning instead to peer groups. A possible issue for many children, whose parents have a mental illness, is that because they take on caregiver roles and responsibilities, they become 'parentified'. Such children may drop out of school earlier than children whose parents do not have a mental illness to assume their care-giving roles, either for their parent and/or other siblings. Thus, opportunities to interact with other children in a fun, supportive and nurturing environment are important.

Peers become a very important influence on behaviour and attitude formation. As well, the need to fit in and adapt socially to school becomes increasingly more important for children in this age range. Complex social skills are practiced in these social contexts, the ability of which improves, given appropriate role models and opportunities for practice and feedback. At the same time, because of the circumstances of their families, COPMI might be under socialized, and not have the opportunity to join different social groups and activities. They might also be afraid of bringing friends home because of their parent's behaviour. Children may become aware of how different their parent is from other parents, because they do not fit in or socialise with other parents, or because their behaviour is unconventional.

Concurrent with sophisticated social skills is children's increasing sense of competence or, on the other hand helplessness. If success is met in learning new skills and tasks, a child feels a sense of achievement and pride. On the other hand however, if a child fails, or these developmental milestones are too difficult and complex to completely accomplish, he or she might develop feelings of inadequacy and learned helplessness. Positive feedback, direction and appropriate feedback are essential for children to grow and learn adequately in this period of their lives.

Program

The VicChamps approach was designed for children and parents living in households with a parental mental illness with a key component being peer support programs for children aged 8-12 years. Programs aim to be supportive, educative, build on peer connections and create connectedness to the community beyond the province of mental illness. Peer support programs for this age group have been widely implemented in a variety of settings. It is also considered that an approach utilizing peer support is developmentally appropriate for this age group. Two types of peer support programs were implemented: peer support school holiday and peer support after school programs in Eastern Region and North East Victoria. Both programs aimed to:

- reduce isolation and improve social connectedness;
- provide opportunities to engage with parents and carers;
- provide recreational, social and creative skills;
- provide respite for children and parents;
- provide support and age appropriate information about mental illness and emotional well-being to children;
- develop and establish a strong collaborative role for health professional and family workers;
- build on children's strengths and promote resilience by bolstering protective factors.

The two types of programs (i.e. after school and school holiday programs) have been shown to cater for the individual needs of children and their families. Historically, both have had a high retention rate. At times, some children elect to do both programs.

School holiday programs

School holiday programs are run over four consecutive days. The opportunity for children to meet regularly provides a sense of belonging and acceptance, which is very important to children of this age. The programs also aim to increase independence from parents and other adults, accompanied by a parallel dependence upon peers.

After-school programs

The essential difference to that program is the time frame (i.e. short blocks of time-weekly or fortnightly compared to days of intensive activity). This is an open group that is operating during each school term. The program includes an information session for parents/guardians, and an end-of-term session which promotes the use of community activities and encourages families to investigate utilizing these community facilities.

Program delivery

The following tables highlight the number and types of programs, including the participant numbers in specific locations according to region.

Table 3.1: Number of school holiday and after school programs delivered, including number of participants from 2003 to 2005 according to region, location and program type.

Region	Location	Number of programs		Attendees
		Holiday	After School	
Eastern	Ferntree Gully	1	1	11
	Lilydale (fortnightly)		8	32
	Box Hill		4	30
	Croydon Hills	1	3	9
	Ringwood	1		11
	Tecoma	2		10
	Bayswater	3		26
	Total	8	16	129
North East	Wangaratta		2	15
	Wangaratta	2		22
	Wodonga		4	33
	Wodonga	4		32
	Benalla	1		8
	Total	7	6	110
Overall Total		15	22	239

In total there were 37 programs for 8⁵-12 year olds completed during the 2003 to 2005 period. Table 3.1 shows that eight school holiday and 16 after school programs were run in the Eastern region, with 56 and 73 of children respectively. In the North East, there were seven holiday and six after school programs with 62 and 48 number of children respectively.

Key Finding
VicChamps ran 37 programs including 15 holiday programs with 118 children, and 31 after school programs with 121 children during the 2003 to 2005 period.

Evaluation

The evaluation was undertaken in several parts. The first component sought to determine whether there were differences in the functioning of children from families with a mental illness (VicChamps intervention) compared to those from a community or normative sample. This preliminary focus sought to verify whether the target group was at greater mental health risk than other children, and to establish in what mental health domains (e.g. strengths, difficulties, connectedness) these risks are most prominent. This sought to determine an evidence based need for the programs.

⁵ Note that these programs also included some younger children in the North East.

The second component aimed to establish what changes occurred in the mental health and well-being of children as a result of their involvement in the VicChamps programs. Changes were sought according to program type (holiday and after school), as well as location (Eastern and North Eastern), at pre to post intervention points. Such an analysis sought to establish an evidence base regarding the impact of the programs on the children.

Collecting Intervention (VicChamps) and Normative (community) data

There was one methodology to obtain data from the intervention or VicChamps children, and another to obtain data from the community or normative group of children.

Intervention (VicChamps) sample

Participants

Data was collected from 222⁶ children who participated in school holiday programs and/or after school programs in the Eastern region or North East region of Victoria. Table 3.2 below illustrates the age of the children by gender.

Table 3.2: Participant numbers and percentages for the intervention sample age by gender.

Age	Male	Female	Total (%)
5	1	5	6 (2.7)
6	5	9	14 (6.3)
7	12	13	25 (11.3)
8	21	14	35 (15.8)
9	17	18	35 (15.8)
10	17	12	29 (13.1)
11	5	14	19 (8.6)
12	4	7	11 (5.0)
13	1	3	4 (1.8)
<i>Missing</i>			<i>44 (19.8)</i>
Total	83	95	222 (100)

There were 83 male and 95 female participants evaluated in the intervention group ranging from 5 to 13 years of age. The mean age for all participants was 8.82 years; the mean age for male participants was 8.75 years of age and for female participants 8.85 years of age.

The nature of the intervention allowed participant attendance at both the school holiday programs and after school programs. Eighty-three (37.4%) children were identified as attending multiple programs, that is holiday and after-school programs and/or repeated the same program.

The severity of the impact of mental illness on family functioning was assessed by key workers upon referral to the program (pre-intervention). Seven (3.2%) participants were identified as coming from families which had experienced little or no impact, some impact on family functioning was experienced in 45 (20.3%) of children and 133 (59.9%)

⁶ Please note this total number includes some children from the 5-7 year age group – some 7 year olds were included in analyses from Eastern region.

children were assessed as coming from families which experienced a severely disruptive impact on their functioning. The child's understanding of mental illness was also assessed by workers upon referral. One hundred and five (47.3%) children were identified as having little or no understanding, some understanding was identified in 67 (30.2%) children and 11 (5.0%) of children were assessed as having a reasonable to excellent understanding of mental illness. The majority of children participating in the intervention had little or no understanding of mental illness, and had experienced a severely disruptive impact of mental illness on their mental health.

Procedure

Children of parents with a mental illness were referred to the program by community, mental health agencies or by the parent. Following parental consent, the child was enrolled to attend the school holiday program or the after school program. Separate informed consent for participation in the program and evaluation of the program was obtained from parents in the weeks prior to commencement of the program. It was outlined to participants that their involvement in the evaluation was voluntary, and not related to participating in the program. Ethics approval was sought and gained for the evaluation.

On the first day of each program, each child was asked to complete measures of Kids Problems, Kids Connections, Kids coping and the Rosenberg-Simmons self-esteem scales, while parents were asked to complete the Strengths and Difficulties Questionnaire (SDQ). These measures formed the pre-measures, for the intervention.

On the last day of each program, feedback forms (satisfaction style questionnaires) were completed by children and parents, which directly assessed the beneficial or negative aspects of particular activities of the program.

Approximately four weeks after the program, the child measures (self-esteem, coping, connections and problems scales) and the parent-completed SDQ were sent to each family for completion. Whilst it would be advisable to obtain post scores immediately upon completion of the program, this was not possible, given that many of the well-being measures require a longer reflective time frame, and therefore could not be used at the end of a brief intervention.

Two reply paid envelopes were enclosed for the parent and child to return completed form(s) separately. A \$10 K-Mart voucher was offered to each child/parent as an inducement to complete the post data collection phase of the evaluation.

Children of parents who were not able to give informed consent (due to their mental health problems) were not asked to complete the evaluation measures. Additionally, VicChamps facilitators collected information regarding demographic characteristics, including gender, age, family functioning, and the child's understanding of mental illness during the referral process. All information collected was given to the researchers in a de-identified condition.

Normative (community) sample

The normative data were collected during 2005 as part of a fourth year psychology project by a team of researchers under the supervision of Dr Darryl Maybery (Charles Sturt

University, Wagga Wagga Campus). The students were Sharron Steer, Sharon Lopez, Kerrie Bowles, Peter Marcon, Deborah Costa, Rani Ritchie, Mia Neville (Post Graduate Diploma of Psychology students) and Jessica Wilson (Psychology honours student).

While data was collected from a total of 833 participants, Table 3.3 below includes only matching parent and child information (The greatest proportion of missing data was from parents not returning questionnaires to the various schools.) Overall, there were 701 matched parent-child questionnaires. Table 3.3 shows the age of the children by gender.

Table 3.3: Participant numbers and percentages for the normative sample age by gender.

Age	Male	Female	Total (%)
7	11	6	17 (2.46)
8	54	58	112 (16.18)
9	67	82	149 (21.53)
10	76	93	169 (24.42)
11	80	76	156 (22.54)
12	37	43	80 (11.56)
13	6	3	9 (1.30)
<i>Missing</i>	5	4	9 (1.30)
Total	331	361	701 (100)

There were 331 male and 361 female participants in the study, ranging from ages seven to 13 years, and there were 9 missing values (Table 3.3). While gender was almost equally represented in the sample, the eight and 12 year olds were underrepresented and the nine, 10 and 11 year olds were over represented in the sample⁷ (Chi square = 38.92, p=.000). As the target group was 8 years and above, the small number of 7 and 13 year olds were retained in the sample. However, the 7 and 13 year olds were removed for the above Chi square analysis.

The participants were from locations across New South Wales, Queensland and the Australian Capital Territory in both urban and rural settings. Sixty-three (9.0%) of parents completing the survey were males and 673 (91.0%) were female.

Procedure

Five levels of consent were obtained prior to the completion of the questionnaires; Charles Sturt University Human Ethics committee (protocol number 2005/005), relevant state Department of Education ethics applications (NSW DET SERAP 04230; ACT file reference 2004/01015-2), school Principal consent for the school to be the conduit for participation, as well as parent and student consent.

After gaining verbal consent from the school Principal, parents of the students were sent a general information letter and an informed consent form. Following the return of completed consent forms, questionnaires were then sent to the parents and classroom

⁷ As this data was collected over approximately 2 months during June and July 2005, the children's age was calculated to the end of financial year. For example, children born July 1997 to June 1998 were considered to be 7 years of age.

teachers regarding arrangements for completion of the student questionnaires. Prior to distribution, the parent and child questionnaires were linked using a coding system allowing the questionnaires to be linked for analysis purposes. Student questionnaires were generally administered by the research students with small groups of children in class or lunch times (as arranged with individual schools and teachers). This was undertaken to ensure that the students received consistent instructions regarding the completion of the questionnaires, and to avoid any procedural bias.

As with the intervention sample, parents completed the SDQ in relation to their child and the children completed Kids Problems, Kids Connections, Kids coping and the Rosenberg-Simmons self-esteem scales. The parents completed their measures at home, while the children completed theirs at school.

Prior to completing the questionnaires, the students were instructed to read the general information sheet. If the children had reading difficulties, the information sheet was read out loud. The students were then asked to sign a consent form, they were informed that their involvement was voluntary, and they could withdraw from the study at any time without incurring penalties.

Instruments⁸

The following outlines a brief rationale for each of the measures employed to measure changes in the children involved in the project.

Strengths and Difficulties Questionnaire (SDQ)

The SDQ is designed as a brief behavioural questionnaire, with an emphasis on strengths as well as weaknesses (Goodman & Scott, 1999). It can be administered to the parents and teachers of children aged 4 to 16 years old. A self-report version designed for adolescents was not used. The 25-item questionnaire covers 25 positive and negative attributes that fall into five broad scales each containing five items. Table 3.4 below illustrates each of the SDQ subscales,⁹ with example items for each.

Table 3.4: SDQ subscales and example items.

Subscale	Representative Items
Emotional symptoms	<i>Many worries or often seems worried</i>
Conduct problems	<i>Often loses temper</i>
Hyperactivity/Inattention	<i>Restless, overactive, cannot stay still for long</i>
Peer Problems	<i>Rather solitary, prefers to play alone,</i>
Prosocial behaviour	<i>Considerate of other people's feelings</i>
Total Difficulties	Total of emotional symptoms, conduct problems, hyperactivity and peer problems subscale – excludes the Prosocial behaviour subscale.

⁸ The questionnaires and/or survey packages are available from the first author of this report.

⁹ An impact supplement can also be used with the SDQ, in which the respondent is asked to indicate the chronicity of the problem to the child and to others. This was not used here.

The benefits of using the SDQ compared to other questionnaires (e.g. Rutter questionnaires, Child Behaviour Checklist) is its focus on strengths as well as difficulties, and its brevity (Goodman, 1997; Goodman & Scott, 1999).

The SDQ is a commonly used tool to screen for psychiatric illness in children in a community setting, and shows good sensitivity (Goodman, Ford, Simmons, Gatwald & Meltzer, 2000) and applicability for this age group (Mellor, 2004). Good reliability and validity have been found using the SDQ, with high correlations found between parent, teacher and clinical respondents (Goodman, 2001; Hawes & Dadds, 2004; Muris, Meesters, Eijkelenboom & Vincken, 2004; Mathai, Anderson & Bourne, 2004). In addition to the kids measures (see below), the parent version of the SDQ is also used to ascertain the views of the family regarding any problems that present in the child at home. This also sought to provide added reliability of measurement. Finally, the SDQ is mandated for routine use across all Australian CAMHS.

Self-esteem

The Rosenberg self-esteem scale is one of the most widely used measurement tools for self-esteem. Rosenberg (1965) defines self-esteem as a ‘favourable or unfavourable attitude towards self’ (p.15). The 6-item Rosenberg-Simmons Self-esteem scale is modified from the 10-item Rosenberg Self-esteem scale for adolescents. Responses are generally scored on a three point scale (0-2), with higher numbers signifying high self-esteem.

Kids Connections and Kids Problems

A parent’s mental illness might result in disruption to the primary attachment relationship between child and parent (Rutter, 1979). It has been pointed out that if or when the primary adult is not able to appropriately attach and support the child, meaningful social and emotional connections might be effectively made elsewhere (Harrison, 2003; Howes, 1999). Thus, it is important for children to develop positive relationships with a broad number of adults both within and outside of his or her family. Consequently, we developed a measure that attempted to tap into all of the possible relationships that might exist for 8-12 year old children.

In addition to making a distinction between the relationships a child might make within and outside the family, it is also important to distinguish between the positive and negative affective distinction of relationships. Considerable research indicates that people have two relatively independent systems in relation to affective life experiences; one for negative events impacting on negative mood, and one for positive events and their impact on positive mood (Hart, 1992; Headey & Wearing, 1989; 1992; Zautra & Reich, 1983). When positive and negative mood are measured as independent constructs, positive relationship events have been found to generally only impact on positive and not negative mood (Maybery, 2004), whereas negative relationship events tend to only impact on negative mood (Maybery, 2003a). Given the increasing support for dual affectivity dimensions, it was important to develop measures that reflected the key positive relationships for children (Kids Connections) and the key negative relationships for children (Kids Problems). Table 3.5 below outlines the connections and problems measures, and illustrates examples according to within family and outside family dimensions.

Table 3.5: Types of Kids Connections and Problems within and outside of the family.

Orientation	Kids Connections	Kids Problems
<i>Within family</i>	<i>Time spent with your mum.</i>	<i>You had problems with your mum.</i>
	<i>Time spent with a special grandparent (or other relative).</i>	<i>You had problems with your grandparent (or other relative).</i>
<i>Outside family</i>	<i>Time spent with your school teacher.</i>	<i>You had problems with your school teacher.</i>
	<i>Time spent with your best friend.</i>	<i>You had problems with your best friend.</i>

Acknowledging that relationships might be positive and negative, and might exist within and out of the family, allows four dimensions of impact of the program to be measured in terms of a child's relationships with others. These were the within family connections and problems and outside family connections and problems.

Also included on the Kids Connections measure were a number of questions regarding friendships and their use of relationships. Considering the ages of the target audience, these questions were designed to be as behavioural as possible. The questions were as follows:

- Some people have a lot of friends, others have few. Think about your friends now. How many friends do you have?
- In the last month, how many times have you done the following:
 - gone to a friend's house to play?
 - had a friend over to play?
- If you had a problem, how many of your friends (including adults) would be able to help you with that problem?

Coping

Other problems that have been identified in children whose parents have a mental illness are maladaptive coping strategies. Maybery, Ling and Szakacs (2002) found that many children adapted problematic coping styles when their parent was ill, such as withdrawing, avoiding and distancing. Coping has been an important development in the stress field (Headey & Wearing, 1992), and is intricately linked to the secondary appraisal model, within Lazarus and Folkman's cognitive appraisal model (Bakal, 1992). The central question asked by an individual during secondary appraisal is 'what can I do in relation to this stressor'? (Lazarus & Folkman, 1984). Coping actions have been defined as:

...constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984, p.141).

Although not capturing the response complexity, many dichotomize coping as either emotion (EFC) or problem-focused (PFC; Folkman, et al., 1991; Frederikson & Dewe, 1995), with these two categories being the best general method for classifying strategies (Trenberth, Dewe, & Walkey, 1996).

Problem-focused activities are regarded as efforts to change the environment or oneself in relation to it, and emotion-focused coping generally involves strategies that better manage an individual's emotional response to the stressor (Bakal, 1992; Folkman, et al., 1991).

Problem-focused forms of coping include cognitive problem-solving and decision making, interpersonal conflict resolution, information gathering, advice seeking, time management, and goal setting as well as problem-oriented behaviours such as joining a weight control program...(Folkman, et al., 1991, p.243).

Emotion-focused actions include efforts to minimise the emotional impact of the problem or using such things as exercise or relaxation (Folkman, et al., 1991). However, Folkman and colleagues (1991) found that the long-term overuse of emotion-focused activities (such as those illustrated above) can be problematic, and consequently highlighted the need to develop problem-focused activities that aim to change the environment or oneself in relation to it. Consequently, problem-focused coping actions can be seen as adaptive in relation to stressors or concerns, whereas emotion-focused can be seen as maladaptive.

A third important coping strategy is social support. Social support has been shown to contribute significantly to mental health and well-being. Kemper (1993) has suggested that social relations serve as a mediator that allows individuals to adapt to their environments. There are numerous reports that people with good social support are in better health than those who have less support (see Cohen & Wills 1985 for a review). Additionally, social support was considered an extension to the Kids' Connections questionnaire described earlier; social support is thought to be employed in times of difficulty, whereas connections is focused on the type and valence of the event that occurred. The following table outlines items according to coping categories (emotion, problem-focused and social support), and the cognitive or behavioural domain they represent.

Table 3.6: Types of cognitive and behavioural coping items.

Type of Coping	Cognitive	Behavioural
<i>Problem focused</i>	You tried to think of different ways of solving the problem. You tried hard to fix the problem (<i>both a cognitive and behavioural strategy</i>).	You tried your best to make things better. If it was your fault, you would say that you were sorry.
<i>Emotion focused</i>	You did not want to think about it You did things to stop thinking about it (<i>both a cognitive and behavioural strategy</i>).	You avoided the problem or where it happened.
<i>Social support</i>	You thought about what others might do.	You asked someone for help.

Consequently, the Kids Coping scale was designed to have three clear factors representing problem-focused coping, emotion-focused coping and social support. The measure was designed to be a brief (nine item) general measure of activities important for this age group. The items were designed to reflect distinct cognitive and behavioural coping actions. The development of the measure was a trade-off between the brevity of the overall measure, an attempt to capture both cognitive and behavioural coping strategies within categories and, from a measurement perspective, to attempt to ensure a clear three factor structure. The measure can be adapted to be a situation-specific coping measure.

Results

The first project employed a normative or community data set that allowed a baseline or normative level of mental well-being to be established for children. In addition, it allowed a comparison point for the VicChamps pretest scores, so that conclusions could be drawn regarding mental health problems in this target group of children. Three groups of children were then compared, (i) VicChamps children (ii) children whose parents have a mental illness as drawn from the general community and (iii) children whose parents do not have a mental illness, as drawn from the general community.

The second project, outlined here, evaluated the VicChamps programs by comparing the mental health and well-being of children according to program type and location, pre and post intervention.

Normative (community) - Intervention (VicChamps) comparison

As it has been found that 12.5 percent of the adult Australian population has a mental illness (excluding substance abuse only, ABS, 1997, p.29), it was expected that a large normative data collection would also identify children whose parents have a mental illness. Consequently, the normative data outlined below highlights a distinction between children from families where a parent does not have a mental illness and families that do. It should be noted that 14.4 percent of the normative sample had at least one parent with a mental illness.

Table 3.7 highlights the means and standard deviations for the total Strengths and Difficulties scale and subscales within the normative and VicChamps data sets. Also shown are indicative ranges of scores for the SDQ according to typical, borderline and clinical functioning.

Table 3.7: Means (SD) for Strengths and Difficulties parent report total and subscales scores within normative and VicChamps data sets, including indicative ranges of scores.

Subscale	Indicative ranges of scores			Normative		VicChamps
	Typical	Border-line	Clinical	No Illness ¹⁰ (n=598)	Illness (n=101)	Pretest (n=134)
Total Difficulties	0-13	14-16	17-40	8.65 (5.84)	10.81 (6.27)	14.94 (8.09)
Emotional symptoms	0-3	4	5-10	2.12 (2.09)	2.75 (2.40)	4.12 (2.69)
Conduct Problems	0-2	3	4-10	1.62 (1.72)	1.96 (1.81)	2.91 (2.54)
Hyper-activity	0-5	6	7-10	3.27 (2.38)	4.04 (2.87)	4.75 (2.90)
Peer problems	0-2	3	4-10	1.63 (1.75)	2.06 (1.79)	3.16 (2.27)
Prosocial behaviour	6-10	5	0-4	7.71 (1.65)	7.64 (1.65)	8.10 (1.88)

Table 3.7 demonstrates that children in the normative sample and those with parental illness sub sample (drawn from community group) scored in the typical¹¹ range for the SDQ and subscales. However, the community group of children who had a parent with a mental illness generally scored higher on difficulties compared to the normative group. The VicChamps pretest group scored in the borderline range for total difficulties, emotional symptoms and peer problems. This group also scored in the upper typical range for hyperactivity and conduct problems being close to being in the borderline category.

¹⁰ Tabachnick and Fidell indicate that statistical analyses can be problematic where there are large differences in the size of samples (2001, p.296-7 for details). Consequently, some caution should be undertaken interpreting these findings.

¹¹ Indicative SDQ scores suggest cut-off levels at which point children are considered to be at a level of risk to their mental well-being.

As there were significant differences within these variables across the three groups it was decided to classify the percentage of children according to the indicative range of scores originally proposed by Goldman (see above table for ranges of scores according to typical, borderline and clinical¹²). Figure 1 below shows pie charts for each of the three groups on the total difficulties scores.

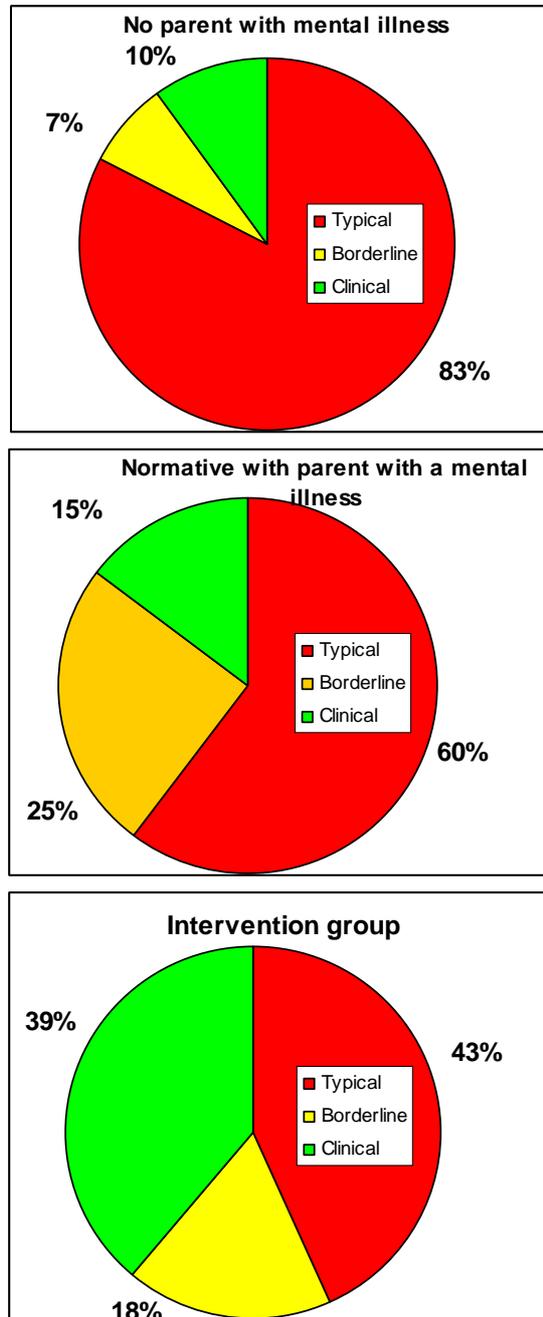


Figure 3.1: Percentage of children in the indicative ranges of typical, borderline and clinical for total difficulties according to normative and intervention subgroups.

¹² Others have called borderline – *query* and abnormal – *of concern* (Mellor, 2005).

The above pie charts show that the normative group with no parental mental illness has almost 20 percent of children in the borderline and clinical ranges. This increases to 40 percent for the normative COPMI group, and this becomes almost 60 percent in the intervention group.

Key Finding
The normative, normative COPMI and intervention groups have approximately 20, 40 and 60 percent of children in the combined borderline and clinical ranges respectively for total difficulties.

The following table shows the percentages for all SDQ subscales according to the three groups.

Table 3.8: Percentages of children classified according to typical, borderline and clinical indicative ranges within the normative and VicChamps data sets.

SDQ Subscale	Group	Typical	Borderline	Clinical
Total Difficulties	No Parent with Mental Illness	82.61	7.36	10.03
	Normative with Parent with a mental illness	60.40	24.75	14.85
	Intervention group	43.28	17.91	38.81
Emotional symptoms	No Parent with Mental Illness	77.93	8.70	13.38
	Normative with Parent with a mental illness	68.32	8.91	22.77
	Intervention group	43.28	11.19	45.52
Conduct problems	No Parent with Mental Illness	76.76	9.36	13.88
	Normative with Parent with a mental illness	64.36	13.86	21.78
	Intervention group	53.73	13.43	32.84
Hyper activity	No Parent with Mental Illness	82.44	7.19	10.37
	Normative with Parent with a mental illness	69.31	7.92	22.77
	Intervention group	63.43	9.70	26.87
Peer problems	No Parent with Mental Illness	74.25	10.37	15.38
	Normative with Parent with a mental illness	62.38	15.84	21.78
	Intervention group	45.52	13.43	41.04
Prosocial behaviour	No Parent with Mental Illness	90.47	6.86	2.68
	Normative with Parent with a mental illness	90.10	3.96	5.94
	Intervention group	90.30	5.97	3.73

The two subscales with the highest percentage of children scoring in the clinical range were emotional symptoms (45%) and peer problems (41%). These children were from the VicChamps group.

Key Finding
The greatest percentage of problems was found in the emotional symptoms (45%) and peer problems (41%) categories, within the VicChamps intervention sample.

A MANOVA was then undertaken to determine whether there were significant differences within the strengths and difficulties variables in terms of parental disorder status. The MANOVA was statistically significant, $F(5, 826) = 17.07, p = .000$; Wilks' Lambda = .82; partial eta squared = .09. Each individual subscale of the SDQ was then examined for differences according to parenting status. Univariate ANOVA statistics are illustrated for the SDQ subscales in Table 3.9.

Table 3.9: ANOVA table of degrees of freedom (df), F-ratio, p-values and effect size¹³ (partial eta squared) for SDQ subscales.

Subscale	Df	F	p-value	Effect size
Total Difficulties	2,830	55.83	0.00	0.12
Emotional symptoms	2,830	44.31	0.00	0.10
Conduct problems	2,830	25.61	0.00	0.06
Hyperactivity	2,830	20.44	0.00	0.05
Peer problems	2,830	38.08	0.00	0.08
Prosocial behaviour	2,830	3.27	0.04	0.01

The table shows that, for parenting status, all SDQ scales were significantly different. Post-hoc tests were then undertaken to determine which groups were significantly different. Initially it should be noted that, for all difficulty subscales, the normative group scored lowest, the normative who were COPMI scored next lowest, and the highest scores were those of the intervention sample. All groups were significantly different to each other for total difficulties and emotional symptoms. The intervention group was significantly higher than both other groups for conduct problems and peer problems, and the normative group was lower than both other groups for hyperactivity.

¹³ Effect size is the proportion of the variance in the dependent variable explained by the independent variable. In an analysis of variance, effect size is calculated using *partial eta squared*, and .01 is considered a small effect size, .06 moderate and .14 large. (see Pallant, 2005 for more detail). In t-tests, effect size is calculated using a slightly different methodology (called *Cohen's d*), and Cohen (1988) suggests that .20 is a small effect size, .50 is moderate and .80 large. Both methodologies are employed throughout this document with the approach employed indicated at the various sections.

Key Finding
The VicChamps children scored significantly higher than other children in terms of total difficulties, emotional problems, conduct problems and peer problems.

The normative and VicChamps data sets were then examined for differences in responses by children. Table 3.10 below shows the means and standard deviations for the Kids Connections, Problems, Coping and Self-esteem measures.

Table 3.10: Means (Standard deviations) for Connections, Problems, Coping and Self-esteem total and subscales scores within normative and VicChamps data sets.

Measure	Scale/subscale/item	Normative Data		VicChamps
		No Illness (n=593)	Illness (n=100)	Pretest (n=178)
Connections	How many friends do you have?	13.25 (6.24)	12.22 (6.88)	6.84 (4.46)
	How many times you went to a friend's house to play?	5.08 (5.85)	4.72 (5.91)	3.81 (3.93)
	How many times a friend came to your house to play?	4.78 (5.57)	4.00 (4.94)	2.98 (4.31)
	How many friends (including adults) do you have that could help you solve a problem?	8.90 (6.34)	7.82 (6.12)	4.47 (3.45)
	Connections total	1.90 (0.49)	1.74 (0.52)	1.51 (0.59)
	Connections within family	1.89 (0.63)	1.70 (0.62)	1.39 (0.62)
	Connections outside family	1.91 (0.54)	1.79 (0.62)	1.66 (0.71)
Problems	Problems total	0.72 (0.44)	0.75 (0.52)	0.75 (0.47)
	Problems within family	0.66 (0.47)	0.77 (0.57)	0.79 (0.55)
	Problems outside family	0.77 (0.60)	0.73 (0.65)	0.74 (0.58)
Coping	Problem-focused coping	1.51 (0.37)	1.55 (0.36)	1.33 (0.43)
	Emotion-focused coping	1.03 (0.43)	1.05 (0.35)	1.05 (0.50)
	Social support	1.13 (0.50)	1.15 (0.47)	1.14 (0.50)
Self-esteem	Total	5.85 (2.03)	5.51 (2.27)	5.95 (2.12)

Note that the only significant difference between the normative groups was for connections within the family.

Three MANOVA's and one ANOVA (self-esteem) were then undertaken to determine any differences in scores. The first MANOVA with the initial four connections questions indicated statistically significant differences, $F(4, 678) = 12.51, p = .000$; Wilks' Lambda = .87; partial eta squared = .07. The second MANOVA, which included the three connections and three problems measures, was also statistically significant, $F(6, 863) = 15.30, p = .000$; Wilks' Lambda = .82; partial eta squared = .10, as was the third MANOVA, $F(3, 878) = 6.69, p = .000$; Wilks' Lambda = .96; partial eta squared = .02 with the three coping subscales. An ANOVA with the remaining self-esteem measure, $F(2, 886) = 1.53, p = .22$ showed no significant differences. Each subscale (item) was then examined for differences according to groups.

Table 3.11: ANOVA's for connections, problems, coping and self-esteem measures, showing degrees of freedom (df), F-ratio, p-values and effect size (partial eta squared).

Scale/subscale	df	F-ratio	p-value	Effect size
How many friends do you have?	2,681	43.92	0.00	0.11
How many times you went to a friend's house to play?	2,681	2.01	0.14	0.01
How many times a friend came to your house to play?	2,681	4.94	0.01	0.01
How many friends (including adults) do you have that could help you solve a problem if you had one?	2,681	21.88	0.00	0.06
Connections total	2,668	40.17	0.00	0.08
Connections within family	2,668	43.53	0.00	0.09
Connections outside family	2,668	13.11	0.00	0.03
Problems total	2,668	0.51	0.60	0.00
Problems within family	2,668	5.99	0.00	0.01
Problems outside family	2,668	0.33	0.72	0.00
Problem-focused coping	2,880	18.31	0.00	0.04
Emotion-focused coping	2,880	0.19	0.83	0.00
Social support	2,880	0.01	0.99	0.00
Self-esteem	2,886	1.53	0.22	0.00

The univariate analyses showed significant differences between groups in terms of: How many friends do you have?, How many times a friend came to your house to play?, How many friends (including adults) do you have that could help you solve a problem if you had one?, as well as all three connections variables, problems within the family and problem focused coping. Post-hoc tests were then undertaken to determine which groups were significantly different for these variables.

The post-hoc tests revealed that the VicChamps children scored significantly lower on total and within family connections, how many friends do you have and how many friends that could help you solve a problem, and problem-focused coping compared to the two normative groups. They also scored significantly lower than the normative-non mental

illness group for connections outside the family and problems within the family. The only significant difference between normative groups was for connections within the family, with the group consisting of parental mental illness scoring lower.

However, some concern should be noted with the four individual items regarding connections (e.g. How many friends do you have?). An examination of these variables showed that they were considerably skewed as a result of outlying cases. For example, the first question had over 20 participants who scored as having 100 plus friends, while over 150 had between 20 and 100 friends. In the second variable, six indicated they had 100 or more friends, and 18 indicated that they had between 20 and 70. In the third variable, six indicated that they had 100 or more friends, and 19 that they had 20 to 70. Finally, 10 indicated that they had 100 or more friends, and 60 indicated that they had 20 to 70. As a consequence, all of these variables were adjusted to an upper limit of 20 friends, and this then brought outliers under control for these variables. However, the data for these variables should be interpreted with extreme caution.

In summarizing the child data and with this limitation in mind, it is notable that the major differences for the intervention group (and normative COPMI) were connections in general (which included both connections within the family and those outside). The intervention or VicChamps group scored lower than both other groups on these variables. However, the effect size information in Table 3.11 indicates that the largest concern is related to connections within the family. Although accompanied by a moderate effect size, problems within the family were also greater for both the normative COPMI and intervention groups. The other major concern was that the intervention group recorded lower levels of problem-focused coping. Problem-focused coping involves such things as problem-solving and interpersonal conflict resolution (Folkman, et al., 1991, p.243). Also notable were other factors not significantly different, including other forms of coping, problems outside the family and interestingly self-esteem.

Key Finding

The VicChamps children score significantly lower in terms of connections within their families and problem-focused coping, and higher than the other groups in terms of problems within the family.

In summary, the average child who entered the VicChamps intervention programs generally scored significantly higher (worse) than both the normative sample and the normative children who had a parent with a mental illness. While there are notable exceptions (such as self-esteem and prosocial behaviour), this finding suggests that the children who enter VicChamps programs have greater mental health and well-being concerns than other children. This may occur because VicChamps children are commonly referred from Adult mental health services, and their family circumstances may (in comparison to the normative groups) be more affected by their parent's illness.

Key Finding

Overall the VicChamps children score significantly lower on a range of well-being variables compared to normative children, from their own and their parents' perspectives.

However, it is also notable that they had comparable and sometimes higher scores on variables such as self-esteem and prosocial behaviour.

Pre to Post Intervention Comparisons

The changes in children as a result of VicChamps are highlighted in this section. Summarized are changes in children's well-being scores pre and post for the combined intervention programs. Additionally, pre and post mean scores for the school holiday and after school program interventions are graphed. While means and standard deviations are shown in an appendix, it should be noted that statistically significant differences are not highlighted as differences are noted in programs according to region. The final section demonstrates different outcomes for the two types of programs, according to region. It should be noted that participants were only included in the data¹⁴ if they had completed both pre and post intervention measures.

Program evaluation

The majority of parents reported being extremely satisfied with the intervention overall, reporting that the programs created a comfortable environment for their child to talk and learn more about mental illness. The majority of children report that, following the intervention, they have learnt to feel more comfortable about asking questions about mental illness (77%), and they attained a sense of not being the only child coping with a parent with a mental illness (71%).

Overall changes

Table 3.12 highlights pre and post scores for the parents' and childrens' completed measures. Improvements are noted on almost all measures.

¹⁴ Due to the within-subject nature of this evaluation, the data analysis requires participants to have completed responses at both pre and post time frames. Some of the earlier reported (i.e. pre-test scores compared to normative data) participants did not respond to questionnaires after the intervention and are not included here.

Table3.12: Means (M), standard deviations (SD)and sample sizes (n) for pre and post program intervention for the parents’ (SDQ total and subscales) and childrens’ (connections, problems, coping and self-esteem) completed subscales.

Subscale	Pre (M, SD)	4 week Post (M, SD)	n
<i>Parent completed measures</i>			
Total difficulties	14.3 (7.7)	13.4 (8.6)	58
Emotional symptoms	3.8 (2.6)	3.5 (3.2)	58
Conduct problems	2.9 (2.3)	3.0 (2.5)	58
Hyperactivity	4.5 (2.8)	4.2 (2.8)	58
Peer problems	3.0 (2.1)	2.7 (1.9)	58
Prosocial behaviour	8.1 (1.9)	7.6 (2.2)	58
<i>Child completed measures</i>			
Connections total	1.4 (0.5)	1.5 (0.5)	118
Connections within family	1.3 (0.6)	1.4 (0.6)	118
Connections outside family	1.6 (0.7)	1.7 (0.6)	118
Problems total	0.8 (0.5)	0.7 (0.6)	107
Problems within family	0.8 (0.6)	0.7 (0.6)	107
Problems outside family	0.7 (0.6)	0.7 (0.9)	107
Problem-focused coping	1.3 (0.4)	1.4 (0.4)	113
Emotion-focused coping	1.1 (0.5)	1.1 (0.5)	113
Social support	1.1 (0.5)	1.2 (0.5)	113
Self-esteem	5.9 (2.1)	6.3 (2.1)	119

The largest reduction in scores from pre to 4 week post program were improvements in total difficulties and on the SDQ subscales, with reduced emotional difficulties, hyperactivity and peer problems. Alternatively, there were slight increases in conduct problems, but the most noticeable negative finding was a relatively large significant reduction in prosocial behaviour over the time period.

The children reported generally smaller changes in the desired direction across almost all connections, problems and coping measures. The largest change was an improvement in self-esteem.

Key Finding

The well-being of the children increased as a result of the program with reduced emotional difficulties, hyperactivity, and problems with others, and a corresponding increase in connections and self-esteem.

Key Finding

There was a significant reduction in prosocial behaviour.

These findings, however, must be read with the provision of region and type of intervention program differences in mind. Initially summarized below are pre and post intervention mean scores in school holiday programs for the combined regions. Following this are the equivalent pre and post intervention mean scores for the after school programs, once again for the combined regions. Significant differences and effect sizes are shown for the subscales following each series of figures.

School holiday programs

The four figures below highlight the changes in mean scores pre and post intervention for the SDQ (completed by parents), the Kids Connections and Problems, Kids Coping and self-esteem measures (completed by the children) respectively, in relation to all the school holiday programs undertaken. This is followed by a table showing the means, standard deviations, t-statistics and effect sizes for these same factors.

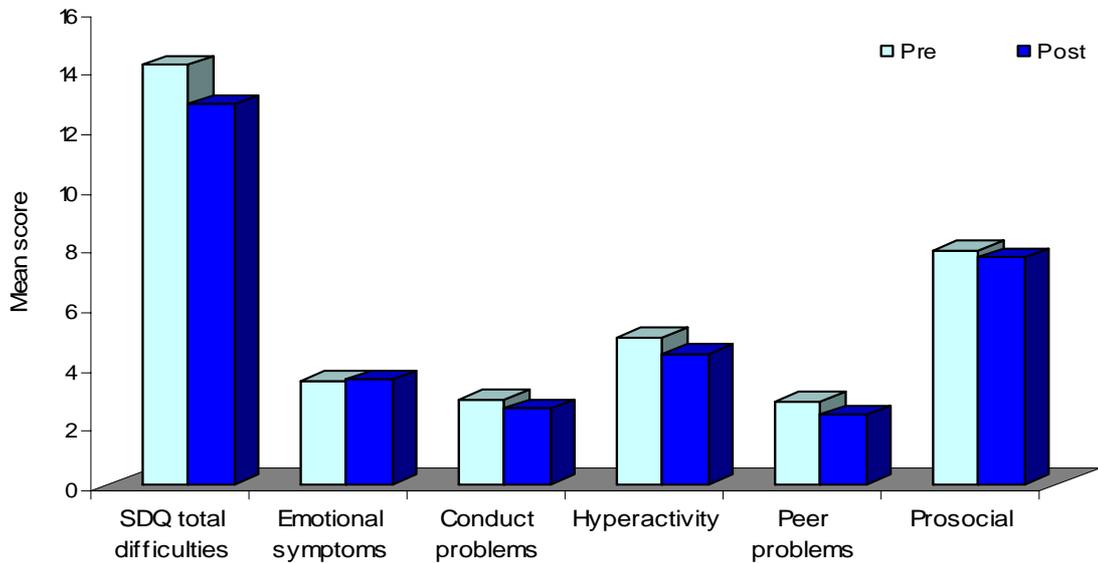


Figure 3.2: Mean scores for the total SDQ and the SDQ subscales pre to post intervention in the school holiday program.

Figure 3.2 shows that, apart from emotional symptoms, the school holiday programs led to a reduction in scores for total difficulties, conduct problems, hyperactivity and peer problems. There was also a small reduction in prosocial behaviour.

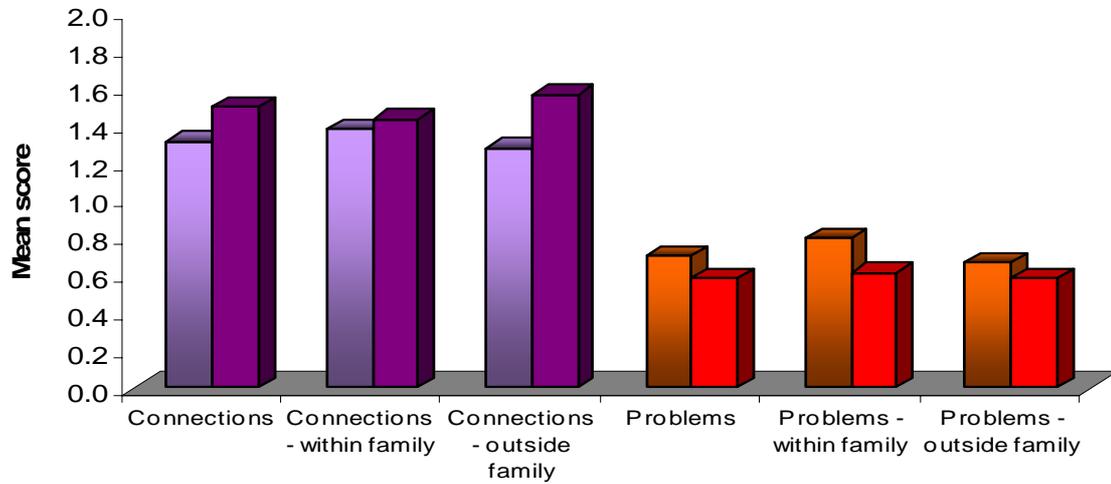


Figure 3.3: Mean scores for total Connections, Connections within and outside the family, total Problems, and Problems within and outside the family pre to post intervention in the school holiday program.

In terms of Kids Connections and Problems, Figure 3.3 shows that there was an increase in total connections that reflected such changes within and outside of the family. There was also a corresponding reduction in total Kids Problems, reflected within and outside of the family.

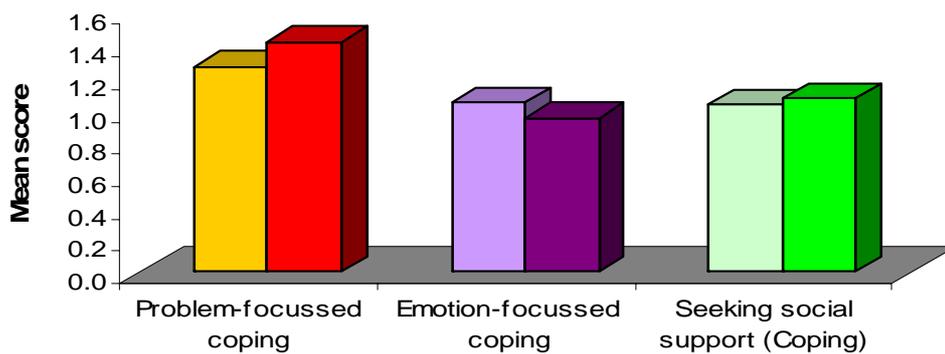


Figure 3.4: Mean scores for Kids Coping strategies pre to post intervention for the school holiday program.

Problem-focused coping increased, emotion-focused decreased, and there was a slight increase in seeking social support (Figure 3.4).

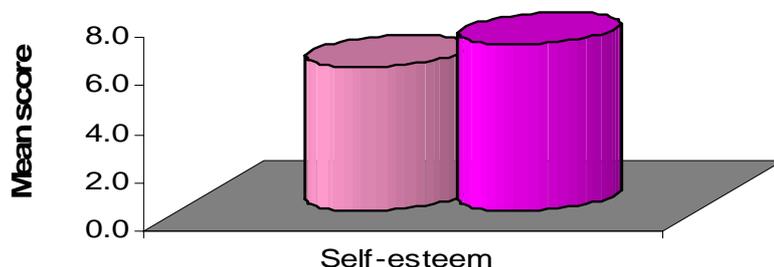


Figure 3.5: Mean scores for Kids self-esteem pre to post intervention in the school holiday program.

There was an increase in self-esteem after the holiday program (Figure 3.5). With few exceptions, both parents and children reported improvements in components of the children’s well-being over time (Table 3.13).

Table 3.13: Subscale means, standard deviations, t-statistics and effect size (Cohen’s d) for pre and four week post time frames in the school holiday program.

Subscale	Time		t value	df	p value	Effect size
	Pre	4 week Post				
Total difficulties	14.13 (8.50)	12.83 (9.23)	1.49	29.00	0.15	0.27
Emotional symptoms	3.50 (2.60)	3.53 (3.56)	-0.07	29.00	0.94	-0.01
Conduct problems	2.87 (2.49)	2.53 (2.52)	1.06	29.00	0.30	0.19
Hyperactivity	4.96 (3.05)	4.40 (2.98)	2.01	29.00	0.05	0.37
Peer problems	2.80 (2.11)	2.37 (1.83)	1.72	29.00	0.10	0.31
Prosocial Behaviour	7.90 (1.83)	7.63 (2.01)	0.75	29.00	0.46	0.14
Connections-total	1.31 (0.51)	1.50 (0.48)	-3.56	54.00	0.00	-0.48
Connections-within family	1.38 (0.58)	1.43 (0.53)	-0.85	54.00	0.40	-0.11
Connections-outside family	1.28 (0.66)	1.56 (0.59)	-3.85	54.00	0.00	-0.52
Problems-total	0.71 (0.44)	0.58 (0.64)	1.26	48.00	0.21	0.18
Problems-within family	0.80 (0.50)	0.61 (0.51)	2.25	48.00	0.03	0.32
Problems-outside family	0.66 (0.52)	0.59 (1.14)	0.47	48.00	0.64	0.07
Problem-focused coping	1.27 (0.39)	1.42 (0.34)	-2.54	50.00	0.01	-0.36
Emotion-focused coping	1.04 (0.43)	0.95 (0.49)	1.13	50.00	0.26	0.16
Social support coping	1.04 (0.46)	1.07 (0.44)	-0.48	50.00	0.63	-0.07
Self-esteem	5.97 (2.16)	6.90 (1.90)	-3.50	54.00	0.00	-0.47

There were improvements in a number of well-being factors, with specific improvements in total difficulties, conduct problems, hyperactivity, peer problems, problems within family, problem-focused coping (small effect size), connections in total and outside the family, and in self-esteem (moderate effect size). Overall, there were clear improvements in many of the facets of well-being over time, as a result of the school holiday programs across the regions.

Key Finding
Both parents and children indicated positive changes in the children's well-being as a result of the school holiday program.

After-school programs

Pre and post mean scores for the measures (as above) show changes in relation to the after school programs. As indicated earlier, peer support after-school programs operate as open groups for approximately two hours weekly during each school term.

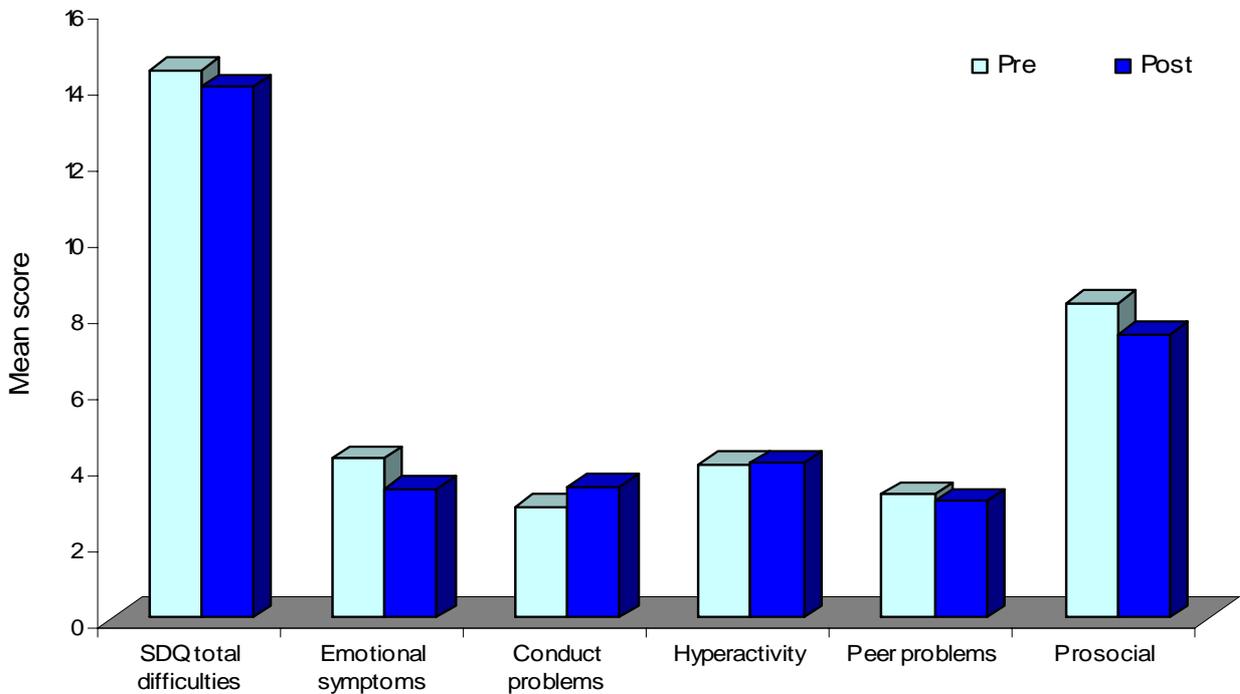


Figure 3.6: Mean scores for total SDQ and the SDQ subscales pre to post intervention in the after school program.

There was a small reduction in total difficulties, most strongly as a consequence of a decrease in emotional symptoms. However, there was also a similar increase in conduct problems over the course of the program, and a reduction in prosocial behaviour.

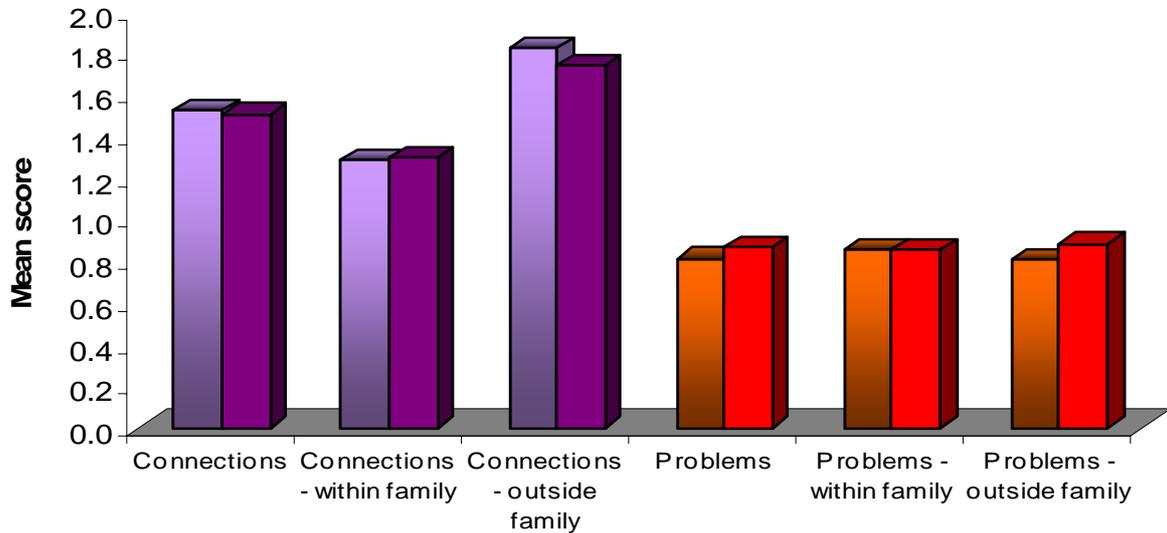


Figure 3.7: Mean scores for total Connections, Connections within and outside the family, total Problems, and Problems within and outside the family pre to post intervention in the after school program.

A divergence of scores is shown in Figure 3.7 that highlights a slight reduction in connections outside the family, along with a similar increase in problems outside the family.

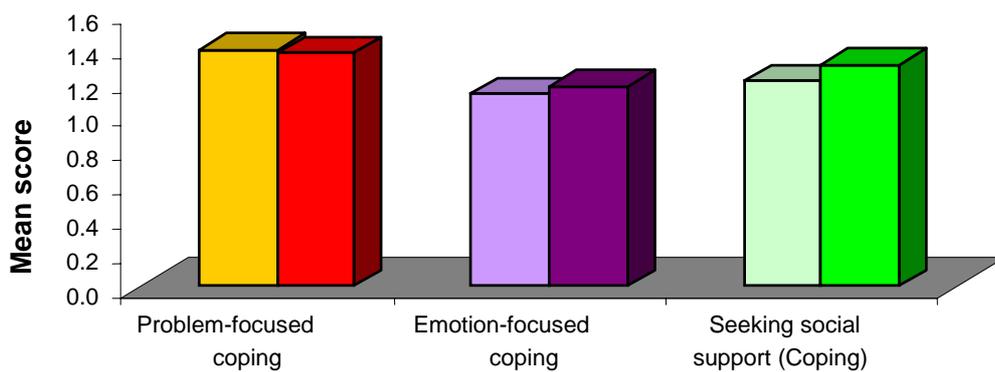


Figure 3.8: Mean scores for Kids Coping strategies pre to post intervention in the after school program.

Little change was found in problem and emotion-focused coping, and a slight increase was shown in seeking social support (Figure 3.8).

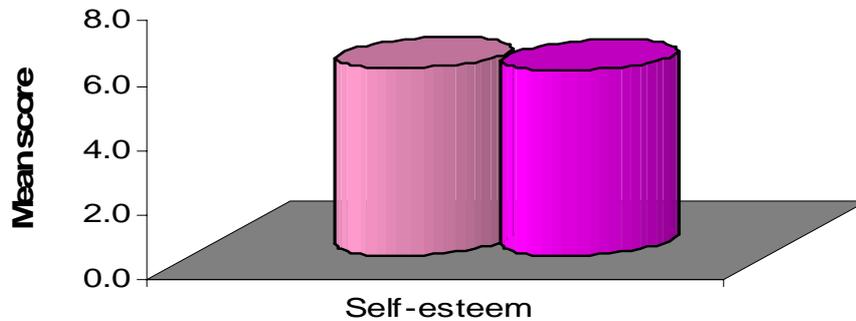


Figure 3.9: Mean scores for Kids self-esteem pre to post intervention in the after school program.

There is a minimal difference in self-esteem scores pre and post the after school program. Subscale means, standard deviations, t-statistics and effect sizes for pre and post time frames for after school programs are shown in the table below.

Table 3.14: Subscale means, standard deviations, t-statistics and effect size (Cohen’s d) for pre and post time frames in the after school program.

Subscale	Time		t value	df	p value	Effect size
	Pre	4 week Post				
Total difficulties	14.42 (6.90)	14.00 (8.07)	0.46	27	0.65	0.09
Emotional symptoms	4.21 (2.67)	3.39 (2.83)	2.20	27	0.04	0.42
Conduct problems	2.93 (2.14)	3.46 (2.43)	-1.75	27	0.09	-0.33
Hyperactivity	4.04 (2.43)	4.07 (2.72)	-0.09	27	0.93	-0.02
Peer problems	3.25 (2.12)	3.07 (1.96)	0.82	27	0.42	0.15
Prosocial Behaviour	8.29 (2.05)	7.46 (2.40)	2.87	27	0.01	0.54
Connections-total	1.53 (0.52)	1.51 (0.50)	0.35	62	0.73	0.04
Connections-within family	1.29 (0.61)	1.30 (0.56)	-0.12	62	0.90	-0.02
Connections-outside family	1.82 (0.57)	1.74 (0.59)	0.89	62	0.38	0.11
Problems-total	0.82 (0.50)	0.87 (0.58)	-0.76	57	0.45	-0.10
Problems-within family	0.86 (0.61)	0.85 (0.68)	0.04	57	0.97	0.00
Problems-outside family	0.81 (0.62)	0.89 (0.74)	-0.80	57	0.43	-0.11
Problem focused coping	1.38 (0.42)	1.36 (0.42)	0.31	61	0.76	0.04
Emotion focused coping	1.12 (0.52)	1.17 (0.44)	-0.66	61	0.51	-0.08
Social support coping	1.20 (0.49)	1.29 (0.51)	-1.29	61	0.20	-0.16
Self-esteem	5.80 (2.11)	5.72 (2.21)	0.22	63	0.83	0.03

In summary, while there was an improvement in emotional symptoms as a result of the after school program, there was also a notable increase in conduct problems and a reduction in prosocial behaviour.

Key Finding

Participants in the after school program improved in terms of total difficulties – mostly as a consequence of and a decrease in emotional symptoms but there was also an increase in conduct problems and reduced prosocial behaviour.

In contrast to the after school program, the school holiday program showed larger improvements in well-being factors such as connections, problem-focused coping and self-esteem, and reductions in difficulties such as hyperactivity, problems with others and emotion-focused coping. In contrast, the after school program showed small gains in some areas such as emotional symptoms, but a deterioration in conduct problems and prosocial behaviour.

Key Finding

Participants in the school holiday programs showed greater improvements compared to after school programs.

Some of these differences in impact regarding the after school and holiday programs are further complicated when accounting for regional differences. Shown below are only those factors that were found to have significant three way interactions between time, type of program and regional differences.

Interaction comparisons including regional differences

While changes and differences according to school holiday and after school programs are shown above, at a more detailed level, important differences in the programs' impact according to region are noted. To determine these specific changes, analyses of variance (ANOVA) were undertaken that included three factors: a within subject factor (pre and post intervention scores), the types of interventions (holiday and after school programs) and the regions (Eastern and North Eastern). While analyses were undertaken with all parent and child measures listed earlier in this chapter, only those measures that were significantly different are shown here. Rather than present mean scores, charts are shown to illustrate these differences here. Data for all measures are shown in the Appendix.

Strengths and Difficulties Questionnaire (SDQ)

The figures below, with the exception of a reduction in the SDQ prosocial variable, shows that all of the SDQ subscales showed improvement across types of program and regions. However, many of the findings can only be considered trends in the data, not converting into significant differences, generally due to limits in sample size. Consequently, readers should be cautious in drawing conclusions from the data.

It should be noted that these results are not straightforward. While there were no significant differences in terms of time, region and type of program for the total SDQ scores, there was a significant three-way interaction effect when these variables were combined.

An interaction effect is where one level of one factor (in this case change over time in SDQ scores) is influenced by the level of another factor - in this case, the two factors of region and program type. This influence is best examined figuratively, as shown in Figure 10.

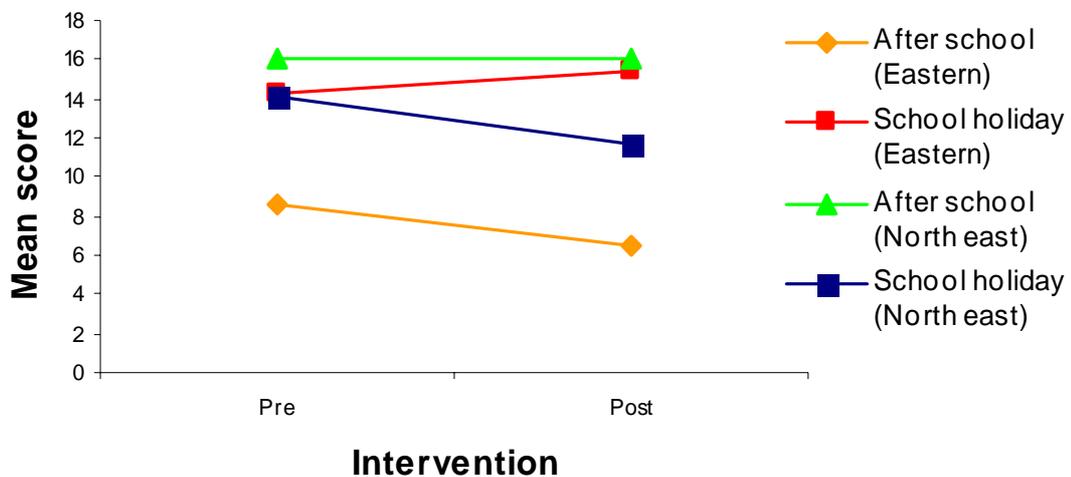


Figure 3.10: Chart showing the Mean scores for total SDQ scores for time, region and program type.

The findings suggest that, in the Eastern region, the school holiday group did not change over time. However, the after school program did improve significantly pre to post, moving from a mean of 8.7 to a mean of 6.5. However, in the North East, while there was a significant reduction in total SDQ mean scores in the school holiday program (from 14.1 to 11.7), there was an increase in scores in this region for the after school program (from 16.6 to 18.0). This suggests that changes in SDQ scores were dependent upon the site and type of program. The figure also shows the importance of examining for interaction effects, as the above data if ‘collapsed across regions or programs’ would shown no significant differences pre to post.

Key Finding

Changes in total difficulties scores were dependent upon the site and type of program. Improvements were found in Eastern regions after school program and in the North East’s school holiday program. Alternatively, total difficulties increased after the North East school holiday program.

Before discussing this differential finding, there are also several other issues within the data that may contribute to this result. The most notable is that the Eastern region scores for the after school program participants were very low (pre and post) compared to the other three programs. On re-examining the indicative ranges of scores in Table 3.7 for the normative and intervention groups, the scores at pretest are even slightly lower prior to the program commencing (8.67 to 8.85) than the normative group with no parental mental illness. Alternatively, the North East after school group scored higher (16.00) than any other group, and this mean score was in the clinical range (see Table 3.7). Using Figure 1 as guide, this would suggest that the Eastern group would have 20 percent or fewer of participants in the borderline/clinical ranges whereas the North East group would have more than 60 in this range. These starting scores should perhaps be taken into account, when discussing the implications of these findings.

Key Finding
The effect of programs for COPMI children may be reliant upon their initial level of well-being (as measured here by SDQ total difficulties) at the commencement of the program.

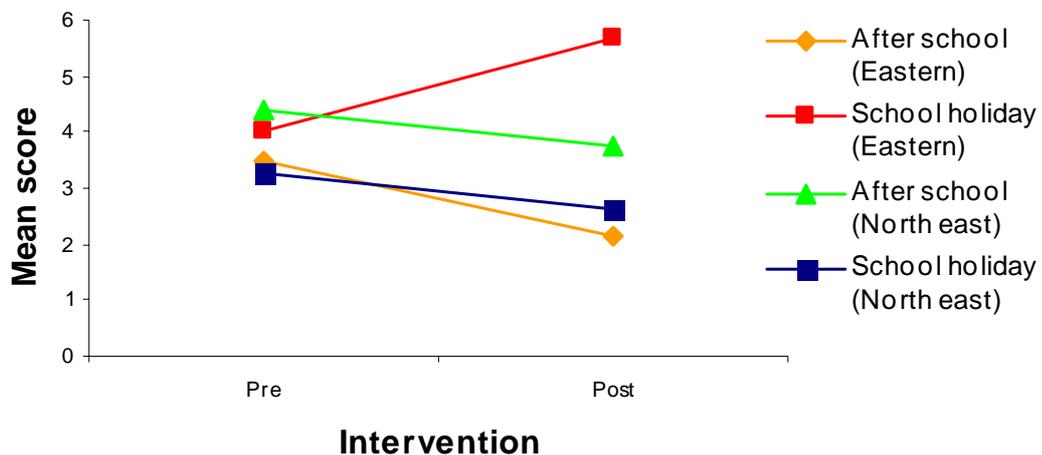


Figure 3.11: Mean scores for the SDQ Emotional Symptoms subscale for time, region and program type.

The major divergent finding (other than prosocial behaviour) within the SDQ subscales, perhaps underpinning this finding, was in terms of Emotional Symptoms. While there was an increase in emotional symptoms for the school holiday program pre (4.0) to post (5.7) in the Eastern region, there was also a large reduction in these scores (3.5 to 2.2) for

the after school program. There was a significant reduction in the mean scores (see Appendix) for both types of program in the North East region.

There were no significant changes (interactions) in the remaining SDQ scales, including conduct problems, hyperactivity/inattention and problems with peer relationships. However, as noted earlier, there was a significant reduction across both regions according to both types of program.

Connections, Problems, Coping and Self-esteem

Repeated measures ANOVA's with two between-subjects factors were also undertaken with children's responses. Once again, these analyses compared pre and post scores for changes associated with the interventions, according to regions and program type. Also once again, only data where there were significant differences are reported. Charts are again included to illustrate and assist with interpretation of interaction effects.

For the introductory questions regarding the number of friends that children had, with few exceptions, the mean changes according to program were in the expected direction, but were not significantly different. Once again, this was related to the small number of participants in some of the groups. However, there was a significant difference (but no interaction effects) for the question 'How many friends do you have?' This increased for both regions over the course of the interventions.

Figure 3.12 highlights the data for the total Kids Connections according to time, region and type of program. The chart illustrates a three-way interaction between these variables.

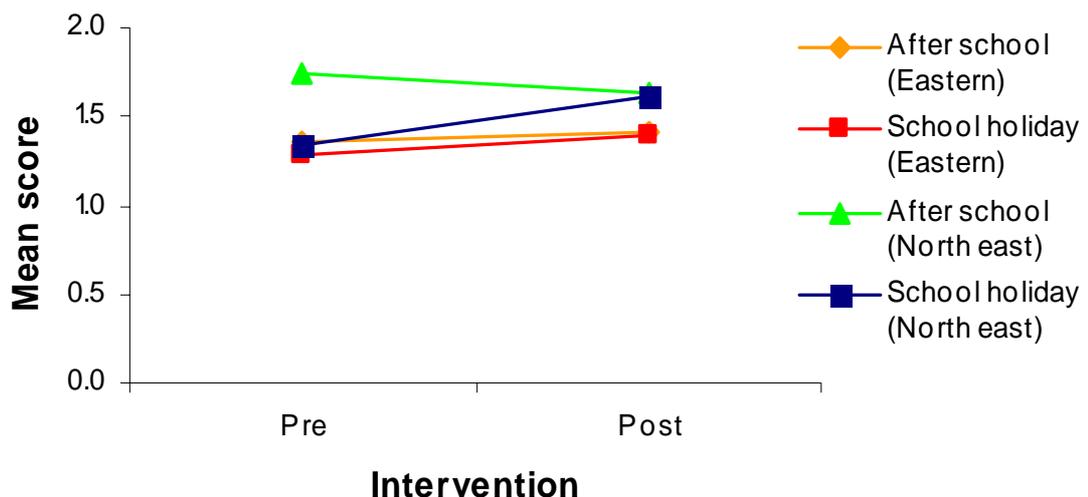


Figure 3.12: Mean scores for total Kids Connections for time, region and program type.

There was a slight increase in connections within both types of programs in the Eastern region (Figure 3.12). However, in the North East, the after school group had a mean of 1.7 before the program that reduced to 1.6 after the program. Alternatively, the school holiday program scores increased from 1.3 before to 1.6 after the program. This indicates that the programs had a slight increase in total connections in the Eastern region, but not for the North East after school program. At the same time, this finding is not associated with a change of within family connections. There were no significant differences in the within family data. The chart below shows that connections outside the family were where the main difference could be found.

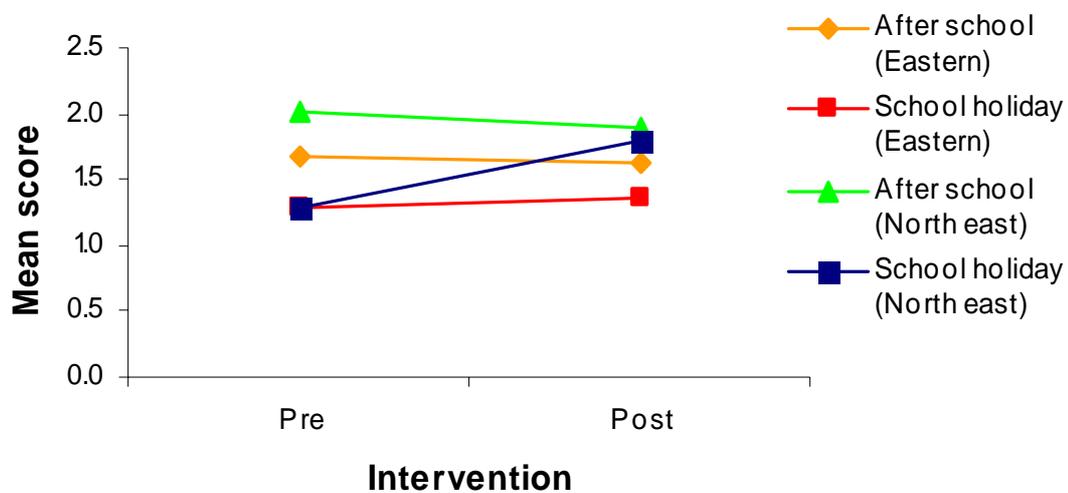


Figure 3.13: Mean scores for connections outside of the family for time, region and program type.

While there was an equivalent slight increase in mean scores in both programs in the Eastern region, there was a reduction from 2.0 pre program to 1.8 post program in the after school program, and an increase from 1.3 to 1.8 in the school holiday program in the North East region (Figure 3.13). While there was little change in the Eastern region, there was a strong positive increase in connections outside the family for the school holiday program in the North East.

Key Finding
The North East school holiday program had a large increase in connections outside of the family.

A comparison of scores for the Kids total problems measure for the two regions according to programs is highlighted in Figure 3.14. Although only total problems is shown here, there were similar significant findings for within and outside the family data, but due to

their similarity they are not reported further. In addition, there were no three-way interactions within this data. However, for consistency of reporting, it was decided to chart the data consistent with that above.

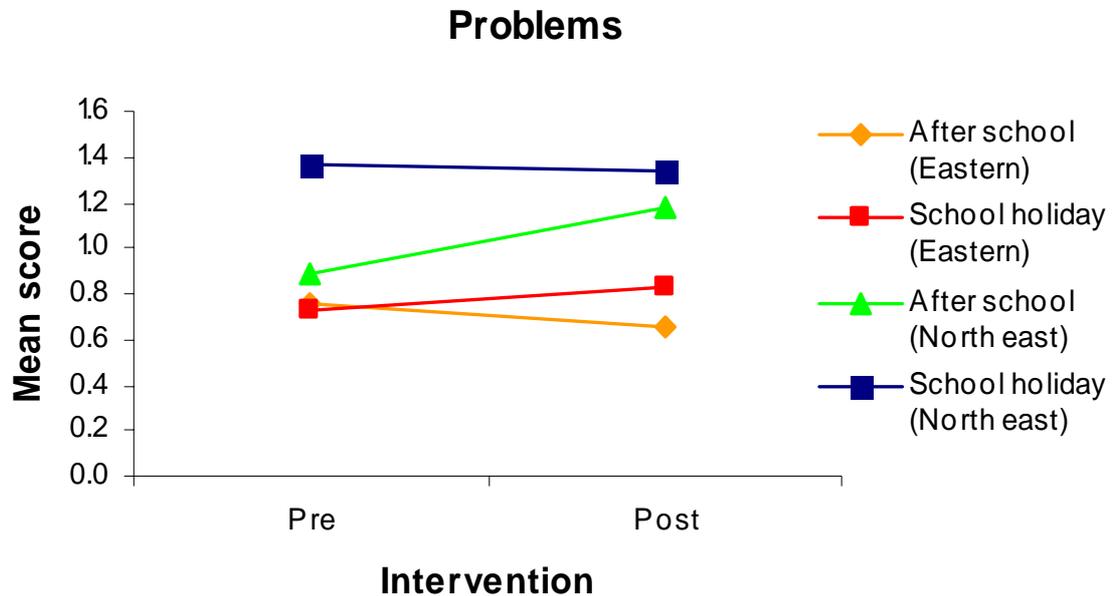


Figure 3.14: Mean scores for total Problems for time, region and program type.

The Eastern region children’s mean scores on these problem variables reduced over time by approximately .20 points while the North East scores for these variables increased by approximately .20 points¹⁵. However, it should be noted that much of the increase (although not a significant interaction) in the latter scores could be attributed to the After School program in the North East. This suggests that the interventions in Eastern region have an impact on these problem variables, but that these variables increased in the North East.

Key Finding

Total problems (inside and outside the family) decreased in the Eastern region, but increased in the North East.

There were no significant interaction effects for any of the coping variables. In addition, neither problem and emotion-focused coping, nor social support changed as a result of the intervention program.

Key Finding

None of the programs produced changes in coping activities.

¹⁵ A simple addition of programs within regions is not accurate due to differences in sample sizes. See appendix to this section for regional total scores.

Figure 3.15 highlights a three-way interaction for the self-esteem variable.

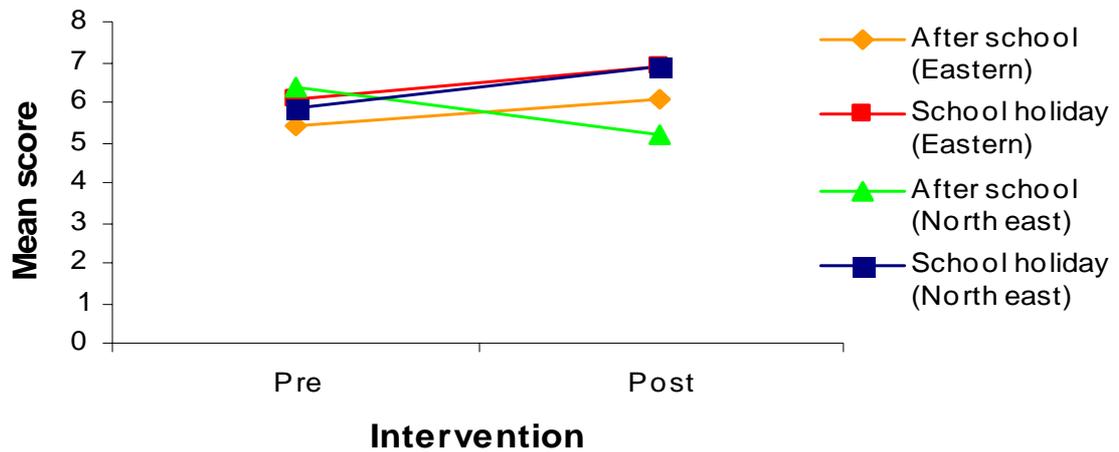


Figure 3.15: Mean scores for self-esteem for time, region and program type.

Once again, Figure 3.15 highlights problems with the after school program in the North East region. The figure clearly shows a substantial reduction in self-esteem for this group. In the other three programs (Eastern school holiday and after school, and North East school holiday) the self-esteem of children was between a mean of 5.50 and 6.00 pre programs and increased approximately one point to be just under 7.00 post program.

Key Finding

There was a large improvement in participant self-esteem in both Eastern region programs and in the North East school holiday program.

Key Finding

Improvements in the children's well-being were found in the Eastern region After School and School holiday programs, and in the North East School Holiday programs.

There was a reduction in several aspects of child well-being as a result of the North East After School program.

Issues for further discussion

The following provides a brief discussion of the issues identified and recommendations in relation to program delivery to 8-12 year old children whose parents have a mental illness. It should be noted that some components of this section also drew on consultations with and feedback from VicChamps program facilitators. In general, this aims to instigate discussion and to suggest solutions about the findings from this chapter in order to be instructive to policy makers and programmers about the design and delivery of future programs. In short, this discussion aims to suggest how evidence about the current programs might be employed to influence future practice.

Groups happen in partnerships not isolation

VicChamps programs do not happen in isolation. Referrals, resources including funding and facilitation, occur in collaboration with many other agencies. Consequently, the development and maintenance of interagency partnerships should be encouraged with a focus upon clear aims, roles and training of partners where necessary.

Recommendation: Interagency partnerships should be encouraged and central to the development and running of programs.

Recommendation: Partners involved in developing and running programs should have clearly articulated roles and responsibilities.

Programs that work

As indicated above, participants in the school holiday programs generally showed greater improvements in their mental well-being compared to those in the after school programs. The current findings suggest that participation in a school holiday program improves the mental well-being of participants.

However, it must also be remembered that improvements were also found in the after school programs in the Eastern region and, as outlined below, the absence of improvements (or worsening) in the after school program in the North East might have resulted from the higher level of mental health problems for some children on entry to that program (also see discussion below). In addition, it may also be argued that such programs (only two hours per week) may lack the intensity necessary to manage children with higher levels of mental health problems.

However, it is also notable that children entering the school holiday programs in both regions are similar on symptom scores (though slightly lower than the North East after school program) and that the Eastern region had an increase in difficulties and emotional symptoms scores¹⁶ for their holiday program. On balance, there may be concerns with all programs where participants' mental health is low at the commencement of the program. (Although this is perhaps more likely with less intense programs). This should be considered in future programs and future evaluations.

¹⁶ It is important to note that there were a small number of participants (n=9) measured pre and post on the parental measures in the Eastern region school holiday program, and that almost all the children's measures (where there was a much greater sample size; n=30) showed positive changes in well-being scores.

Recommendation: School holiday programs are recommended as intervention programs for 8-12 year old children.

Recommendation: After school programs are recommended intervention programs for 8-12 year old children in urban or larger regional settings.

Transporting children to programs is a major barrier in rural areas

Transport and the associated financial considerations were identified as significant barriers to attending programs in rural areas. Funding in the form of vouchers overcame some of these concerns in assisting children to attend school holiday and after school programs in the Eastern region. However, the cost as it related to distances and the available methods of transport were generally problematic in the North East. This problem was exemplified in the attendance of rural and remote children at regional centres for weekly after school programs. Distances of up to 100 kilometers and hour-long (one way) journeys made attendance at these programs impossible. Special arrangements for transport (e.g. buses, pickups) from rural areas were able to be made for getting to and from the four day holiday program, but became prohibitive to attending two-hour weekly sessions in the after school programs.

Recommendation: Planning for the running of after school programs should consider the problems of distance, transport and associated funding issues, particularly for children from rural or remote locations.

Child level of entry well-being may influence intervention outcomes

Generally, children entering intervention programs in this evaluation were at low levels of well-being, with many in high risk to their own mental health ranges. By and large, most current COPMI programs would not consider themselves designed as interventions for mentally unwell children. Given the increasing percentages of children in the borderline and clinical ranges of total difficulties for normative COPMI and the intervention groups compared to normative children, this issue needs to be examined by future programmers.

In addition, the 'level of unwellness' of some COPMI children provides a possible explanation for problems with the after school program in the North East region. Scores on a range of variables from both the parents' (SDQ) and children's measures increased, rather than decreased in this program. Pre scores for this group (16.6) were higher than the total pretest intervention group scores (15.3¹⁷) and were very close to the average participant being in the clinical range (i.e. between 17 and 40). In other words, the scores of participants in this group could be indicative of a mentally unwell group of children to begin with. With a program that is aimed at COPMI, rather than mentally unhealthy children it is perhaps not surprising that children did not improve as a result of the program.

Recommendation: It is essential to have clear referral and selection criteria (specifically with reference to level of mental well-being of a child) prior to entry to programs.

Recommendation: Programs should have clear (including entries in program manuals) behaviour management guidelines for group facilitators to adhere to.

¹⁷ Please note that the matched pre scores for total SDQ were lower again at 13.85.

Changes in programs over time

Facilitators noted changes in program delivery over the 2003-2005 period. For example, as time went on, the 8-12 year old programs more regularly accommodated younger children, both regions negotiated transport and funding problems (see below) differently according to type of program being offered, and the Eastern region increased linkages between after school and holiday programs over the period. A notable finding, as a result, is that program facilitators need to be responsive and flexible to the needs of their group of children and circumstances in terms of mode of program delivery.

The peer support programs in the North East changed for numerous reasons. With increasing experience, they gained more ideas as to what input these children often needed, as well as ways of offering it. For example, it appeared that the children often had difficulty in expressing feelings appropriately, and so work on articulating feelings was added to the program. The timing and delivery mode of different elements of the program also changed. For example, wording was often changed on available mental illness information sheets, so that it became age appropriate and understandable. The watching the 'Hard Words' video was moved from being shown at the beginning of the program to later on in the program, when more trust and rapport between participants had been established. Initially, pre-evaluation assessments were implemented with the group at the commencement of the program, but were later changed to individual assessments, before the program commenced. Often the post evaluation was done via a home visit, rather than just posting it out. Both of these changes were made so as to increase the number of post-evaluations returned, as well as increasing the accuracy and honesty of the data collected from the children. Workers recognized the needs of different groups as well. The strategies used in presenting information were flexible, so that the learning styles of the children could be catered for as best as possible.

Recommendation: Program facilitators must make the mode of program delivery responsive and flexible to the needs and circumstances of the children.

Programs that improve self-esteem may impact on later behaviour of the children in their families

A notable finding was that there was a relatively large improvement in self-esteem (though not significantly different) in the children across the programs. At the same time, parents noted a slight increase in conduct problems, but most importantly a significant reduction in their children's prosocial behaviour. This was found across all programs and regions. One explanation for this finding is that the interventions are helping children to improve their self-esteem and confidence, which in turn leads them to be more critical of others, perhaps family members. Similarly, Professor David Hay (personal communication, 2006) suggested that undertaking interventions with children that increase their knowledge and ability will impact on family interactions. Future programs should recognize that changing children's confidence and skills might have a long-term impact on the dynamics within their families.

Recommendation: Clear information should be supplied to parents about likely changes in their children (e.g. increased self-esteem, lowered prosocial behaviour, greater conduct problems) resulting from programs. If necessary, support to families should be provided following programs including linking parents to parent support programs.

Research and evaluation issues with COPMI

During the course of the evaluation, considerable difficulties were encountered obtaining data from parents and children. Difficulties included such things as obtaining post-program (four weeks later) data from parents and children. Some children (generally younger and with lower academic abilities) experienced difficulty completing questionnaires. Conversely, the learning from the three years of this project has been considerable – exponentially advancing the knowledge about programs for COPMI. Consequently, while undertaking research in ‘real world’ is often problematic, the considerable ‘pay off’ should also be kept in mind.

Recommendation: Ongoing evaluations should be undertaken by future programs with standardized measures (e.g. SDQ) to allow comparisons with other programs or groups, and to develop further research knowledge regarding families with a parent with a mental illness.

Recommendation: A body or organization should be established as the repository for the ongoing collection and entry of evaluation and research data from families where a parent has a mental illness. Such a body would undertake analyses of various aspects of that data, including making the data available to other researchers and evaluators in the community.

Chapter 4: Programs for five to seven year olds

As children in the five to seven age group differ physically, intellectually and psychologically from those in the eight to twelve group, different programs were thought necessary for these children. The needs of children in the five to seven age group are described below, from which implications are drawn for programs targeting children in this age group. This is followed by a description of the programs implemented by VicChamps and the evaluation tools employed. The chapter concludes with results and issues for discussion.

Needs of children in the 5-7 age range

Children in the younger age group tend to think in a factual and reality-based way, while abstract ideas develop later (Pearce, 1994). While most children by the age of six begin to understand that there is 'more to the world than meets the eye', they may become easily confused about what is real and what is imaginary (Pearce, 1994). As a consequence, children in the five to seven year age group might become easily scared of imaginary monsters and mysterious events. As children's understanding of time, position and place, and of people and individuals is still developing, they may easily become confused about what is true and what is false, and what is good and what is bad (Pearce, 1994). Fact and fantasy are easily mixed together.

Consequently, it is important, when delivering information to this age group, that simple explanations, based in facts without too much detail, are important. Too much detail is not only potentially distressing, but may also cause confusion. Consequently, programs and/or activities directed at this age group need to be simple, concrete, not overly complicated, and deal with facts about the parent's mental illness as it pertains to them. Opportunities for children to discuss and express their fantasy lives are essential in order to further clarify the differences between fact and fiction, particularly as related to their family lives. Such children may be vulnerable to stories of fear, and believe their parents' delusions. Children may take things literally; for example, when they hear a parent say, 'I became sick when you were born', children in this age range might assume that the parent became sick as a direct result of something they did (or did not do). Children in this age group may not consider all possibilities for situations, which might then lead to a limited range of problem-solving strategies being identified.

Memory processes are different in younger children than those in the older age ranges, and whilst children in the younger group are now able to label, rehearse and elaborate, these children lack a sophisticated meta-memory that develops in the later years. This means that children in this age range find it difficult to reflect upon the memorization process, and are apt to possess unrealistic beliefs about their own memories and about the circumstances in which they might be incorrect (Peterson, 1984). As children's memory processes are often immature, the repetition of important information is important, albeit in an interactive and entertaining manner. At the same time, these children are only beginning to learn reading and writing and their literacy skills are often very elementary. Accordingly, activities and evaluation tools that require limited literacy skills are important.

Psychologically, younger children are especially sensitive to their parents' emotions, and their own reactions are often a reflection of their parent's emotions and behaviour. This may mean that the more upset the parent is, the more upset they may become themselves. In comparison, older children have a better understanding of the reality of events, and so may develop their own personal reactions rather than mirroring those of their parents (Pearce, 1994). Similarly, young children are generally still egocentric, and often confuse their inner thoughts and feelings with others. This means that young children may not be able to consider other peoples perspectives, nor be as considerate and empathic as older children. Consequently, while some younger children are often able to show empathy towards others in distress, others may do nothing to help, or instead act inappropriately (Yussen & Santrock, 1982). Accordingly, peer support for children aged five to seven may not be as important for those in the older groups, and programs need to also reflect this.

At the same time, children in this age group start to develop more complex emotions, such as shame, guilt and pride. They start to self-reflect, and begin to experiment with different ways of expressing a wider range of emotions. Consequently, programs for this age group need to facilitate and encourage the expression of emotions, in different ways and at different times.

Children's concepts about themselves also undergo developmental change. Before the ages of eight, children describe themselves and others using externally observable physical characteristics, such as the colour of their eyes or hair (Mussen, Conger, Kagan & Huston, 1984). In comparison, older children use more internal, psychological characteristics to describe themselves and others. Though it is difficult to make generalisations to all eight year olds, such a finding has implications for the type of evaluation tools used with children in the VicChamps programs, and the way that facilitators might consider enhancing self-esteem.

Attachment refers to the affectional bond between the child and his or her caregiver(s). The degree of attachment is related, amongst other factors, to the child's rate of cognitive development (Yussen & Santrock, 1982). For instance, children need to first recognize that people are permanent fixtures in the world, in order to then securely attach themselves to a significant adult. As a consequence, children in the five to seven age group may well be more clingy and less willing to separate themselves from their parent/s when in strange, or what they perceive to be threatening, situations. This is particularly the case for many children whose parents have a mental illness, because of their own family's histories of disruption and stress (Williams, 2004). Consequently, when developing programs targeting children in this age group, facilitators need to be mindful that parents may need to be in close physical proximity, or at times physically present.

Key Finding

Differences in children aged five to seven compared to those aged eight to twelve need to be reflected in the content and delivery of COPMI interventions as well as the evaluation techniques.

Programs

Different approaches were employed across the two regions to address the needs of children in the 5-7 year range.

Eastern health

It was thought that children aged 5–7 years and their parents might benefit from a more intensive type of intervention that would focus on concurrent parent and children groups. A model of peer support formed the basis of both groups, which was run according to school terms. In addition, the program was collaboratively run between mental health services and the child and family welfare sector. The objectives of the groups were:

- To strengthen relationships within families and focus on those strengths;
- To provide education and support to parents and their children;
- To provide a parenting group that is consumer-focused and driven;
- To establish a group program which is sustainable and able to be adopted in other services in the state of Victoria
- To identify parents and children at greater risk who may require further assessment and support.

In addition, the program aimed to:

- Promote optimal social, emotional and cognitive development for children using a model of peer support and play;
- Offer parents and children a higher level of support and reduce their isolation;
- Improve communication and strengths between parent and children;
- Develop and establish a strong collaborative role for health professional and family workers
- Facilitate access for these families to community support – health, leisure, sporting, creative.

Appendix 4.1 provides a suggested outline for a YoungChamps children’s program.

North East

The North East region chose not to run a 5-7 year old specific program for several reasons. In the first instance, feedback from parents with children in this age group indicated an unwillingness for their children to be discussing mental health issues. While committee members considered this to be an educative issue for parents, the committee also believed that it was important to work with the parents, rather than impose something on them they would not support or send their children to.

Additionally, and more importantly, many younger children and their parents wanted siblings to attend the program together. This was by far the main reason for the groups being run in this way. Sometimes this was a pragmatic concern (ie transport), though overall, parents wanted a focus on families rather than on individual children. Program facilitators also wanted to focus on enhancing sibling support, rather than creating different programs for the different ages of children. Most families involved in VicChamps in the North East have children in the older age brackets, (e.g. three children aged 10, 9, and 7). In these instances, facilitators and parents preferred to keep such

family units together, so that all such sibling groups attended the 8-12 year old program). Subsequently, the children aged 5-7, in the North East, attended programs alongside children in the 8-12 year group.

In incorporating younger children within the older program, North East program facilitators ensured the following:

- Age appropriate activities were chosen or developed. These activities were flexible and easily adapted to the different age group, as well as having a number of open-ended tasks so that children could work at their own level. Many of these activities were visual, creative and hands on.
- Discussions about mental illness were often done in small groups, and in different age groups. A leader or volunteer would be in each group facilitating the conversation. In one School Holiday Program the group worked as a whole during the discussion about mental illness, and everyone was able to contribute in their own way. No contribution was seen as less important than another.
- A benefit of having the two age groups together was that the older children were able to share their knowledge with the younger children by 'peer teaching'. Thus, the older children had an opportunity to reinforce their own knowledge about living with a parent who experiences mental illness, and the younger children were able to gain this knowledge through a medium and using a language which they would understand.

Appendix 4.2 details the aims and approaches in the North East program when working with children aged 5-12.

Key Finding

In the North East, children and their families preferred to stay in family groupings, rather than attend age-specific programs.

Programs delivered

Eastern Health has run one group for this age group, which was held during Term four, 2004, at the Wantirnia South Neighbourhood Centre. The group started with six children and five parents, though three of each finished the program. There have been problems in running further programs, including:

- Problems regarding childcare for families which have children younger than 5-7 years of age (mothers attend the parent support group at the same time and report not having anyone to look after younger siblings). Childcare and transport were key issues in not being able to run further programs.

- Timing of programs; the first, planned program was to be held over winter, but was postponed because many family members had the flu or were unwell.

Key Finding

Childcare, transport and the timing of programs (over Winter when young children were ill) were issues in attracting participants in YoungChamps.

Evaluation

Intervention programs targeted at this age group are primarily aimed at building children's resilience, self-esteem, coping, and enhancing the family environment of children whose parents have a mental illness. Evaluation tools subsequently focused on those theoretical areas. However, considering the specific developmental needs of this age group, including their literacy skills, it was considered inappropriate to administer a multitude of self-report pen and paper type assessments. Whilst a variety of evaluation tools were specifically developed (see Appendix), due to the low numbers of participants in both the child and the parent program, only significant and meaningful results are presented here. The evaluation tools presented here include (i) facilitator interviews with children and (ii) the parent evaluation questionnaire.

Methodology

The following outlines the measures (see Appendix 4.3) developed and employed to capture pre and posttest changes according to the program. It should be noted that a number of North East children from this age group participated in 8-12 year old programs, and evaluations were undertaken with those children using measures outlined in the preceding chapter. Data was included in that evaluation only where it was thought valid and reliable.

Facilitator interviews with children

The three children were asked a series of questions by the program facilitators at the end of the program including 'How have you found the group?' 'Has being in Champs changed things at home?' and so on.

Parent support group evaluation

In order to evaluate the parent support group two measures were developed as pre and posttests. These measured the ability of parents to access further community support, and to what extent they felt supported and better educated as a result of participating in the parent support program.

Results

Child responses

The following outlines verbatim responses from the three children attending the child group as recorded by VicChamp facilitators.

Table 4.1: Verbatim responses from 5-7 year old children following attendance at VicChamps program.

Question	Verbatim responses
How have you found the group?	Enjoyed Good and fun, sometimes bad.
Has being in Champs changed things at home?	Yes, easier to talk. No.
Have you learned anything new?	Talk to mum. Archery. Yes – art and [I've learnt] to share.
Has anything we have done or talked about in the group upset you/worried you?	No. Yes. Mum being angry at me.
Have you any ideas for future topics or ideas about what we can do in the group or how the group can be improved?	More sport. Puppet making, play outside.
What has been the best thing about Champs?	The camp, canoeing, swimming pool, made new friends on camp. Playing outside, new friends.
What have you enjoyed the least?	Answering lots of questions.

Key Finding

The three children who attended the YoungChamps program report having fun and making new friends. One child found it easier to talk to his/her mother.

Parent responses

The three parents who attended the support group completed a questionnaire pre and post support program (see Appendix for further details). The responses are summarized in Table 4.2.

Table 4.2: Pre and post program responses to parenting questionnaire.

Item	Pre program	Post program	Change
Confidence in parenting strategies	Moderately confident	A little less than moderately confident	Participants feel a little less confident in their parenting skills
How understood participants felt	Not well understood	Not well understood	No change
How supported participants felt	Moderately supported	A little less than moderately supported	Participants feel a little less supported in their parenting role
How often participants talk to other parents about their children	Not often	Sometimes	Participants reported being able to talk to other parents more often about their children post program
How often participants discuss parenting concerns with community, health, educational workers	Sometimes	A lot	Participants talk to workers more often about parenting concerns.
How confident participants are about accessing parenting support and information	A little confident	Somewhat confident	Participants are more confident about accessing parenting support and information
How much knowledge participants have about mental illness and parenting	Little knowledge	Some knowledge	Parents know more about mental illness and parenting
How often participants positively interact with child/children	A lot	A lot	No change; parents report interacting positively with their children pre and post program
How participants describe their family environment	Mostly positive	Mostly positive	No change: parents report their family environment as mostly positive

In addition, there were a number of general comments about the program. These included such things as:

- It has been good to have the opportunity to attend the Champs group. Both (daughter's name) and myself have got a lot out of the sessions.
- Now got lots of booklets etc with heaps of contacts and info.
- My son and I enjoyed the program. I need my son with me, so I can be the mother I want to be.

Key Finding

After the program, parents reported increased ability to discuss their parenting concerns with others, and to access further parenting support and information.

In summary, the biggest impact that the support program had on parenting issues was that the participants felt they could now discuss, more often, their parenting concerns with community, health and/or educational workers. The participants also felt they could talk to other parents a little more about their children, knew a little more about mental illness and parenting, and were somewhat confident about accessing parenting support and information. The program had no impact on their overall levels of confidence as a parent, how understood they felt as a mentally ill parent, their family interactions and overall family environment (the last two items were quite positive to start with).

Key Finding

Two support strategies were trialed; age-specific programs and sibling groups. It is still unclear which is the most effective for this age group.

Issues for further discussion

The following is a brief discussion of issues identified in relation to program delivery to 5-7 year old children. Once again, raising these issues aims to instigate discussion about how evidence about the current programs might be employed to influence future practice.

Specific program for this age group

It is difficult to ascertain the effectiveness of the groups run for the 5-7 year olds and their parents, because of the small numbers of participants. It would appear that, while children in this age group whose parents have a mental illness have specific needs, it is still unclear how best to support such children; the options trialed here include having age-specific interventions and involving sibling groups in programs. The small numbers of children, who have attended the program, certainly appear to have enjoyed the program, and the parents, who attended the support program, are working more closely with professionals about parenting issues. However, over the three years of VicChamps, there appears to have been minimal success in attracting participants for these programs, for a variety of reasons as outlined previously.

Including younger children with 8-12 year age group

The strategy of including younger children in the 8-12 year old program appeared to be successful. However, this approach is perhaps only appropriate if children are in the upper age range of this age group (e.g. six or seven years), are developmentally more advanced, and/or have older siblings attending the 8-12 year old program. Conversely, while such an approach may be appropriate for these younger children, those planning or running a program for 8-12 year olds might need to consider the impact of having

younger children in a program with older children (e.g. 12 year olds with sophisticated cognitive and language abilities). Their inclusion may reduce the effectiveness of the program for those at the upper age ranges. Additionally, in the North East, younger children tended to be included in the 8-12 year old program when they had an older sibling. It remains to be seen how younger children, who do not have an older sibling, might be best supported.

Recommendation: It is recommended that programs are developed, trialed and evaluated with children aged 5-7 to provide evidence for program effectiveness.

Recommendation: It is recommended that different methods of attracting 5-7 year old children to support programs be determined and trialed. Including younger children with their older siblings in the 8-12 year old program has been one successful strategy in attracting children to VicChamps programs.

Chapter 5: Workforce development

Human service agencies traditionally take a categorical approach to their clients with a tendency to focus on either the child (in terms of child protection) *or* the adult (for his or her mental health needs). In addition, funding of mental health services is formula-determined, based on registered client contacts. Such formulae constitute major difficulties for children of parents with a mental illness, as they are not able to become clients of adult mental health services. Adult mental health workers do not routinely engage with children under 18 years of age, nor do they characteristically focus their clinical interventions upon children of their clients. These children only become a focus of attention (or client) if they are case identified and attend Child and Adolescent Mental Health Services (CAMHS). Most children of parents with a mental illness do not fall into this category.

Consequently, an important component of the VicChamps project was to enhance the capacity of mental health services' to respond to families in which a parent has a mental illness. In addition, the program also sought to raise the capacity of mental health and welfare professionals generally, and to enhance the awareness of, and responsibility for, such children and their families.

Initially outlined in this chapter are: a brief review of literature underpinning the program and evaluation, the goals of this component of the program including a brief description. Then follows detailed information regarding the evaluation, including the methodology, results and issues for discussion.

Background literature

The use of literature search terms such as 'capacity building' and 'children whose parents have a mental illness' in **proquest** or **psychinfo** results in negligible relevant publications. This is consistent with there being a substantial lack of evidence-based research available in the general area of children who have a parent with mental illness, and the level of organisational knowledge, skills and resources in relation to this area of practice (AICAFMHA, 2001). The Australian Infant, Child, Adolescent and Family Mental Health Association in their recent scoping report, *Children of Parents Affected by Mental Illness*, highlights the need "...for improvement in mental health agencies in the identifying and responding..." to children in such circumstances (AICAFMHA, 2001, p. 44) and "...to ensure appropriate service responses to the needs of children whose parents have a mental illness" (AICAFMHA, 2001, p. 17). This part of the program and the evaluation sought to examine, from the mental health and welfare professionals point of view, the most important issues regarding both need, treatment and barriers to intervention and support for such children.

A focal source of information underpinning this area of the evaluation was the scoping report 'Children of Parents Affected by Mental Illness' undertaken by the Commonwealth Department of Aged Care (2001), which makes a number of major recommendations in regard to improving inter-sectoral agency activities. These recommendations include the encouragement of mental health agencies to take a leadership role in developing community linkages and, in general, the need to increase information and the education of mental health and community agencies regarding the issue. The report specifically

highlights the need “...for improvement in mental health agencies in identifying and responding...” to children in such circumstances (and this should be focused on developing mental health organisation literacy regarding this issue along with protocols and procedures AICAFMHA, 2001, p. 44). “Professional development and supervisory support...” should be provided for mental health workers and “...education for other workers with regard to special issues in service provision for this group” (2001, p.5). Furthermore, the report recommends that “Barriers to appropriate and collaborative service delivery for children with parents affected by mental illness should be clearly identified, along with practical strategies for overcoming these” (2001, pX).

Previous mental health literature from the North East region of Victoria was also examined. A report into mental health needs in the region had indicated that increasing mental health literacy in the area was important (Maybery, Dalmau, Harrington, Hoare, Lane, Malcolm, Malcolm, Massey, Sprunt & Vine, 2002), and the report title ‘Meeting the needs of children whose parents have a mental disorder’ (Maybery, Ling & Szakacs, 2002) has documented this specific need within North East Victoria mental health and community agencies. Maybery, Ling and Szakacs 2002, p. 6) argue that it is important “to develop and strengthen links between mental health agencies” and “to strengthen links between the health and education systems to create support networks for children”.

Capacity building

A central premise of the VicChamps approach is to improve the capacity of mental health and welfare services in the Eastern and North Eastern regions of Victoria to respond to this issue in an ongoing manner. It has been suggested that “Capacity can be built by developing strategies across several key components including workforce development, organisational development, partnerships and resource allocation.” (O’Hanlan, Ratnaike, Parham, Kosky & Martin, 2002, p.3). In their conference presentation to VicServe, Johnson and Foster (2002) outlined the commitment within these regions to encouraging mental health services, community agencies and parents “...to work together to respond to these identified needs”.

The chapter that follows provides a description of the day-to-day workforce development activities undertaken by VicChamps staff (e.g. developing networks, secondary consultations) designed to increase regional workforce capacity. In addition, the more formal ‘Getting There Together’ program was employed with the aim of increasing workforce knowledge and basic skills regarding the COPMI issue. The evaluation attempted to capture changes regarding work force capacity in each region, according to these workshop activities, but also tried to recognise changes that occurred during the three year period in relation to less formal day-to-day activities undertaken by staff that impacted on the regional workforces as a whole. Consequently, these two chapters are inherently linked in both activities and evaluation.

The evaluation goal of this section was to examine changes to the capacity of the workforce¹⁸ in relation to children whose parents have a mental illness. Specifically, the evaluation sought to measure changes in mental health and welfare staff across the regions according to:

¹⁸ Workers and workforce are used generically to refer to Eastern and North East regional mental health and welfare staff.

- the referral skills and/or processes undertaken;
- the levels of responsibility and activity undertaken for such children by workers;
- any systemic organizational change to accommodate children in such circumstances.

In addition, as the evaluation process unfolded, a research gap (and subsequent opportunity) was identified in the literature regarding the barriers that mental health and welfare workers might have in relation to working with their adult clients regarding parenting and other issues involving their client's children and family. The literature regarding worker barriers is now presented.

Worker Barriers

Children of parents with a mental illness are sometimes referred to as 'hidden children' (Fudge & Mason, 2004), because adult mental health services and other professionals are often unaware that their clients are parents. As mental health workers are a point of intervention for mentally ill parents, these workers have the opportunity to identify issues regarding the dependent children of their clients. The barriers that mental health workers encounter in discussing parenting issues with adult clients, as well as working with the children themselves, was consequently sought as an additional component of this evaluation.

Service delivery to families, where a parent has a mental illness, is often problematic. As mentioned above, many agencies traditionally take a categorical approach to clients. In a survey of programs across North America, Nicholson et al. (2001) found that participation in programs was limited to eligible adults or eligible children, but not both. However, Wang and Goldschmidt (1996) found that psychiatric patients wanted family-focused interventions, rather than focusing solely on themselves as the identified patient. Consequently, service delivery needs to focus on families, rather than individuals.

As well as organisational barriers, it is thought that many human and health agency workers do not have the skills and knowledge to identify, refer and/or intervene appropriately with diverse family members. Working with families affected by parental mental illness requires what Fleck-Henderson (2000) refers to as 'seeing double'. This is the ability of workers to simultaneously engage with the needs of both adult clients and of their child/ren. Cousins (2004) points out that this might not be possible for all workers, for both personal and professional reasons. Bibou-Nakou (2004) illustrated this problem with Greek teachers who acknowledged that supporting children whose parents had a mental illness were part of their responsibilities, but at the same time reported inadequate knowledge and skills to do so.

As well as a skills and knowledge deficit, Ackerson (2003) contends that many human and health agency workers take a problem and deficit approach when working with clients. Nicholson et al., (2001) points out that organisational responses tend to be only available when parents or children have a diagnosable problem, or after abuse and/or neglect has been identified. Consequently, while children of parents with a mental illness are at risk of various problems, preventative based interventions are not often implemented.

Overall, there appears to be a substantial lack of evidence-based research regarding the organisational knowledge, skills and resources required for working with families affected by parental mental illness. As a consequence, the Australian Infant, Child, Adolescent and Family Mental Health Association highlighted the need "...for improvement in mental health agencies in the identifying and responding..." to children in such circumstances (AICAFMHA, 2001, p. 44), and specifically the need to identify the barriers for adult mental health workers when working in this area (AICAFMHA, 2001).

Several studies (Bibou-Nakou, 2003; Byrne, et al., 2000; Dean & Macmillan, 2001; Grunbaum & Gammeltoft, 1993; Nicholson, 2005) have sought to identify the barriers for mental health staff, when working with families affected by parental mental illness. Dean and Macmillan (2001) found organisational structure and role constraints to be significant barriers. Similarly, Grunbaum and Gammeltoft (1993) found issues regarding service ideologies and professional role boundaries to be problematic for workers with mentally ill clients. A lack of knowledge and skills has also been identified, particularly as they pertain to judging parenting capacity, working with children and mental health prognosis (Bibou-Nakou, 2003; Dean & Macmillan, 2001). Additionally, Byrne et al. (2000) highlighted barriers associated with poor communication between agencies and a shortage of appropriate community resources.

Barriers have also been identified within clients and their families. Workers' perception that family members were not willing or able to acknowledge a parent's mental illness proved an impediment to responding to the needs of parents and their children (Dean & Macmillan, 2001). However, Nicholson also points out that

Parents with mental illnesses express concern that if they disclose their parenting status or, more important, problems with parenting, treatment providers will file reports with child protective services, thereby increasing the probability that they will lose their children. (2005, p. 357).

Furthermore, Bibou-Nakou (2003), in focus group interviews with 18 workers, found that a child's age was considered to be a major obstacle for talking to children about their parent's mental illness, although she suggests that this assumption may be based on inadequate knowledge regarding child development.

The need to identify the barriers to working effectively with families affected by parental mental illness is important, particularly for adult mental health workers (AICAFMHA, 2001). However, the relative importance of barriers, and the differences in barriers between adult mental health workers and others, has not been previously investigated. Such knowledge has important administrative and training implications. Consequently, there were three aims to this section of the evaluation. The first was to identify the core barriers that impede adult mental health and other workers from working with clients about parenting and their children. Based on previous studies (Bibou-Nakou, 2003; Byrne, et al., 2000; Dean & Macmillan, 2001; Grunbaum & Gammeltoft, 1993; Nicholson, 2005), it was hypothesised that organisational and role constraints, a lack of skills, knowledge and resources, ineffective liaison between agencies, and issues within families themselves would be identified as core barriers for workers. The second and

third aims were to rank the importance of these barriers, and to compare barriers for adult mental health workers with other workers.

Description of Getting There Together program

There are two education/training components to the VicChamps program. The first is the 'Getting There Together' (GTT) Professional Development package for service providers in the health and welfare sector and for adult mental health professionals. The core components are presentations by a carer and a consumer who is a parent. A key aim of this part of the project is to empower workers to assist parents to be parents rather than purely taking over and doing the talking for them. The educational modules aim to:

- Increase confidence in participants' ability to engage with parents and children;
- Enhance capacity to address issues of identifying those children and families in need of support;
- Increase understanding of adult mental illnesses, symptoms and treatment;
- Increase understanding of the impact of mental illness on parenting, and parenting on the mental illness;
- Increase understanding of the impact on family members;
- Increase confidence and skill to support parents to talk with their children about their mental health.
- Increase confidence and skills in talking with children about their parents' mental illness where required;
- Enhance capacity to develop group programs for children and their parents;
- Increase knowledge of resources available to them and to the families concerned.

The second component focuses on the early identification of dependent children of clients of adult mental health services and subsequent strategies for providing support to those children and their families. Adult mental health clinicians require additional skills, resources and a measure of confidence to incorporate this into their practice. The GTT program was undertaken as a part of this skilling process. This aspect of the project sought to:

- Provide professional development that aims to increase the routine identification, engagement and referral of children whose parents have a mental illness by adult mental health clinicians;
- Increase knowledge of the problem and local services available for children;
- Implement and utilize a proforma for the identification of adult clients and their children in the intake process, which provides comprehensive information on the potential support requirements of the family, especially the children;
- Improved service planning, which includes discussion of parenting issues, a family crisis plan and linking children to support services in the community;
- Involve adult mental health clinicians in activities for children, such as peer support programs and camps.

VicChamps Professional Development activities provided

Professional development activities ranged from individual resourcing of portfolio holders/ key workers to broad service-wide lunchtime seminars to ½ day training for mental health staff. The four tables that follow highlight the professional development

activities delivered to mental health and health and welfare workers in the Eastern and North Eastern regions during the last three years.

Table 5.1: Professional development activities delivered to mental health workers in Eastern Region.

Location of activity	Dates of activity completed	Number of Programs	Number of Participants
GTT Adult Mental health program wide	12/5/04, 17/5/04	2	20
OT specific	21/6/04	1	9
Portfolio holders meetings/training	7/12/04, 15/2/05, 17/5/05, 16/8/05, 29/11/05, 21/2/06	6	33
West Ward	22/6/04, 15/3/05, 3/5/05, 7/6/05, 1/8/05, 8/8/05	6	12
OECAT	10/8/04, 5/10/04, 14/6/05	3	28
CECAT	7/12/05	1	9
Chandler	11/3/04, 13/9/05	2	11
Murnong	26/2/04, 29/4/04	2	15
Koonung	15/9/03, 21/4/05,	2	14
Waverly	6/1/04	1	8
OEMST	12/7/04, 19/5/05, 24/5/05, 6/6/05	4	11
CEMST	12/7/04, 5/4/05	2	9
OECCU	15/6/04, 13/07/04, 24/5/05	3	16
CECCU	8/3/05	1	2
Professional Development Team	9/8/05	1	7
Medical	29/11/04	1	5
CAMHS Professional development session	24/8/04,13/6/05, 21/2/06	3	82
Total		41	291

Table 5.2: Professional development activities delivered to health and welfare workers in Eastern Region.

Location of activity	Dates of activity completed	Number of Programs	Number of Participants
GTT (Ringwood)	23/6/04, 14/7/04, 9/8/04	3	38
GTT Queen Elizabeth Centre	20/5/04	1	50
Carers Vic young carers training	25/10/05	1	9
GTT Train the Trainer	2/3/05, 9/3/05	2	10
GTT - DHS Early Learning Years Forum	12/5/05, 24/5/05	2	198
Running groups for Children (Ringwood)	19/10/05, 25/10/05	1	22
GTT – South West Area Mental Health Service	4/8/04	1	31
GTT - Beechworth	7/10/05	1	31
GTT – Manningham Council	21/6/05	1	25
GTT - Forensicare	28/4/05, 19/5/05	2	19
Eastern Region Intake Workers Network Presentation	7/9/05	1	19
GTT - Deakin University	5/5/05	1	16
Total		17	468

Table 5.3: Professional activities¹⁹ with mental health workers by North East region.

Location of activity	Dates of activity completed	Number of Programs	Number of Participants
Kerferd	11/12/03	See footnote	4
Kerferd	1/7/04		6
Wangaratta AMHS	11/12/03		6
Wangaratta AMHS	21/04/05		12
Wodonga AMHS	1/4/05		6
Primary MH	3/2/04		9
Total			43

Table 5.4: Professional development activities delivered to health and welfare workers by North East region.

Location of activity	Dates of activity completed	Number of Programs	Number of Participants
Supporting Kids Launch	7/10/03	1	50
Benalla East PS	30/10/03	1	17
Trinity Community Support Assoc.	26/11/03	1	5
Yarrunga PS	11/11/03	1	25
Hume Counsellor Support Group	4/12/03	1	9
Child Protection and Care Forum	17/5/04	1	5
Ovens and King Community Health	28/4/05	1	7
Catholic Education Welfare Meeting	18/10/05	1	5
Foster Carer's Camp	4/12/05	1	8
Total		9	131

¹⁹ Note that these professional activities were not considered professional development activities per se.

Evaluation

The following is segmented into method, results and issues for discussion sections. The general methodology used three approaches. First, a workers' questionnaire was purposely developed that tracked levels of workforce capacity across two time frames during the project. The second approach focused on participant satisfaction with the Getting There Together program. Third, interviews were undertaken with regional stakeholders at the end of the project to determine any key issues for subsequent planning and sustainability.

This part of the evaluation aimed to measure changes in two key workforce areas. The first was to determine general changes in the mental health and welfare workforce across the regions over the course of the project. The second was to determine whether there were specific changes in knowledge and behaviour over time in relation to the following:

- Regional differences between Eastern compared to North Eastern regions.
- Workforce differences in relation to the adult mental health work force compared to other community health and welfare workers.
- Those who attended the 'Getting There Together' program of education and training compared to those who did not.

In general the evaluation examined changes within each of the regions, for each of the workforce types, as a consequence of the increased activity regarding children whose parents have a mental illness.

Methodology

The research involved pre and post data collection phase, employing a survey format that examined knowledge, skills and general activities in relation to COPMI. While the survey questions are outlined in detail below, additional items were developed (as outlined in the worker barrier section above) as part of the first questionnaire using an open question format. This qualitative component involved collecting verbatim responses from the participants about barriers to working with COPMI and/or their parents. Based on this qualitative information, additional questionnaire items were developed, scaled and completed by participants at time two.

Participants

The 87 participants who returned questionnaires included 59 females and 14 males²⁰ mental health and welfare worker participants. Of these respondents, twelve had insufficient data to be included further in the study. Thirty-three participants responded to the second phase of the study, who were able to be matched to data in the first phase.

Instruments

The questionnaire was developed with respect to the aims of the program and with reference to past research and reporting. Items were developed in consultation with the steering committee of the project, and generally focused on measuring knowledge and current practices in relation to the issue. This included questions targeting the level of

²⁰ Some workers wished to remain anonymous, hence identifying characteristics were not provided for a larger proportion of workers.

support, information, education and referral provided by these workers (see Appendix of this section for the time 2 questionnaire).

In addition, the first questionnaire had the following question:

‘For those of you that you *could not* discuss the problem/s, what would be the barriers to you doing so? Please list below (in order of greatest importance)’. This question resulted in the identification of four, central barrier themes and seven sub-themes. These themes were used to generate 17 items (see question 8 in Appendix) for the second phase of this study. These items were preceded by the stem question:

For those of you that *could not* discuss the problem/s, what would be the barriers to you doing so? Using the following scale as a guide, circle the number that best represents your answer to each of the barriers/issues below. Please indicate your level of agreement or disagreement as to how much each barrier/issue applies to you. Participants responded as Not applicable (n/a) or on a five point scale from Strongly Disagree (0), Disagree (1), Neither agree or disagree (2), Agree (3) or Strongly agree (4).

Procedure

Data was collected using two, opportunistic approaches. The first approach involved the voluntary participation of workers prior to attendance at a ‘Getting There Together’ training program. The second was when researchers and steering committee members (see acknowledgements) asked workers in the community to voluntarily respond to the first qualitative phase and to the second quantitative phase of the study, approximately six months later.

All participants signed informed consent forms and responded using reply paid envelopes. Participation in the study was voluntary and anonymous to trainers and steering committee members. Ethics approval was gained from Charles Sturt University (2004/018) and Eastern Health Region ethics committees (ref ks:200/04).

Results

The central interest of the results was to determine whether there were changes in the knowledge and behaviours over time of Eastern compared to North Eastern regional workforces, differences in relation to the adult mental health work force compared to other community health and welfare workers and differences in those who attended the GTT program of education and training compared to those who did not. In statistical parlance, the ideal analysis of data would incorporate a time (time one compared to time two) by region (Eastern compared to North Eastern) by worker (adult mental health compared to others) by GTT program completed (completed compared to those who did not) to examine differences that include interactions between these variables.

Ideally such an analysis would require approximately 20 participants per subgroup to provide meaningful results – requiring approximately 320 participants. Unfortunately, although there were over 80 respondents to the first phase, there were only 33 respondents matched at the two time frames. Of the total respondents, 25 had completed GTT training and 53 had not, 40 were from the North East and 36 from Eastern Health, and 20 were adult mental health workers and 24 were other workers. As a consequence, a series of less ambitious statistical analyses were undertaken. Due to this lower sample size and lower statistical power, it was decided to examine each of the ‘between subject’ variables (i.e. region, worker type and attendance at program) separately, but with each paired with the ‘within subject’ factor of time. These analyses are outlined below.

Prior to these analyses is descriptive information regarding numbers of families with a mental illness seen by workers and general changes in knowledge regarding COPMI.

Numbers of COPMI and knowledge gained over time

57.7 percent of respondents did not have clients or patients younger than 13 years of age (28 did and 45 did not work with clients younger than 13).

Of the approximately one-third who did have clients/patients younger than 13 years of age all indicated that at least some of these children had a parent with a mental illness.

There were 78 respondents at time 1 and 32 at time 2 in relation to level of worker knowledge about COPMI. Figure 5.1 highlights that there was only one respondent at time 2 who had no knowledge about COPMI. In addition, the figure shows that the level of knowledge had increased over time with the time two graph showing increases within the ‘some’ and ‘a lot’ greater knowledge categories.

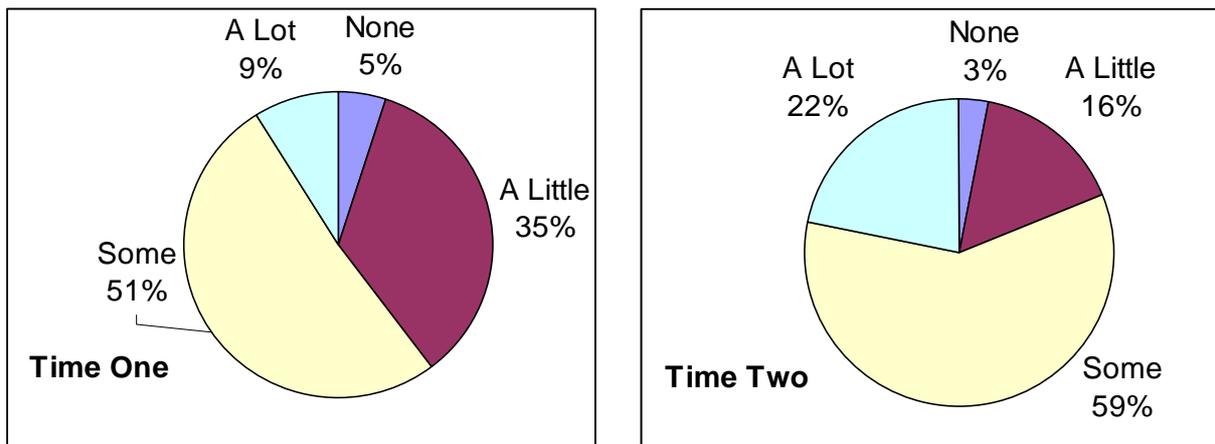


Figure 5.1: Frequency of respondents at times one and two according to level of worker knowledge about COPMI.

At time one, those participants who had some prior knowledge about COPMI were asked to indicate the source from where it had been obtained. Table 5.5 below indicates those sources.

Table 5.5: Respondents' sources of knowledge regarding information about the issue.

Source of knowledge	Number (%) respondents
I have had previous training (e.g. presentation/workshop) in this area.	24 (40%)
I have been involved in a camp or other program for such kids (e.g. after school program).	6 (10%)
Someone close to me has/had a mental illness (e.g. parent, friend).	16 (27%)
My own self-directed learning (interest) led me to investigate this issue (e.g. read something) further.	35 (58%) ²¹

The most common source of gaining information about the issue was from self-directed learning (58 percent). Also of interest was that 40 percent of participants had had some form of previous training in the area.

Key Finding

The methods through which Workers obtained information about COPMI were through training programs and self-directed learning.

²¹ Please note that participants could choose more than one area, hence the total percentage is greater than 100.

Changes over time according to region and type of worker

As a result of the lower sample sizes for subgroups, two series of two by two mixed method ANOVA's were undertaken. Both sought to determine whether there were changes within participants across the two time frames. The first analysis examined differences according to region, and the second according to type of worker. No significant differences were found for items 2-7 or 9-11 (see Appendix for items) either for region or workforce type. Question 8 items related to barriers are outlined in a later section of this chapter.

Key Finding

There were no differences in knowledge and/or skills in relation to COPMI, according to worker type or region, over time.

Changes over time for GTT

Once again, as a result of the lower sample sizes, a series of two by two mixed method ANOVA's were undertaken with time as the within subject factor and attendance or non-attendance at GTT training. In addition, as the sample sizes were relatively small (e.g. 13 attended and 19 did not), it was decided to report effect size data as well as significant difference statistics. This was undertaken as the former are not conditional upon sample size. Descriptive information is shown where necessary.

Table 5.6 shows means and standard deviations over the two time frames by attendance at GTT for questions 3-7.

Table 5.6: Means and standard deviations for changes in responses over time for questions 3 to 7 according to attendance or non-attendance at the GTT program.

Question	Time	GTT		No GTT	
		Mean	sd	Mean	sd
3. How much knowledge do you have about children whose parents have a mental illness?	1	1.62	0.77	1.68	0.58
	2	2.23	0.60	1.84	0.76
4. Over the last 12 months, what percentage of your clients/patients with a mental illness were also parents with at least some of their children living in their home?	1	51.67	43.55	34.00	25.58
	2	50.00	35.78	35.20	27.16
5. With that percentage of your clients, how often do you focus on their needs (or role) as a parent?	1	3.75	1.66	3.17	1.42
	2	4.00	1.04	3.22	1.22
6. Also with those clients, how often do you discuss or focus upon the needs of their children?	1	4.08	1.55	3.00	1.14
	2	3.92	1.26	3.28	1.23
7. What percentage of your clients/patients who have children living at home, could you discuss the problems that those children might have related to the parent's mental illness?	1	48.33	29.80	42.67	35.55
	2	52.50	39.34	48.80	35.31

There were generally increases in focus on COPMI of both attendees to GTT and non-attendees over time. While none of the analyses reached significance, the ANOVA for question 3 approached a statistically significant difference, $F(1, 30) = 3.56$, $p = .07$; Wilks' Lambda = .99; effect size = .11. This is a moderate to larger effect size, and suggests that the GTT made an important increase in the knowledge of participants about COPMI.

Key Finding

GTT improved the knowledge of participants about COPMI.

Barriers to working with parents and COPMI

Following on from question²² seven, participants were asked at time 1, "In the circumstances where they could not discuss the problems for the children what would be the barriers to them doing so?" Their verbatim responses to this question were combined, and then collated into categories and sub-categories where appropriate. Initially, the verbatim responses were examined independently by two of the researchers, and categories and sub-categories were created. Following slight changes, this led to the

²² Much of the following section is currently in press: Maybery, D.J. & Reupert, A.E. (in press). Workforce capacity to respond to children whose parents have a mental illness. *Australian and New Zealand Journal of Psychiatry*.

summary table of categories, sub-categories, number of times mentioned and sample verbatim responses (to illustrate the categories) in Table 5.7 below.

Table 5.7: Categories, subcategories, amount of times mentioned and sample verbatim comments from workers regarding barriers to effective service delivery to families affected by parental mental illness.

Category	Number of times mentioned (percent)	Sub-theme	Verbatim comments
Parent-related issues	14 (21)	Parent's mental illness	Level of discussion varies because of unwellness of client, chaotic day-to-day, lack of family support, poor decisions, high levels of stress, parents unable to focus on children's needs. Parents in survival mode, unable to see past themselves.
	17 (25)	Parent's lack of insight and knowledge about their mental illness and the impact of illness on children.	Client's denial that she has a mental illness. They [the clients] do not see they have an issue or they do not want to talk about it.
Child-related issues	3 (04)	Child availability	Children in foster care and client has little access. Child does not believe that parent has an illness. Children do not want to be involved.
Worker-related issues	9 (13)	Worker role, resources and time	Other agencies currently address children's needs (ie Human services, NECAMHS, Education). Distance, lack of transport. My time is taken up with addressing the needs of the parent. General lack of resources and time – helping parents etc is not seen as 'core' business.
	2 (03)	Worker lacks the appropriate knowledge and skills regarding <u>children</u>	Limited knowledge of child protection services. Limited personal and professional experience of children and child development.
	5 (07)	Worker lacks the appropriate knowledge and skills regarding <u>adults and mental illness</u>	Lack of information about the parent's problems. Not having a full understanding of a parent's mental illness – ie type and severity/impact.
Client-worker relationship	18 (26)	Potential disruption to the client-worker relationship, from both the client and the worker's perspective	Concerned that any comments made will be insinuating poor parenting. Parent is defensive.

Workers highlighted four key barriers to effective service delivery for families affected by parental mental illness. These were:

1. Issues within the mentally ill parent, such as his or her general state of sickness, preoccupation or lack of insight and knowledge about his or her mental illness and the impact of the illness on the child/ren;
2. The degree of access that the worker had to the child, as well what the workers considered to be an unwillingness of the child to be involved;
3. Worker issues including; worker role, resources and time²³, a lack of appropriate knowledge and skills regarding children, and a lack of appropriate knowledge and skills regarding adults and mental illness;
4. Client-worker relationship with participants reporting a potential disruption (or loss of rapport) to the client-worker relationship if they raised the issue of parenting and mental illness.

Key Finding

Barriers to working with COPMI families included the functioning of the ill parent, workers' level of access to children, inadequate resources for the worker, including time, and workers' perception that there would be a disruption to the worker-client/parent relationship.

As outlined earlier, these barriers were then developed into questionnaire items for inclusion in the second phase of this study.

These items were then included in all questionnaires that were then distributed including the time two measure. The focal aim of this point of the evaluation was to establish, through worker ratings, the relative importance of these barriers, and to determine any differences in barriers for adult mental health compared to other workers.

²³ On several occasions verbatim comments are summarised or combined to illustrate the points.

Table 5.8: Totals and worker type means and standard deviations (sd) for barriers to talking to clients about parenting issues and child-related issues.

Barriers	Adult worker (n=20)		Other worker (n=12)	
	Mean	SD	Mean	SD
c. The client does not see their illness as being a problem for their child/ren.	2.53	1.22	2.36	1.03
b. The client denies that they have a mental illness.	2.50	1.25	1.90	0.88
o. The children are not able to (e.g. they are in foster care) or do not want to be involved.	2.21	1.03	1.83	1.03
a. The client's mental illness is too active or they are too medicated.	1.94	1.30	2.20	1.14
p. There are problems of distance and transport for doing things with the child/ren.	1.95	1.27	1.92	1.00
d. The client just does not want to talk about their children.	2.05	1.31	1.73	0.90
q. Your organisation does not have the resources (inc time) to involve the children.	2.25	1.37	1.08	1.00
k. You have limited skills in working with such children.	2.00	1.21	1.33	1.07
m. If it would jeopardise the relationship you were trying to build with the adult client (e.g. rapport).	1.65	1.14	1.92	0.90
i. You have limited knowledge about working with children and the issues involved for them.	2.03	1.20	1.08	1.08
e. Client doesn't want to talk about it because they are concerned it will make things worse for their children.	1.74	1.37	1.45	0.93
j. You have limited knowledge about working with adult clients regarding the issues for their children.	1.82	1.12	1.17	1.03
l. You have limited skills to work with adult clients regarding their children.	1.60	1.10	0.92	0.67
f. You don't think your client's illness is a problem for their child/ren.	1.21	0.92	1.25	1.29
g. You don't have time to spend on the issue of the children.	1.40	1.23	0.90	1.10
n. You think that it will burden and be detrimental to the children.	1.10	1.02	1.17	1.19
h. It is not part of your role to get involved with the issues of your client's children.	0.65	0.59	0.92	0.90

Independent t-tests were then undertaken to compare responses from adult mental health professionals with other workers. For three barriers, the adult professionals responded with stronger agreement compared to the other workers. These included 'Your organisation does not have the resources (including time) to involve the children' ($t(30)=2.56$ $p=.02$), 'You have limited knowledge about working with children and the

issues involved for them' $t(30)=2.23$ $p=.03$ and 'You have limited skills to work with adult clients regarding their children' $t(30)=2.19$ $p=.04$.

Key Finding

Adult mental health workers are not adequately resourced (including time) to involve children.

Key Finding

Adult mental health workers are not skilled to work with children.

Also notable given the significant findings regarding knowledge and skill levels of workers was the higher agreement by adult workers on the two other skill and knowledge items 'You have limited skills in working with such children' and 'You have limited knowledge about working with adult clients regarding the issues for their children (ie impact of the problem on children, advising parents regarding parenting issues etc)'. Scores for both items were consistent with the scores on i and l above, suggesting that adult mental health workers have limited knowledge and skills in working with parents and their children.

Key Finding

Adult mental health workers lack the skills and knowledge to help their client's parents regarding their children.

In order to compare the barriers in terms of relative importance, Means and Confidence Intervals for the 17 barriers were calculated. It was decided to illustrate the relative importance of the barriers in this way for several reasons. The scores can be viewed and compared graphically, readers can also determine the relative spread of scores across the participants (i.e. the interval in which 95% of scores fall) for each barrier, and finally significant differences²⁴ can be determined (i.e. where Confidence Intervals do not overlap. For a detail exposition of the approach see Cumming & Finch, 2005. These are shown in Figure 5.2 below (the legend for barriers/items is shown in Table 5.8 above).

²⁴ For the purposes here it was not thought necessary to undertake t-tests to compare each of the barriers with each other. In addition, such an approach would increase the likelihood of family wise error.

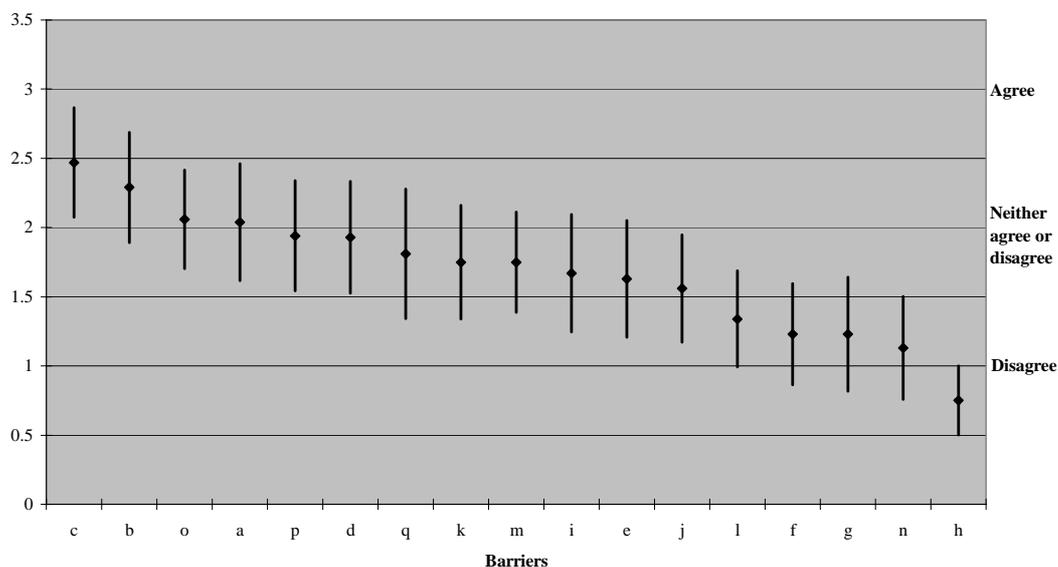


Figure 5.2: Comparison of Means and Confidence Intervals for the 17 barriers identified by workers.

Four groups of responses could be classified when participants were asked to rank the barriers. The group of items with the highest level of participant agreement were related to the illness and denial that there is an illness (i.e. c, b). The second group were rated as neither agree nor disagree, but somewhat ranging down to slightly disagree in relation to a broad range of issues such as accessibility to the child (e.g. distance and transport; p, o), lack of resources (q), lack of knowledge and skills (k, j, i) and issues to do with client rapport (m). A third group with means ranging around disagree included skills (l), creating a burden on the children (n), not being a problem to the child (f) and issues of time (g). The final and most disagreed with statement (and significantly different to the twelve other barriers) was in relation to not being part of my role to be involved with the child (h). It should also be noted here that confidence interval for this barrier was relatively small, indicating similar views across the participants in the study.

Key Finding

The greatest barriers for workers were when clients denied having a mental illness or did not see their mental illness as a problem for their children.

Changes in support to children and consultations over time for GTT

Two groups of questions (see totaled responses in Table 5.9 below) were devised to focus on changes in the behaviour of workers over time. The first of these included eight questions (see question 9 in the appendix) that focused upon the *level of support, education and referrals undertaken from time 1 to time 2*. The second group of 10 questions focused on *how often workers consulted with others (including referrals)* during

the period (question 10). Participants responded to both groups of questions on a 0-Never, 1-One Case, 2-A Few Cases, 3-Some Cases, 4-Many Cases, 5-All Cases.

As each group of questions was conceptually similar, and to simplify the analysis and reporting, as a first step, it was decided to combine these items to examine significant interactions (and effect sizes). However, differences were discerned between those who attended GTT programs compared to those who did not. Table 5.9 shows the changes in means and standard deviations for attendees and non-attendees over time. It is important to note here that attendees at GTT programs completed the first questionnaire just prior to attendance at a GTT training program, and generally there was a six month follow-up for completion of the second questionnaire (time two). However, it should be noted that the non-GTT attendees were from the same regions as those attending GTT and would have been likely to receive information about VicChamps and COPMI generally from other means (e.g. meetings, media, colleagues who did attend).

Table 5.9: Means and standard deviations for changes in responses over time for questions 9 and 10 according to attendance or non-attendance at the GTT program.

Question	Time	No GTT (n=20)		GTT (n=13)	
		Mean	sd	Mean	sd
9. Level of support, education and referrals undertaken from time 1 to time 2.	1	13.05	13.65	16.91	12.92
	2	12.68	9.19	21.55	8.58
10. How often workers consulted with others (including referrals).	1	4.86	5.61	11.55	7.88
	2	7.43	8.47	12.73	9.20

There was a slight decrease in activity reported by non-GTT attendees in the support questions, and a larger increase for attendees. While this did not reach significance in an ANOVA, there was however a small to moderate effect size, $F(1, 28) = 1.12$, $p = .37$; Wilks' Lambda = .96; effect size = .04 for the interaction between time and attendance at the program. This suggests that attendance at GTT made an incrementally greater increase in the knowledge of participants about COPMI compared to those who did not attend the training. There was no significant difference or effect size of note for question 10.

Key Finding

Attendance at a GTT program led to an increase in support, education and referrals regarding COPMI compared to non-attendance.

It was then thought pertinent to examine changes over time of individual items among these questions. Charts are shown below for those not attending and those who did attend a GTT program²⁵ with information from pre and post time frames. The two figures that follow show items from question 9: support, education and referrals. Figure 5.3

²⁵ As there were a total of 18 items, across the two questions, and the sample size was relatively small statistical analyses were not undertaken.

highlights changes that occurred generally in the workforce that were not associated with the GTT program (i.e. non-attenders).

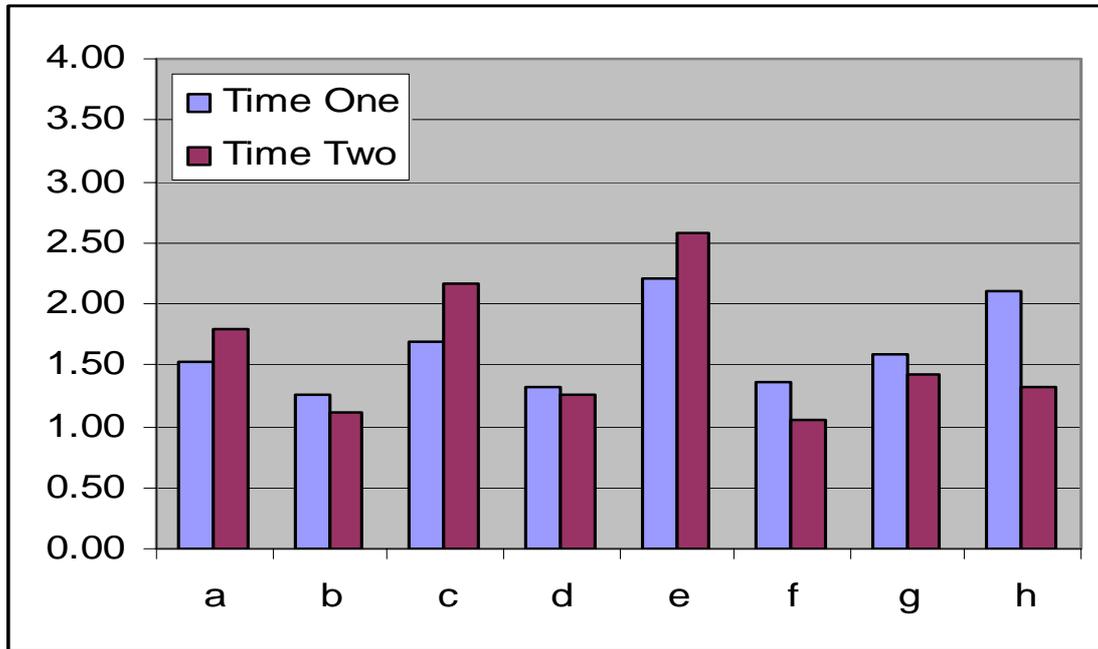


Figure 5.3: Changes in mean scores for sub items within question 9: Level of support, education and referrals undertaken by non attendees.

Legend: a=Meet with the family together, b=One to one contact with the child/ren, c=One to one counselling to the parent about the children, d=Emotional support to the child/ren, e=Emotional support to the parent about the children, f=Provided education or information to the parent to educate child/ren about mental health problem, g=Provided education or information to the child/ren about the parent’s mental health problem, h= Made a referral regarding the child/ren to another agency or practitioner

The greatest changes were in relation to ‘meeting with the family together’, providing ‘one to one counselling to the parent about the children’, and providing ‘emotional support to the parent about the children’. This suggests that the mere fact of programs operating in the regions led to improvements in meetings with families, more counselling and support to parents.

Key Finding

Changes in workforce activities resulted from the VicChamps programs operating in the regions.

A further interesting finding was that there was a reduction in ‘providing education or information to the parent to educate child/ren about mental health problem’ and ‘making referral to another agency’.

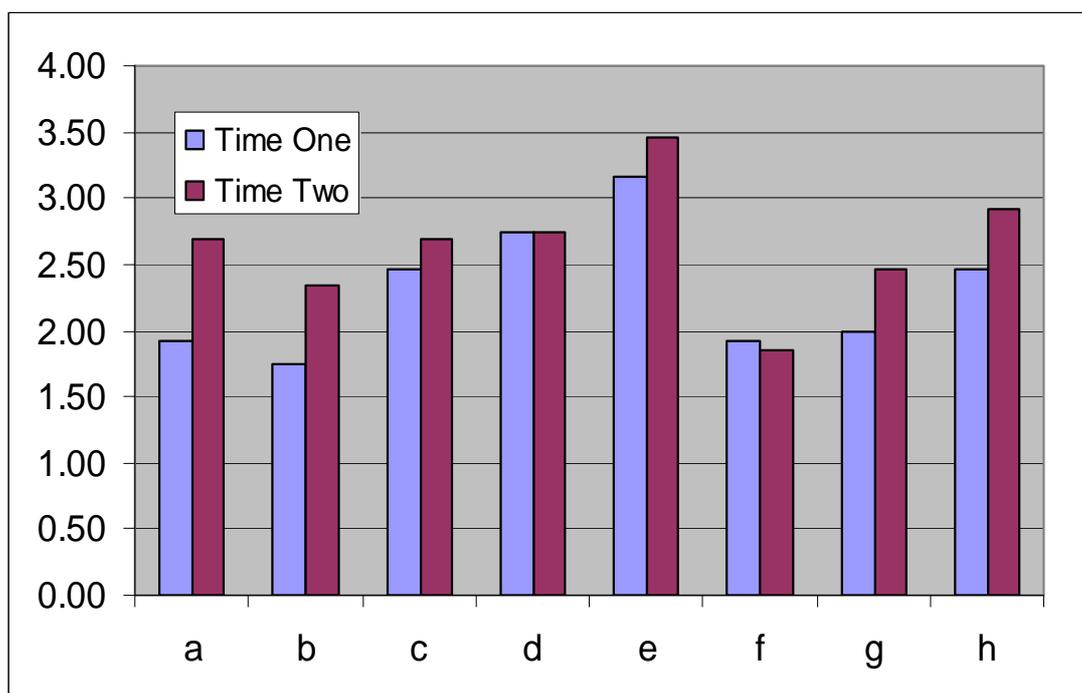


Figure 5.4: Changes in mean scores for items within question 9: Level of support, education and referrals undertaken by GTT attendees.

Legend: a=Meet with the family together, b=One to one contact with the child/ren, c=One to one counselling to the parent about the children, d=Emotional support to the child/ren, e=Emotional support to the parent about the children, f=Provided education or information to the parent to educate child/ren about mental health problem, g=Provided education or information to the child/ren about the parent's mental health problem, h= Made a referral regarding the child/ren to another agency or practitioner

Among the GTT attendees, there were larger increases in relation to 'meeting with the family together', 'having one to one contact with children', providing 'emotional support to the parent about the children', 'providing education or information to the child/ren about the parent's mental health problem' and 'making a referral regarding the child/ren to another agency or practitioner'. This suggests that the GTT leads to improvement in these areas.

In summary, while several changes were consistent for both groups, the most notable finding was that the GTT attendees did not decrease their COPMI behaviours across any activities, whereas the non-attendees did for several questions. In addition, the non-attendees reduced their behaviours regarding one to one contact with the children, providing education to parents, and in making referrals regarding the children, whereas the GTT group increased activities in these areas.

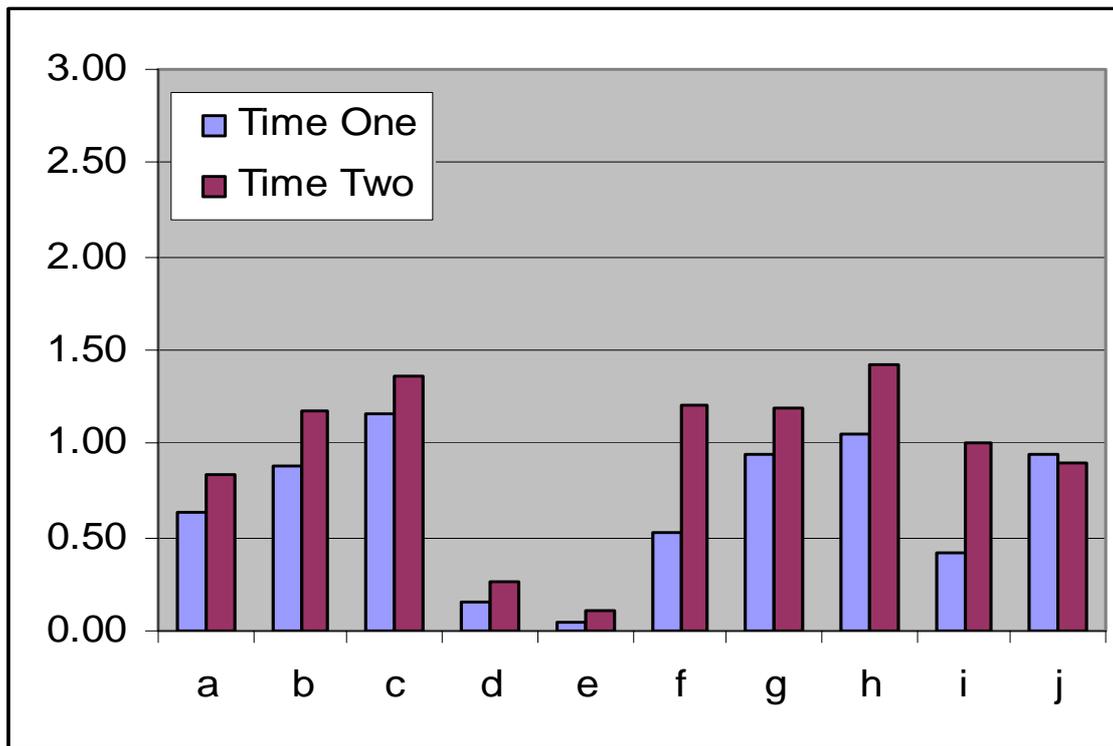


Figure 5.5: Changes in mean scores for items within question 10: How often workers consulted with others (including referrals) undertaken by non attendees.

Legend: a=GP, b=Mental Health Service Psychiatrist, c=Adult Mental Health Service Worker (e.g. Psychologist, nurse, social worker, O.T.), d=Private Psychiatrist, e=Private Psychologist, f=Psychiatric Inpatient staff, g=child protection worker²⁶, h=VicChamps/Supporting kids project worker, i=Education department personnel (e.g. school teacher, guidance), j=Health and welfare sector worker (e.g. community health worker).

The scores for non-attendees on question 10 showed increases in behaviours for almost all activities. The largest were for increased consultations with psychiatric inpatient staff, VicChamps and education department personnel and health and welfare sector workers. While caution should once again be maintained in interpreting these results, this suggests that regional employees, who did not attend a GTT program, increased their COPMI-related behaviours over time.

²⁶ Unfortunately, as this item was only included in the second phase of the questionnaire, conclusions are not able to be drawn concerning this item.

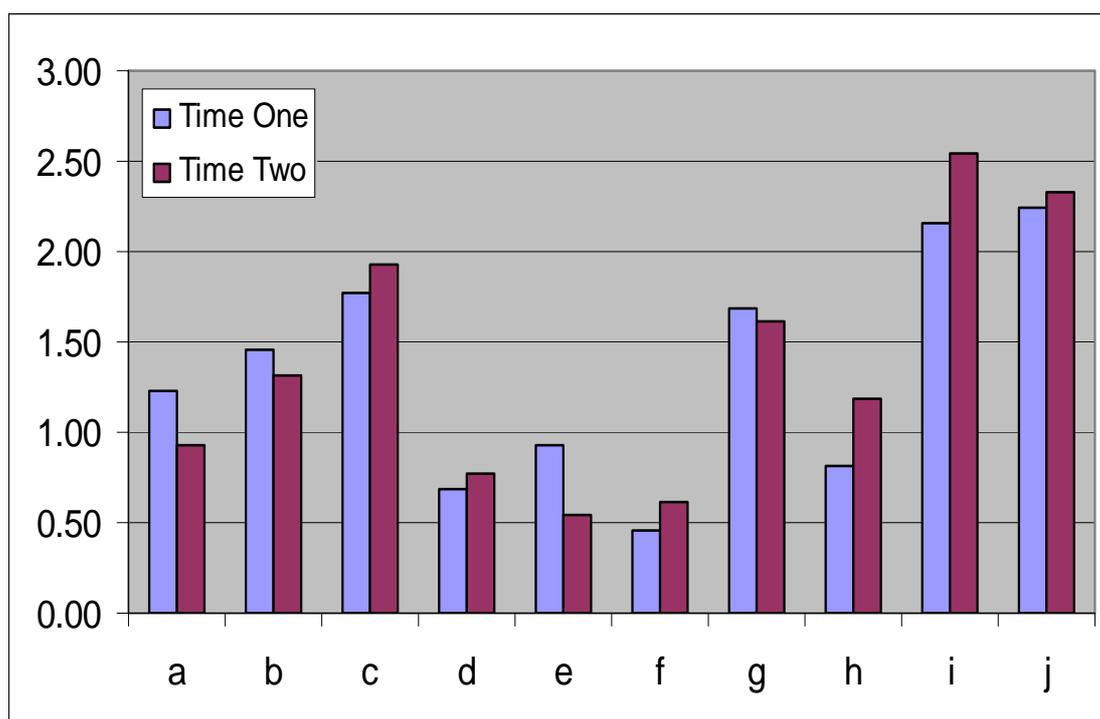


Figure 5.6: Changes in mean scores for items within question 10: How often workers consulted with others (including referrals) undertaken by attendees at GTT session.

Legend: a=GP, b=Mental Health Service Psychiatrist, c=Adult Mental Health Service Worker (e.g. Psychologist, nurse, social worker, O.T.), d=Private Psychiatrist, e=Private Psychologist, f=Psychiatric Inpatient staff, g=child protection worker, h=VicChamps/Supporting kids project worker, i=Education department personnel (e.g. school teacher, guidance), j=Health and welfare sector worker (e.g. community health worker).

The highest increase in activities during the period was in relation to VicChamps project workers and education department personnel. However, it is interesting to note that some other activities decreased. These included consultations with GP's, mental health psychiatrists and private psychologists.

Key Finding

Over time all regional workers consulted more often with VicChamps personnel.

In addition, GTT participants scored much more highly on all items at time one compared to non-attenders. This suggests that those who attend GTT programs are a 'special subgroup' of workers in the community. This also perhaps highlights the need for additional means of educating those who do not attend GTT programs.

Key Finding

Attendees at GTT undertook more activities in relation to COPMI prior to attending than non attendees.

Satisfaction with and benefits from VicChamps activities

For those participants who completed this part of the questionnaire at the two time frames, there was no difference between their scores for how beneficial the VicChamps program was during the period (question 12). As a consequence, the following data is reported from the second (i.e. most recent) recording from those participants who completed the questionnaire at both times. In addition to how beneficial the program was overall, this section reports the level of benefit of various sub-activities within the question (e.g. items 13(a) to 13(f)).

The following figure highlights the level of benefit from VicChamps across regions, workers and programs. Level of benefit was scored on a scale of 0 = None, 1 = A Little, 2 = Some Benefit, 3 = A Lot or 4 = Very Beneficial.

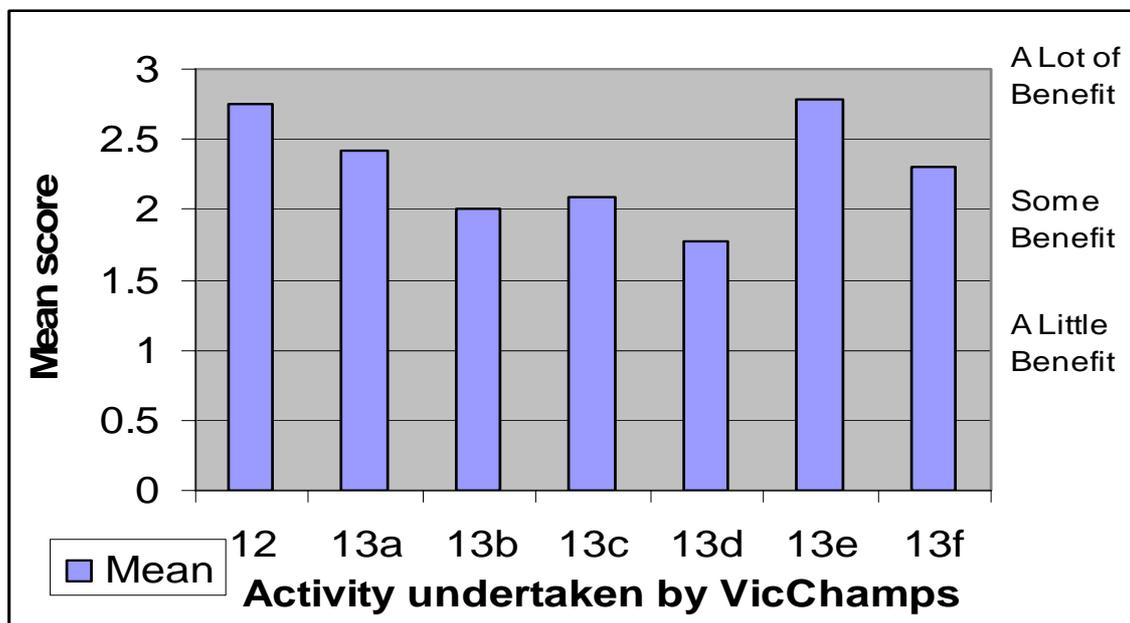


Figure 5.7: Level of benefit from components of the VicChamps program.

Legend: 12. How beneficial has VicChamps been overall, 13a. Provided information/knowledge about COPMI (e.g. GTT), 13b. Improved my skills regarding COPMI, 13c. Improved my skills regarding working with parents, 13d. Provided secondary consultation/s regarding COPMI, 13e. Provided programs for COPMI, 13f. Provided (improved) resources (e.g. materials, books etc).

Participants generally scored the VicChamps program as approaching a lot of benefit overall and, apart from secondary consultations being lower, the specific items were each scored to be between some and a lot of benefit. However, regarding secondary consultations, it should be remembered that these were tempered by the higher level of consultations overall to adult mental health workers. The finding here suggests that the 'other workers' lower scores regarding secondary consultations reduced the overall mean score.

Programs for COPMI was seen as providing a lot of overall benefit to workers. Providing information, knowledge and resources regarding COPMI were scored as providing some benefit to workers (with the exception of secondary consultations as discussed above).

Key Finding

All Workers considered the VicChamps program to be from some to approaching a lot of benefit.

General workforce changes–regional differences

A series of independent sample t-tests were then undertaken to determine whether there were significant differences in general and specific activities undertaken by VicChamps personnel (see Table 5.10 below for activities). There were no differences in any of these activities according to the attendance at GTT, and there were only two differences in the specific activities. These differences were regional, in that workers' skills from Eastern region for working with parents (M=2.47, sd=1.23) were improved to a significantly greater degree compared to the North East (1.53, 1.42; $t(1,32) = -2.07, p=.047$).

Key Finding

Skills in working with parents were enhanced to a greater degree in the Eastern compared to North East region.

There were also significantly more secondary consultations provided (across both regions) for adult mental health workers (M=2.40, sd=1.30) compared to other workers (1.00, 1.13); $t(1, 28) = 3.15, p=.004$.)

Key Finding

Significantly more secondary consultations were undertaken across the regions with Adult mental health workers.

Additional feedback from questionnaire participants

Two final open-ended questions at time 1 asked participants for their opinions regarding what additional things might support them to assist the children of their clients/patients. The participants focused on assessment (the need for assessment tools), interventions (How to support and communicate with the parent and child) and referral (Who/what refer to) of COPMI family members. The other key issues were a need for greater resources (including specialised services for the client group), services for older children and adolescents (over 12), greater information (More training and information on impact to child of having a parent with a mental illness) and issues to do with agency policies (Standards of practice).

A final question focused upon the design of future training in the area, asking what do you believe you need to have further information on? From the sixty time one respondents:

- 70 percent indicated that they would like more information on how to educate or inform children about the parent’s illness;
- 68 percent wanted programs to help such children in the local area;
- 65 percent wanted information/education regarding attachment/connectedness issues for the children;
- 62 percent wanted more training programs for workers; and
- 60 percent wanted information about problems for children regarding parent hospitalization for their illness.

Evaluation of Getting There Together: Satisfaction questionnaire

Participants at a number of Getting There Together seminars/presentations anonymously responded to a single page satisfaction questionnaire immediately following the program. The following data reports from fifty-seven participants²⁷ from two separate presentations held in May and June 2004.

Initially, participants were asked if the program met their needs. Forty-five participants said yes, two said no and three said yes and no. To the question, ‘would you recommend the program to others?’ 44 said yes, two said no, and one said yes and no. Participants also rated the seminars on a four-point scale from Very Good to Unsatisfactory (see Figure 5.7 below).

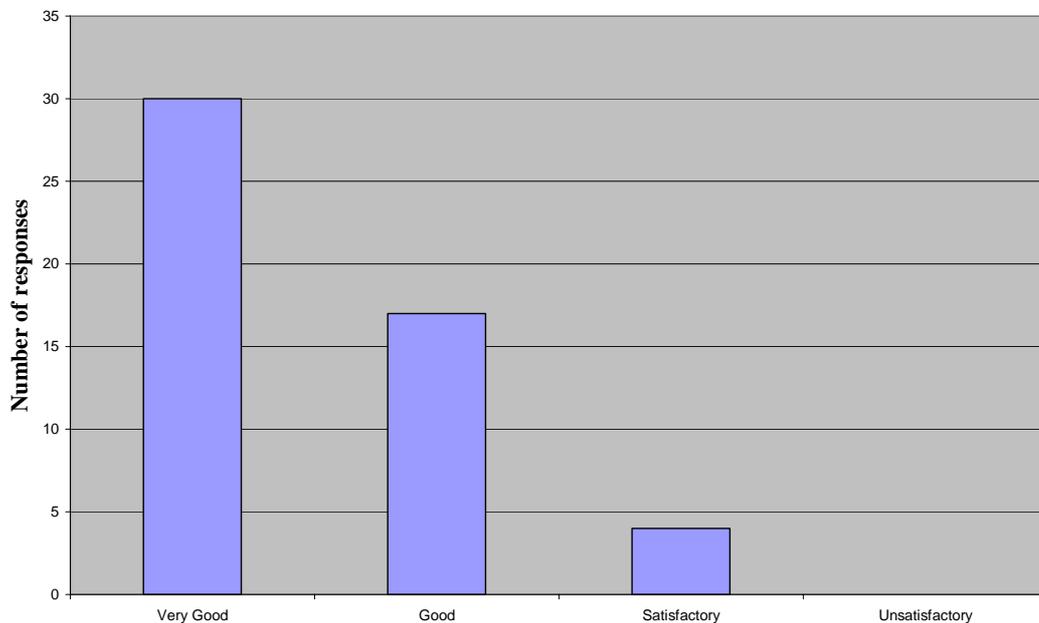


Figure 5.7: Participant rating of Getting There Together seminar

Overwhelmingly, the participants thought the seminars were Very Good, with none indicating that they were unsatisfactory.

²⁷ Note that there is missing data on some items.

Key Finding

Participants rated the Getting There Together presentations as very good.

Participants also were asked the most and least useful aspects of attending the training program. Tables 5.10 and 5.11 summarises their verbatim responses.

Table 5.10: Categories, description and sample verbatim comments of feedback about Getting There Together program regarding *What were the most useful aspects?*.

Category	Description	Verbatim comments (selection of responses only)
Presentation by consumer	Personal experience with mental illness in parent/family context – personal account of problem.	Parent and carers story - grounded the stats back in reality Hearing a personal account The personal stories (numerous) Parent experience Consumer presentation, talking to children Interacting with parents with mental illness, children of parents with a mental illness Clients/families perspective
Knowledge	Improved knowledge and information re mental illness and its impact on family	Understanding the hurdles that families face. Very informative practical level Overview of mental illness, risks for 2-8 year olds, clear outline of issues Strategies for working with young people
Resources	Resource information including service availability	Knowing about resources Discovering community links for families helps.
Presenters	Quality of presenters	Well presented This was really helpful and informative

Key Finding

The Getting There Together program increased the knowledge of participants about COPMI.

Participants found that the presentations by consumers, including the presenters' personal experience with mental illness in the parenting and family context, to be very worthwhile. They also indicated that the information and improved knowledge regarding mental illness and its impact on the family was important, as was the knowledge gained about resources including service availability. Finally, participants were very positive regarding the quality of the presenters.

Key Finding

Participants reported that important aspects of the Getting There Together program are quality presenters and the personal experiences and stories of parents/carers.

Table 5.11: Categories, description and sample verbatim comments of feedback about Getting There Together program regarding *What were the least useful aspects?*

Category	Description	Verbatim comments
Risk/resilience	Risk and resilience factors for children	Risk/resilience session could have been more concise Risk/resilience factors (numerous)
Working with mentally ill client	Strategies for working with mentally ill clients (such as at DHS)	Would have been helpful to get some strategies for working with clients who deny that they require intervention There was limited information for DHS workers specifically when trying to engage resistant families ie parents reluctance to express the reality of the situation due to fears of the child being removed
Mental illness	Information regarding illness and current treatments	Minimal information regarding current drug treatments - this may have been deliberate but I hoped to be updated in current treatment drugs as many families are on them. Mental illness

In terms of the least useful aspects, participants indicated that there could have been more information regarding factors contributing to risks and resilience for children, more on strategies for working with mentally ill clients (such as at DHS), and information about mental illness generally including current treatments.

While several criticisms of the program are highlighted above, readers should note that the positive feedback on the program far outweighed the negative. This was exemplified by several comments to the question, What were the least useful aspects? “Nothing – all of the information was useful” and comments such as “Excellent training - the usual high standard of presentation from Eastern Mental Health Service.”

Key Finding

Criticisms of Getting There Together program were far outweighed by positive responses.

Finally, participants were asked to respond to “Are there any other topics/education sessions that you would like to know more about?” They indicated according to two categories. The first was associated with the need for greater skills associated with working with the mentally ill parent, and included such things as:

- Actual strategies for working with parents with mental illness and teaching parenting styles (numerous);
- Working with people in denial; and
- Yes, programs/education for mothers re baby bonding for mothers with postnatal illness.

The second focal area was related to the child. This focused on future sessions regarding:

- More in-depth information from the child’s side (re attachment, bonding and the impact on development);
- Mental illness and attachment – the prevalence of disability/delay;
- Working day-to-day with mothers and more from an infant point of view - impact on infants; and
- How mental health issues impact on sibling to sibling relationships.

Key Finding

Additional training should focus on more detailed information regarding attachment, risk/resilience, the impact on development and siblings for children, treatments and skills and strategies for working with mentally ill clients regarding parenting and bonding with their children.

Issues for further discussion

The following provides a discussion and recommendations regarding issues identified in this section in relation to workforce development. As with earlier sections, raising these points aims to instigate discussion about the findings in order to be instructive to policy makers and programmers about workforce development and policy, suggesting how evidence about the current ‘state of play’ might be employed to influence future practice.

Programs that work

The Getting There Together program made important improvements in the knowledge and activities of participants about families with a parental mental illness. This included increasing the number of meetings with families, one to one contact with the children, emotional support to parents about the children, and providing education or information to the parent to educate child/ren about mental health problems. The program also led to increases in support, education and referrals compared to non-attendees. In addition and over time, workers consulted more often with VicChamps personnel as a result of the program. The Getting There Together program is an important vehicle for the delivery of information and skills regarding COPMI issues.

Recommendation: The GTT program is recommended as a vehicle to develop knowledge and practice changes in both mental health and health and welfare workforces.

Recommendation: That GTT type programs be implemented in regions in order to engender cultural as well as systemic, change within regional workforces.

Strategies for improving knowledge, skill and activities of those who don't attend Getting There Together style programs

While Getting There Together is an important vehicle for change, there remain many workers who did not attend this program. The finding that those who attended had more knowledge and skill prior to their attendance suggests that there must be at least a minimum level of understanding of the issues before a worker will attend. In addition, further strategies may be necessary to target those people who do not attend. This might include approaches such as using the media, in-house training and/or multi-media approaches. It should also be kept in mind that the main methods used by workers to obtain information about COPMI were from training programs and self directed learning. In addition, this perhaps points to a need for workers to receive a basic level of training regarding COPMI issues as part of their tertiary education prior to commencing employment.

Recommendation: That other awareness-raising media be implemented to improve knowledge about the issue in the current workforce, and that information be provided to new workers as part of interview and orientation to positions.

Recommendation: That mental health workforce competency standards include principles in relation to knowledge and skills regarding working with families with a parental mental illness.

Recommendation: That universities and TAFE colleges provide knowledge and training to mental health and welfare students (e.g. psychologists, social workers, occupational therapists) as part of their undergraduate and postgraduate degrees.

Workforce barriers to improving outcomes for children of clients/patients with a mental illness.

The greatest barrier for workers was their perception that clients do not recognise their mental health as being a problem for their children, and clients denying they have a mental illness at all. Consequently, training programs need to focus upon skills training that helps workers maintain client rapport, but also defuse and/or manage clients who are resistant and/or reluctant to discuss parenting issues or the impact of their mental illness on their children. All workers need to develop the skills to manage clients regarding these barriers.

Recommendation: That workers in mental health and welfare generally receive skills training regarding the management of clients who are resistant and/or reluctant to discuss parenting issues or the impact of their mental illness on their children

Barriers specific to Adult Mental Health Workers

There were important differences between adult mental health and other workers in the types of barriers reported when working with families affected by parental mental illness. Adult mental health workers reported limited skills in working with children and with adult clients on issues regarding their children. The table below summarises these areas of deficit (along with information from previous research in this area (e.g. Bibou-Nakou, 2003; Byrne, et al., 2000; Dean & Macmillan, 2001; Grunbaum & Gammeltoft, 1993; Nicholson, 2005), and includes training implications.

Table 5.12: Skill and knowledge deficits reported by adult mental health workers, when working with families affected by parental mental illness and their training implications.

Client	Knowledge/skill deficit	Training implication
Parent	Assessing parenting capacity Providing parenting advice Knowledge regarding the impact of a parent’s mental health on family and child functioning	Training in assessing and judging parenting capacity, providing parenting advice, and the ability to discuss with clients the impact of their mental illness on their children, in a sensitive and empathic manner.
Children	Knowledge in working with children, and the issues involved with them Knowledge about child development and the likely impact of illness at various stages Knowledge and skills regarding information transfer to children, according to their age and stage of development	Training that focuses on how to work with children, including how to talk and engage children. Training also needs to include specific information about child development, and the impact of a parent’s mental illness on such development. Enhance workers’ skill in providing age appropriate education to children of different ages about parental mental illness.

Training for adult mental health workers should thus be considered from two general foci, the first pertaining to their client's parenting capacity and the second, issues associated with the child/ren of the parent with the mental illness.

Recommendation: Adult mental health workers should receive skill and knowledge training regarding the impact of parental mental illness on children (developmentally), and in how to work with children.

Recommendation: Adult mental health workers should receive training regarding working with their mentally ill adult clients regarding family-related issues (e.g. parenting).

Recommendation: That adult mental health workers should identify clients who are parents on entry to the service, and plan their treatment with that in mind.

Resourcing mental health workers

While there is a clear need for the training of Adult Mental Health workers, as described above, this would seem a fruitless exercise unless resources (most notably time) are increased to allow such workers to engage with a family rather than merely their individual clients who are parents.

Recommendation: Adult mental health services should be provided with additional resources to allow workers additional time to work with their mentally ill clients who are parents regarding family-related issues.

Barriers to working with families for other key health and welfare personnel

Other than minor comments regarding the need for greater training/information for Human Service workers, little information is known about the barriers to working with families where a parent has a mental illness from the perspective of several other key groups of personnel. Future evidence should be gathered regarding the barriers to working with COPMI families among child safety and family workers within the Department of Human Services and General Practitioners. These would appear to be important front-line workers relevant to interventions for COPMI families.

Recommendation: Future research should be undertaken to examine the barriers faced by Department of Human Services personnel and General Practitioners to working with their mentally ill clients who are parents, regarding family-related issues.

Chapter 6: Program facilitator networks and network development

Networking activities implemented by the VicChamps staff aimed to facilitate a cohesive and coordinated approach across different sectors, agencies and community groups in responding to the issues affecting children whose parents have a mental illness. Networking was seen as vital to the VicChamps process in order to increase community and agency awareness of the needs of these children and to enhance systemic sustainability, so that the responsibility of supporting these children is broadened to many organisations and agencies.

In the literature, network evaluation and analysis is generally focused on the number and strength of relationships between organisations. In terms of VicChamps networking, the different co-operative alliances refer to *referrals to* VicChamps, *referrals from* VicChamps, the running of *joint programs*, *sharing information* (for example at conferences, at meetings and professional development activities), *collaboration on projects and clients* and finally input to *policy formation*. These types of linkages are amongst the most frequently mentioned coordination activities associated with successful service integration (Agranoff, 1991; Milton & Provan, 1998). As many of these activities are closely related to workforce change and a systematic capacity for working with families affected by parental mental illness, this chapter needs to be read alongside the previous workforce development chapter (5).

It is important to evaluate network effectiveness in order to identify whether services are being duplicated and to ensure resources are being effectively utilised across the community (Milton & Provan, 1998). When evaluating networks both *breadth*, that is how many organisations VicChamps network with, as well as *depth*, how closely VicChamps network with these organisations, need to be considered (Milward & Provan, 1998). Furthermore, network changes over time also need to be identified, in order to highlight what Bardach (1996) described as ‘interorganizational capacity’, which in this context indicates how agencies increasingly become interrelated over time.

The types of network activities undertaken by VicChamps staff

Various activities were undertaken (other than direct referrals) by the two VicChamps teams to establish and facilitate networking within and between community groups and other agencies. The type and frequency of these activities are listed in the two tables below.

Table 6.1: The type and frequency of network activities undertaken by North East.

Networking activities	Frequency over 3 years
Attend and/or organise various <u>networking meetings</u> such as the Wodonga District Interagency team, UMPC programs.	6
<u>Joint program facilitation</u> : running VicChamp activities with a worker from another organisation. Worker from Wangaratta AMHS at 3 programs; one from Wodonga AMHS and another from NECAMHS	5
Contributing to policy formation: Kerferd now includes questions about parenting status as a result of VicChamps input.	1
<u>Other organisations for venues</u> in which VicChamp programs and meetings might be run: UMFC both Wodonga and Wangaratta, Wodonga AMHS and NECAMHS, and Trinity.	5
<u>Education activities</u> such as ‘Getting there together’, ‘SKIPS’, conference and staff presentations. These have occurred at Kerferd Unit twice, Wangaratta AMHS 3 times, Wodonga AMHS twice, TheMhs three times, and once at each of the following: DHS at risk children meeting, Hume region counsellors network, Yarrunga PS, Benalla East PS, Trinity. Rural health week conference. TAFE presentations, twice in Wangaratta, once in Wodonga. Mental health week community expos, one in Wangaratta and one in Wodonga. Presentation to CAMHS, Albury.	21
<u>Media presentations</u> : Radio interviews at 2CO and Wodonga community radio. DHS newsletter article. Twice in Bordermail (Wodonga), twice in Wangaratta Chronicle.	6
Distribution of brochures, flyers, posters and referral packages	500 approx

Table 6.2: The type and frequency of network activities undertaken by Eastern Region.

Networking activities	Frequency over 3 years
Attend various <u>networking meetings</u> : these include Eastern Network of Family Mental Health, Women’s Mental Health Network, Primary Care Partnerships, Carer’s Network, Healesville Community Network, Lilydale Network, Outer East Liaison Meeting, PATS reference group, FAMHN (Families of Mental Health Network), COPMI ‘e’ network and reference group.	121
<u>Joint program facilitation</u> : running VicChamp activities with a worker from another organisation.	14
<u>Contributing to policy formation</u> : created formal portfolio holders in Eastern Health; delivering a family sensitive practice policy for Eastern Health, Mental Health Program	8
<u>Other organisations for venues</u> such as running peer support groups with family support agencies	9
<u>Education activities</u> such as ‘Getting there together’, ‘SKIPS’, conferences, staff presentations, and ‘train the trainer’ programs	20
<u>Media presentations</u> including school newsletters, radio interviews (3) and newspaper articles (5).	8
Distribution of brochures, flyers, posters and referral packages	532

Key Finding

Key networking activities undertaken by VicChamps staff include (i) attending and organizing network meetings (ii) joint program facilitation (iii) using other organisations’ venues for VicChamps activities (iv) educational activities, (v) media presentations and (vi) distribution of brochures, flyers, posters.

Evaluation

There were four measurement approaches employed to identify and evaluate network development and organization:

1. Facilitator interviews,
2. Network maps,
3. Secondary consultation numbers, and
4. Key stakeholders interviews.

A description of each of these tools and the findings follow.

Facilitator interviews

The aim of the facilitator interviews was to identify the activities that were being undertaken in relation to the issue of networks, policies, and the education of staff regarding the needs of children whose parents have a mental illness. The interviews sought to measure networking themes, as well as provide an opportunity to identify differences in the implementation of programs from the two sites, namely:

- (i) a rural compared to an urban perspective,
- (ii) a service delivered from within mental health compared to one from community agencies, and finally
- (iii) an established service compared to one that recently commenced (i.e. North East).

There have been five interviews with Eastern Health staff and five with North East region staff up until the end of March, 2006. Facilitator interviews were undertaken every three to six months with the two groups of program facilitators (periods were longer towards the end of the three year project). The semi-structured interviews were generally one to two hours and were tape recorded, and transcripts (not verbatim) containing central concepts were developed. These transcripts were then forwarded to the interviewees for comment and changes were subsequently made, as appropriate.

North East Region

Facilitators identified several themes throughout the interviews regarding network activities. These relate to:

- (i) working from a community setting,
- (ii) joint program facilitation with other workers on VicChamps activities,
- (iii) having 'flexible' rather than unclear boundaries of responsibility,
- (iv) creating strong links to child focused community organisations, and
- (v) the importance of interagency network meetings.

Working from a community setting: Working with adult mental health has been somewhat difficult from the commencement of the project. Difficulties have included a lack of referrals, a lack of involvement of adult mental health in district networks, not returning phone calls and the rejection of offers to speak at some adult mental health services. This was partially overcome by an involvement of North East facilitators in cases managed by adult mental health, involving some individuals in programs and attending staff meetings. Developing relationships and spending time with such agencies was very important to

develop these links. While initially workers considered this to be a credibility issue, at present the VicChamps facilitators are confident that they are regarded by other workers as experts in this field, with something to offer to children whose parents have a mental illness. Inviting organisation members to be part of the Supporting Kids committee, and holding committee meetings at the venues of targeted organizations, have been approaches that have attempted to build this network with clinically oriented organisations over time.

Key Finding

Working with adult mental health in parts of the North East has been difficult from a community setting. Working with case managers, involving workers in the peer support programs, and attending staff meetings has helped improve networks with adult mental health.

Joint program facilitation: Inviting personnel from other agencies and organisations to assist in the running of various VicChamp programs has been a successful networking strategy. Solicited feedback (not anonymous) from a program volunteer included:

I feel that having a staff member from within the inpatient facility [herself] has strengthened my relationship with the program staff and strengthened our stance as an organisation with both family members and the participants.

Involving other agency workers in joint program facilitation was easier to implement when the worker's current role or client base encompassed the issues of children or families, for example, the psychologist from NECHAM team whose responsibility was to promote mental health in schools. She then assumed the responsibility to present information to teachers relating to 'Supporting Kids' (aka VicChamps).

Flexible boundaries of responsibility: The VicChamps workers reported that some families and organisations expected that they would offer a broader service than they do at present (for example, provide a long-term service for children and/or provide ongoing support for parent/s), rather than assuming responsibility themselves or considering other avenues of support. As one of the VicChamp workers said:

Well, some people [agency workers] think we are there to work with kids whose parents have a mental illness, so they will refer on to us, rather than consider what they can do themselves.

According to the program coordinator, the boundaries of involvement have deliberately been kept open in the initial stages of the project, as the facilitators were still determining their respective role and responsibilities. As the VicChamps facilitators became more aware of other agencies, and other agencies became more aware of the needs of children whose parents have a mental illness, the rules of engagement became clearer. Rather than unclear boundaries, the approach was flexible types of engagement with the different types of communities (for instance Wodonga versus Wangaratta).

Strengthening links with child focused community groups: North East VicChamps has networked with child-focused community agencies and other local community organizations, such as girl guides, cubs, soccer and so on, to further connect children to their local communities. The networking undertaken by VicChamps staff has involved letting families know about organization, and assisting with any potential problems that families might have with transport and finance.

Interagency networks: VicChamps staff attend and organise various network meetings. These forums provide opportunities for workers to share program information, and to raise awareness of issues affecting young people in their local area. Both facilitators stress the significance of these various networks, and the importance of incorporating this network role into their position statements.

Key Finding

Network development in the North East was initially constrained by VicChamps being community rather than mental health based. Attendance at programs by mental health personnel on VicChamps activities have assisted in developing networks with mental health organisations.

Key Finding

As a recently established service, it was important for North East VicChamps to have 'flexible' boundaries of responsibility.

Eastern Health

Facilitators identified several themes throughout the interviews regarding network activities. These relate to:

- (i) managing an overload of referrals and secondary consultations,
- (ii) working from an adult mental health sector,
- (iii) identifying organisational 'champions',
- (iv) implementing a process of organisational and policy change, and
- (v) establishing a 'Train the Trainer' model of delivery.

Referrals and secondary consultations: Referrals have been consistently high and constant over the course of the current project, because of the strength of existing networks and the facilitators' previous successful experience in the program. At many times, this has been an 'overload' issue.

Working from the adult mental health sector: One of the challenges facing facilitators from within adult mental health has been ensuring that the profile of the needs of children of a parent with mental illness remained on the agenda in the community sector. Although partial links with the community sector were established, and the profile of VicChamps was well established, the facilitators relied on community networking forums to continue to raise the profile of VicChamps and to build stronger relationships with community agencies. VicChamps were represented on a number of network forums operating throughout the Eastern sector. Links with the community sector was further enhanced by participation in VicChamps programs like ‘Getting There Together’ and ‘train the trainer’ programs, and identifying key personnel from different agencies to act as organizational ‘champions’.

Identifying organisational ‘champions’: Facilitators identified ‘champions’ within various services, that is, workers who are interested and able to advocate for the needs of children whose parents have a mental illness, as well as raise the profile of VicChamps within their own organisations. Such ‘champions’ also fulfill the role of educating other workers within their organization, and work as a referral source to and from VicChamps. While sending information out to various agencies was considered important, utilising workers within organisations was regarded as more effective in terms of raising the profile of children whose parents have a mental illness across the agency sectors, and at a policy level. In addition to organizational ‘champions’ in the community sector, similar roles were given to organizational ‘champions’ within adult mental health, and these key people were identified as ‘portfolio holders’.

Key Finding

Identifying ‘organisational champions’ within and outside mental health is very important.

Organisational change: Related to the identification of organisational ‘champions’, a sequenced professional development plan for mental health workers was developed in this region. This involved three steps:

- (i) training workers regarding the issues of children whose parents have a mental illness,
- (ii) recruiting key people in different services so they can advocate and filter through the message of VicChamps (‘identifying champions’), and
- (iii) establishing and maintaining the support of different agency managers. As VicChamps in Melbourne operated from a clinical setting, the prevailing view was ‘change from within’ rather than ‘change from the outside’ when working with agencies. Both a ‘top down’ approach in working with management, as well as a ‘bottom up’ approach in networking with key workers, was seen as essential for facilitating organisational change.

When facilitating organisational change, it was considered important to have support from all levels of the organization. Upper management support was considered imperative to

drive policy and system change. The support of key workers on the ground was also essential to implement these changes in their daily practices. However, the most important avenue of support was from middle management, as it is often their responsibility to mandate and embed these policy changes (e.g. time allocation) for the key workers.

“We realized that when we educated workers on the grass roots level that we also had to target upper management. To ensure change within an organization is sustainable it needs to be ratified by upper management, which takes time, lobbying and respect for their way of doing things.”

Key Finding

Eastern region focused extensively on policy formation and organizational change.

‘Train the trainer’ model: Eastern Health facilitators implemented a ‘Train the trainer’ package in which other agency workers were trained in running the various VicChamps programs, with the support of VicChamps facilitators. A two-day training program for 22 key workers has been conducted that involved broad training on running groups for kids, including VicChamps programs. These training programs were seen as important by the facilitators to build a broader base of programs that could be made available to the target group within their organization. An addition benefit was to pass on their learning experiences of working with mental health clinicians with the target group, which can be disseminated to other workers in their organization. From this training, one program will be run in 2006 without VicChamps staff. Five community agencies have indicated that they would like to facilitate peer support programs within the region, but with on-going consultation and support from adult mental health. Further training is planned in future. There is still a perception within the community sector that expertise is held by adult mental health clinicians for working with the target population.

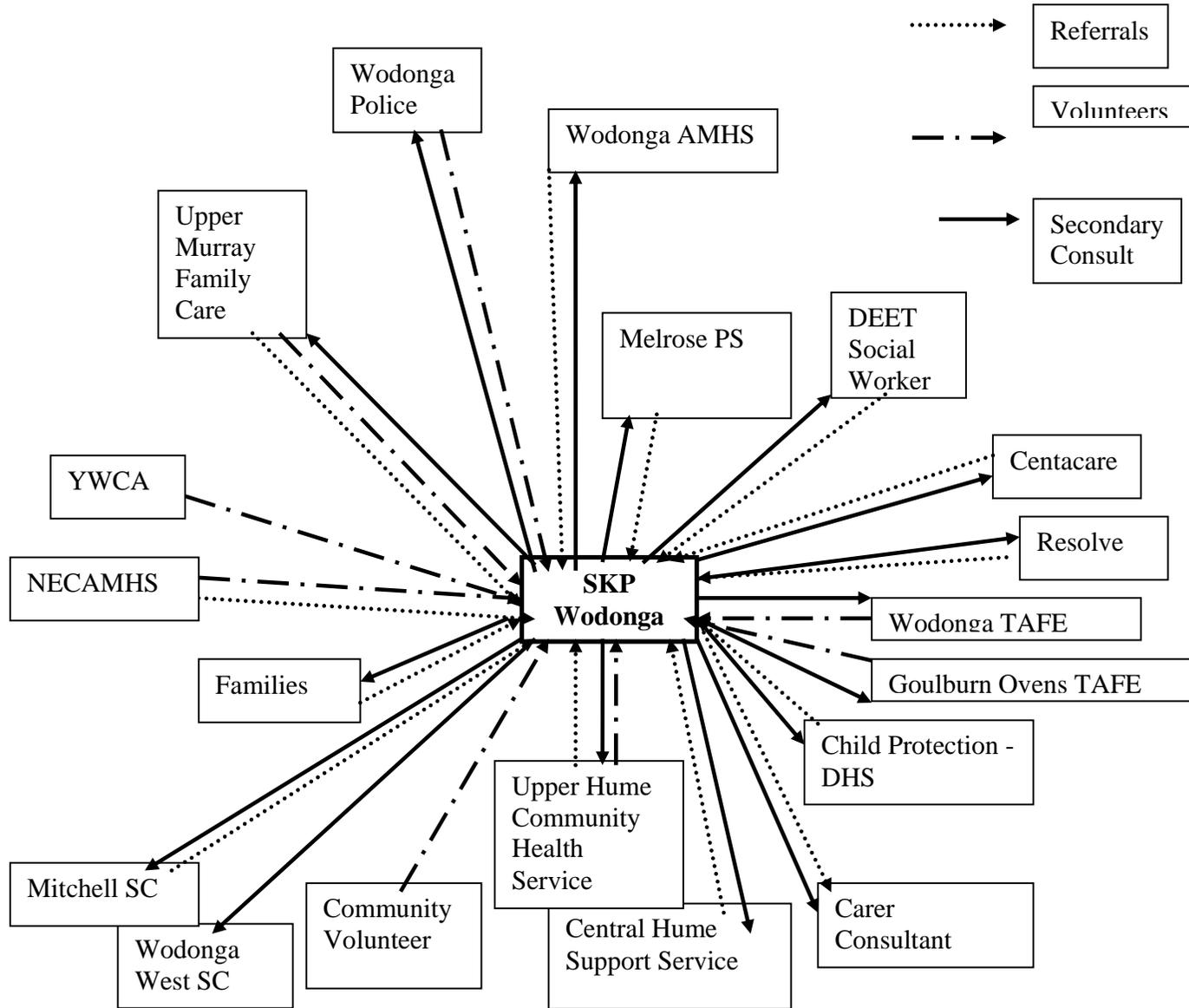
Key Finding

Support from all levels (upper, middle and key workers on the ground) is essential to facilitate organisational change.

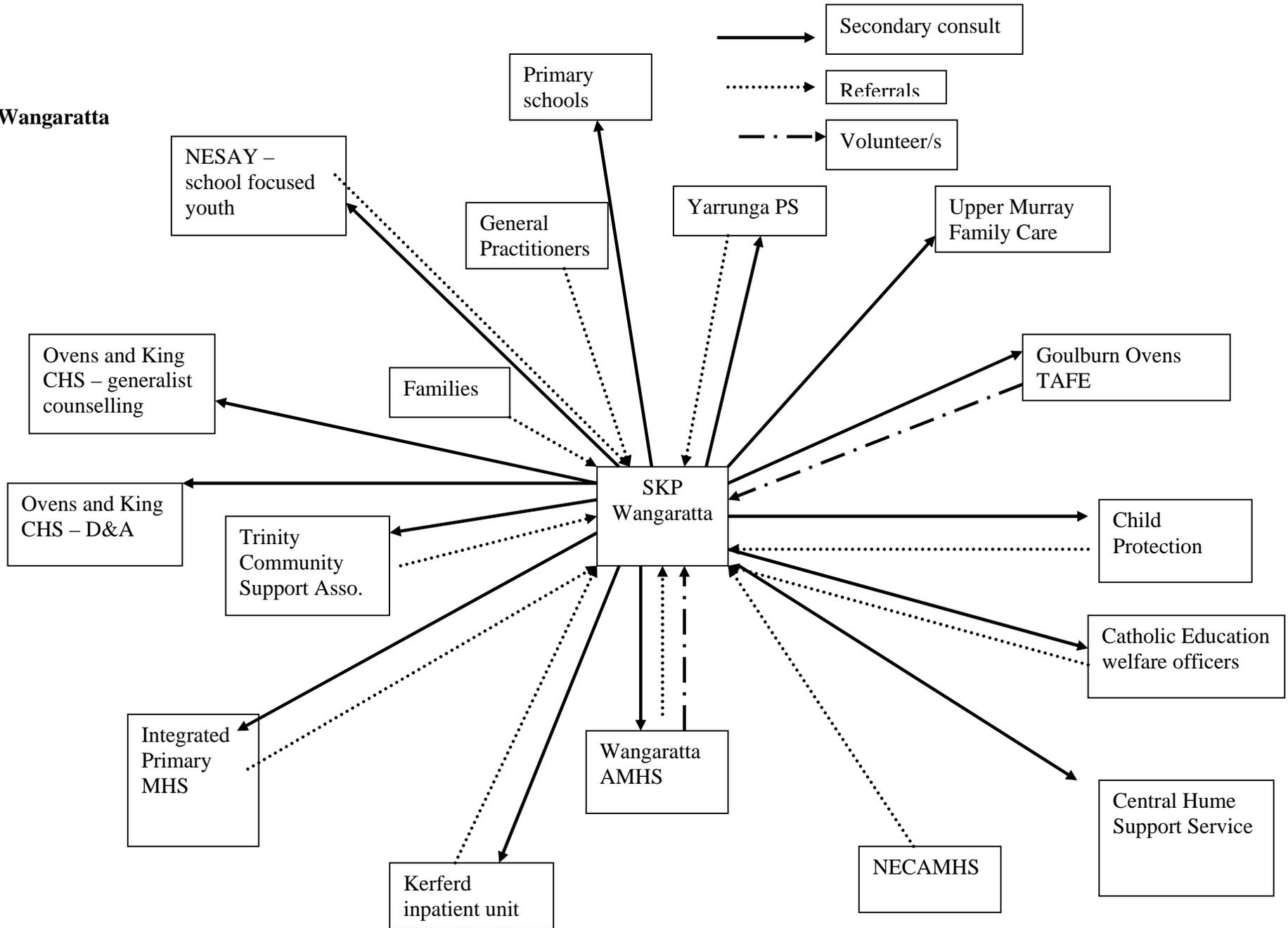
Network maps

Network maps were developed with the aim of pictorially representing the various networks that have been developed and/or have been sustained over the three years. Specific agencies are highlighted in these maps in terms of referral sources (coming into VicChamps as well as referring out of VicChamps), the agencies which provide staff to assist in program implementation, and the agencies in which secondary consultation is given. The two pages that follow show the networks of Wangaratta and Wodonga sites. As the number of networks in Eastern Melbourne was so vast, these networks were tabulated, and are shown in Table 6.3 below.

Wodonga



Wangaratta



Eastern Region

Table 6.3: Types of network relationships formed with the adult mental health (MH), community sector (C), General Health agencies (GH), Educational agencies (E), and Family services (F) by VicChamps.

Agency	MH or C	Referral In	Referral Out	Secondary Consults	Volunteers	Group co-facilitation	Provide resources
Anglicare (Croydon)	C	✓	✓	✓	✓	✓	✓
Anglicare (Lilydale)	C	✓	✓	✓	✓	✓	✓
Anglicare (Knox)	C		✓	✓	✓		
Anglicare (Belgrave)	C	✓					
Anglicare (Healesville)	C	✓		✓			
Anglicare (Parentzone)	C	✓	✓	✓		✓	✓
Prahran Mission (MSP)	C	✓	✓	✓			
Davey House	MH		✓				
Adult MH (portfolioholders)	MH	✓	✓	✓	✓	✓	✓
CAMHS	MH	✓	✓	✓	✓	✓	✓
Primary Schools (Nurses, Student Welfare Officers)	E	✓	✓	✓			
DHS (Child Protection, Adoption Permanent Care)	C	✓	✓	✓			
Anchor FosterCare	C	✓	✓	✓			
Belgrave Library	C						✓
Child and Maternal Health	GH	✓	✓	✓			
PATS	C	✓	✓	✓	✓		✓
Shire of Yarra Ranges	C						✓
YouthWorks	C		✓		✓		
Villa Maria Carer Services	C	✓	✓	✓			✓
ARAFEMI	MH	✓	✓	✓			✓
CARERS	F	✓		✓	✓	✓	
Caerleon	C		✓				
Mental Illness Fellowship	MH		✓				

Agency	MH or C	Referral In	Referral Out	Secondary Consults	Volunteers	Group co-facilitation	Provide resources
Police	C		✓				
COPEs	MH	✓	✓				
Hicci	C		✓		✓		✓
Queen Elizabeth Centre	GH		✓				
GP's	GH	✓	✓				
Private Psychiatrists	MH	✓	✓	✓			
Private Psychologists	MH	✓	✓	✓			
Church groups	C				✓		✓
Community Circus	C				✓		
Patterson St	C		✓				✓
SKIPS	E		✓				
EDAS	C	✓	✓	✓			
Rivendall	MH	✓	✓	✓			
Reach out	MH		✓	✓			
CAHMA	MH		✓		✓		
Consumers	F	✓		✓	✓	✓	
Neighbourhood Houses	C		✓				✓
Knox Community Health	C	✓		✓	✓	✓	✓
Resilient Kids	C	✓	✓	✓	✓	✓	✓
Connections (Box Hill)	C	✓	✓	✓	✓		
Connections (Croydon)	C	✓	✓	✓	✓	✓	✓
Knox Volunteers	C				✓		
Reachout for Kids	C	✓	✓				
Domestic Violence Services	C	✓	✓	✓	✓		✓
REFS	C	✓	✓	✓			
ECASA	C	✓	✓				

There have been extensive networks built and maintained over the three years of the project, particularly in Eastern Melbourne. These networks represent important referral sources (both to and from).

Secondary consultation numbers

Secondary consultation are defined as requests from individuals, community groups or agencies (either in person, telephone or email) to the VicChamps facilitators regarding issues pertaining to children whose parents have a mental illness. Project enquiries were also included here. Program facilitators were asked to document secondary consultation numbers over two week periods every three months.

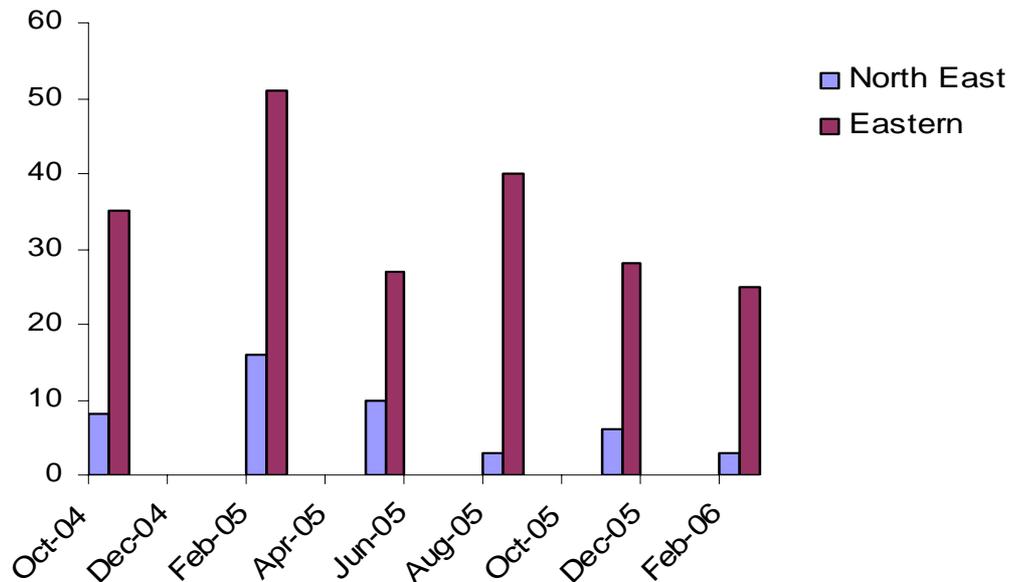


Figure 6.2: Secondary consultations for two week periods every six months in Eastern region and the North East.

Overall, secondary consultation numbers were higher for the Eastern region than in the North East, as might be expected in a pre-existing service. The respective range was between 24 and 50 consultations in a two week block for Eastern Melbourne, while for North East consultations ranged between three and 16, again in a two week period. A significant amount of time is spent by VicChamps facilitators on secondary consultations, particularly in Eastern Melbourne. For both centers, secondary consultations appear to be reasonably constant over time, though highs and lows emerge throughout. Such a result suggests that secondary consultations are not increasing over time.

Key Finding

Secondary consultations form a significant component of the VicChamps facilitators' workload.

Secondary consultations from Eastern Health were broken down into service organizations, in order to ascertain whether secondary consultations changed over time, though this could only be done for five of the six blocks of time (see Figure 6.3). In Figure 6.3, family includes consultations from carers, family members and consumers,

general health includes consultations from general medical workers such as Angliss, community includes consultations from workers from agencies such as PATS and DHS Child protection, education includes those from educational institutions, such as schools and universities, while mental health refers to consultations from mental health workers working in agencies such adult mental health.

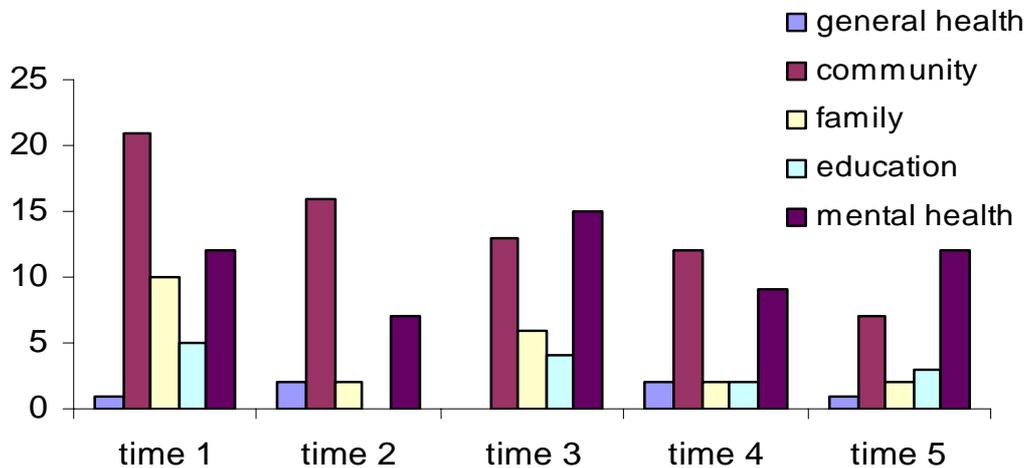


Figure 6.3: Eastern health secondary consultations according to service agency.

Secondary consultations for Eastern health do appear to have changed over time; community consultations appear to be decreasing while mental health consultations, on the whole, appear to be increasing, though again it is difficult to identify clear patterns.

Key stakeholders interviews

Interviews were held towards the end of the three year project with key stakeholders across the two regions to ascertain their views on how effective VicChamps has been in addressing the needs of children whose parents have a mental illness. Stakeholders included carers, consumers, agency managers, case managers, mental health workers, consumers and community workers from the field. Focus groups were held, with questions directed towards their general understanding of VicChamps, the key successes that have come out of the project, any problems or issues regarding the project and its implementation, and finally, how successful VicChamps has been in becoming self-sustaining, that is, in enhancing the capacity of other organisations to address the needs of families affected by parental mental illness.

Points arising from these interviews are summarised below.

Program successes

Participants overwhelmingly reported high levels of satisfaction with the program and the facilitators. They reported good working relationships between VicChamps staff with children, families and other agencies. Identified successes can be grouped in the following areas:

Successes for children

- providing peer support to children, as well as social connection and decreasing isolation,
- providing education and myth busting,
- normalising,
- helping children to create an identity of their own, away from their parent's mental illness, and
- validating children's experiences.

Successes for parents

- providing informal parental support.

Successes for families

- providing families with the permission to talk, opening up communication,
- providing coping skills,
- providing links with the extended family; a grandparent of children whose parents have a mental illness reported that 'VicChamps has helped me, has given me a relationship with my daughter and my grandchildren'.

Successes for organisations and agencies

- There seems to be a greater openness in talking and identifying mental illness in the clients attending an organization.
- Many organisations and their workers are now aware of the needs of children whose parents have a mental illness, and the types of programs that VicChamps offers.
- The program 'raises hope' for workers by working with children on a 'wellness perspective'. VicChamps keeps people engaged because they see the impact, in both the short and long term.
- Some agencies now think 'outside of the box' and consider who might be responsible for these children. Some agencies have provided co-facilitators to run VicChamps programs. Adult mental health now acknowledges that 'the children of our clients are also our clients'.
- Effective interagency networks have been built over the three years. These networks 'help break down funding and responsibility barriers'. For example, in the North East region, three agencies, Adult mental health, Upper Hume Community Health Service (Hume Region Parent Education Service) and Upper Murray Family Care together have developed and implemented a program to support parents affected by parental mental illness, called 'Unfogging the future'. This program was initiated after consultation with reference committee members from VicChamps and the Carers Group, and demonstrates effective interagency networking and organisational sustainability in supporting families affected by parental mental illness.
- Due to VicChamps, the 'support system is organised' with others 'feeling a bit more held'. VicChamps 'relieves clinicians of the responsibility of working with these children'. If VicChamps were to finish without continued funding, this responsibility would fall on other workers who are already working within tight boundaries. As a consequence, it was believed by many that the needs of children, whose parents have a mental illness, would not be adequately addressed.

VicChamps cannot be self-sustaining, with some arguing that this goal is unrealistic: 'It is not fair for VicChamps to fix it for all'. VicChamps was seen as primarily a child-focused program, which focused on wellness.

Key Finding

Stakeholders report high levels of satisfaction with VicChamps, in addressing the needs of children, parents, families and agencies.

Key Finding

Stakeholders report the need for an ongoing, specialised child centred service, for children whose parents have a mental illness.

A need for multi-level of engagement

Some participants suggested that VicChamps was not the 'only answer' for families affected by parental mental illness. While some pointed out that VicChamps was highly flexible and adaptable, others suggested that some families were 'not ready' for the types of support that VicChamps might offer, and that is sometimes a matter of 'timing' and readiness for family members. Similarly, peer support programs may not appeal to all children, some of whom might be better suited to one-to-one support (as might be possible in an 'outreach' type intervention rather than peer support program).

Key Finding

Stakeholders suggest that there is a need for a multilevel of engagement for families affected by parental mental illness, some of which is answered by VicChamps

Gaps in VicChamps

A perceived gap in VicChamps was addressing parental support. Some workers suggested that parent needs could be better addressed by another, parallel service closely aligned to VicChamps, in recognition that 'children are not islands' and that everyone in the family has their own needs. A more effective program would address the needs of the child, in addition to parent support needs. Support for the extended family, siblings, carers and friends are also avenues that could be addressed.

Participants overwhelmingly stressed the need for a child specialised service to be provided, for children whose parents have a mental illness. It was widely recognised that families affected by parental mental illness had various needs, and that while the family and parents had their own issues, the child/ren had specific needs that they believed could only be met through this specialised service. By focusing on the needs of parents as well, some

argued that the rights and needs of children would be ‘watered down’. All participants stressed the need for an ongoing, child specialised service.

Another gap highlighted by some participants was the needs of children once they turn 12 years of age, as well as children under five years of age. Some also pointed out that SKIPS needed to be extended into high schools. Overwhelmingly stakeholders urged for the continued funding of VicChamps, and that the services currently provided be further extended in these ways.

Advertising for programs needs to be more extensively broadcast. At times, workers found out about programs too late for referral to occur. According to workers, transport was an issue for many families in both regions, and needs to be addressed in future programs.

Key Finding

Overwhelmingly, stakeholders urged continued financial support for VicChamps

Key outcomes of network activities

Drawing upon data collected in the facilitator interviews, network maps, secondary consultation numbers and key stakeholder interviews, key outcomes can be identified from the different network activities that VicChamps have been engaged in over the three year period:

1. In North East, Kerferd Unit includes parenting status as part of their intake interview.
2. In the North East, outside organizations have responded to the needs of families affected by parental mental illness by developing a parent support and education program, called ‘*Unfogging the future*’.
2. Formal policy holders in upper management levels have been developed in Eastern Mental Health.
3. A ‘Train the Trainer’ model has been initiated that has increased the number of trained facilitators able to provide VicChamps program delivery and training. The number of trained facilitators is now 22.
4. There is a substantial amount of joint program facilitation with workers from other organisations. This is an important outcome as it ensures that the needs of children whose parents have a mental illness are being supported by agencies other than VicChamps.

Key Finding

Systemic changes include Kerferd Unit including parenting status as part of their intake interview (North East), and formal policy holders in upper management levels (Eastern Health).

Key Finding

Other agencies are now working with children whose parents have a mental illness, either as a result of joint facilitation of VicChamps programs and/or through the ‘Train the Trainer’ program.

Issues for further discussion

This chapter details program facilitator and key stakeholder activities and opinions. Attending network meetings, secondary consultations and undertaking educational activities, including knowledge distribution through various media, were just some of the activities undertaken. The learning and knowledge from these ‘coal-face individuals’ provides important recommendations for future practice.

Recommendation: Substantial effort should focus on developing individual and agency networks and linkages in order to increase worker’s awareness of families where a parent has a mental illness.

Recommendation: Networking is reliant on network forums, worker involvement in children’s programs, and ‘train the trainer’ programs.

Recommendation: Secondary consultations are an important need/task that arises from providing specialized programs which address the needs of children with a parent with a mental illness.

Recommendation: Organisational change is essential for delivering services to this target group. All levels of a mental health or welfare organization should be targeted, including upper management to drive policy change, middle management to implement the policy, and key workers to put the policy into practice.

Chapter 7: Family care plans

Families affected by parental mental illness are likely to experience crises, such as the hospitalisation of a parent, or an acute mental illness episode. For example, in Victoria during 2003-4, clients with dependent children from the Adult Mental Health Service had over 23,000 hospital patient bed days (Maybery, Reupert, Patrick, Goodyear & Crase, 2005). The potential stress generated by crises impacts enormously on those individuals involved, particularly children who often have no understanding or control over their situation. While the strain is felt just after a critical incident occurs, the impact on those involved may endure for a lengthy period (Wilson & Raphael, 1993). Prior planning has been considered to be the key to the optimal management of a critical incident in any setting (Kirkland & Maybery, 2001). Family care planning aims to provide optimal family coping during a major incidence of the parent's illness event (e.g. hospitalisation) during or just following its occurrence. Pre-incident planning focuses upon attempts to pre-empt major problems and develop strategies for best managing those circumstances from a family centred approach that involves and empowers family member (including young children) decision making.

Accordingly, crisis plans are important for such families, in order to better manage, avert or minimize the stress associated with the parent having a mental illness.

There currently exists several crisis plan templates, available electronically, specifically developed for families affected by parental mental illness. For example, COMIC, (Children of Mentally Ill Consumers) an organization in South Australia, have developed a 'Supporting Our Family' Kit available on <http://www.howstat.com/comic/>. Simcoe County Mental Health and Addiction Education in the US have developed crisis plans available at <http://www.mhcva.on.ca/FMHI/fmhicrisis.htm> and the Ministry of Children and Family Development and Ministry of Health Services in Canada have developed advance plans, available at http://www.moh.hnet.bc.ca/mhd/pdf/supporting_families.pdf. To date, it is thought that there have been no formal evaluations of the effectiveness of such plans.

Key Finding

All family members, including children, should take an active role in the development and implementation of family care plans.

To develop a crisis plan, all key stakeholders, including family members and key agency workers, need to be involved. Inherent in the development of the crisis plan is that stakeholders negotiate what they would like to see happen if a crisis were to occur, and their respective responsibilities in such an event. For example, children identify where they might stay if mum needs to go into hospital. The child's nominated person is then consulted as part of the development of the crisis plan, and asked to look after the child, if the parent is extremely unwell or hospitalized. Children take an active role in these plans, as they are often the first to notice early illness symptoms in the parent, and need to know who to turn to, both for themselves and their parent. Additionally, a clearly identified

clinical service response is presented. It typically takes six to twelve months to develop a crisis plan, as it needs to be discussed over several occasions with the family, as well as agency and community members, and at times when the parent with the mental illness is well and thinking clearly.

Common features of crisis plans are a nominated contact person/s if a parent is ill or in hospital, with whom each child will stay in these circumstances, and who needs to be told about alternative living arrangements. The individual needs of the child/ren are usually outlined, including medical and allergy issues. The date that the crisis plan is made and dates for review are included, in recognition that information about the family and service providers often change. Issues of confidentiality are often specified, outlining who needs to know what. The crisis plans are not legally binding, and instead rely on the good intentions of the people nominated to carry out the parent's and children's wishes.

Key Finding

Common features of care plans include a nomination of a contact person, alternative living arrangements, highlighting the specific needs of children, and the respective responsibilities of all involved.

There are several, potential benefits to investing time in developing crisis plans. An important component of crisis plans is for individuals within the family, especially children, to communicate their particular needs, and/or for parents to communicate their own needs and those of their very young children. This assists in minimizing disruption to the child by ensuring, for example, that favourite toys are kept, pets are taken care of, routines are maintained and medical needs are identified. Such planning then avoids further and/or ongoing crises from occurring, such as the children being placed in alternative foster care, the involvement of child protection agencies, and/or the separation of sibling groups.

Key Finding

In times of crisis, the benefits of plans include the coordination of care, minimizing disruption to the family unit and outside activities (e.g. school) and enhanced personal control of family members.

Involving stakeholders, including children, in the development of the family crisis plans increases the levels of situational control for all family members, by ensuring that everyone has a say about what might happen. This involvement, when managed sensitively, might then enhance within-family connectedness by inviting family members to listen to each other, and work together on collective goals.

Key Finding

Care plans have the benefit of improving within-family connections, and improving external supports.

Families are encouraged to identify community supports, as a part of developing these plans, often prompting parents to develop new networks, and/or strengthen existing support networks. The involvement of key stakeholders encourages better coordination of care, thereby increasing the support to the family and its individual members. Finally, the process of establishing crisis plans ensures that the children of parents with a mental illness, who might otherwise be considered 'invisible' (Fudge & Mason, 2004), are recognised by service providers.

VicChamps experience in the North East of Victoria

As the concept of crisis planning was new for VicChamps and families, the workers invited parents and their children to discuss the most appropriate method of establishing a crisis plan in two ways. First, three focus groups were held with six, ten and twelve mothers, and facilitated by the VicChamps workers. These groups were invited to examine and critique current crisis plans, such as the COMIC plan outlined above, and generally discuss their needs when managing crises. These focus group participants included single mothers, as well as those in stable relationships, and mothers who had a variety of different mental illnesses, including depression, schizophrenia and bipolar disorder. The second process involved VicChamps workers visiting seven individual families, consisting of mostly single mothers and their children. In this way, families were invited, through the focus groups and individual consultations, to use their knowledge and experiences to develop a model that could be used for their family and others like them. It is essential to do this in order to understand the phenomenon from the consumers' perspective (Rapp, Kisthardt, Gowdy & Hanson, 1994). Additionally, the facilitators' own views, sourced from their reflection, training and experience of working with families affected by parental mental illness, was another aspect in the development of how family plans were implemented in the North East of Victoria.

Rationale for moving from crisis to care plans

Overwhelmingly parents, their children and the VicChamps facilitators argued that family plans needed to highlight strategies for managing crises, as well as identifying the short and long term goals of the family. This meant that the plans became less crisis focused, but became more as what one participant described as 'care plans'. In other words, rather than focus only on potential crises, the plan became a more general treatment plan that all family members, as well as key agency workers, could be involved in.

The rationale for this shift, according to families included:

- (i) a focus on family strengths,
- (ii) to enhance existing social supports, especially within the family, and
- (iii) to negotiate and co-ordinate agency support for their children as well as themselves.

Key Finding

Plans should be known as ‘CARE’ rather than ‘CRISIS’ plans.

Parents reported that planning solely for crises meant that key stakeholders become overly focused on problems, rather than family strengths and the support systems currently utilised by the family – both as a unit and as individuals. Others suggested that they were not interested in doing a crisis plan, as they did not intend going into hospital again. Parents felt that a focus on crises emphasized their mental illness and them as a ‘patient’. Additionally, VicChamp facilitators considered that focusing only on crises may lead to an over-reliance on their (and other workers’) skills and resources. The facilitators also felt that crisis planning gave the appearance that hospitalisation was inevitable. Thus, families and VicChamps facilitators indicated that the plans should acknowledge and enhance existing strengths and the strategies employed by the family, and to develop and extend these further in the form of ‘care’ plans.

Key Finding

Family Care plans should focus on enhancing family strengths, rather than just managing deficits.

Parents and facilitators were particularly keen to encourage existing support systems. The connections between sibling groups, between the parent/s and their children, and between the children and other supportive friends and adults were considered essential by participants, rather than relying solely or overly on professionals and community workers. VicChamp facilitators suggested that parents’ desire to enhance current support systems within their family and the community was partially due to a lack of professionals in rural areas and, in particular, a lack of professionals who are trained and able to work with both parents and their children.

Finally, the plans were seen by parents and children as an opportune time to focus on their goals. This meant they needed to consider their short term goals, such as ‘existing day to day’ as well as longer term goals. Parents and children considered that the process of developing care plans provided an opportunity to co-ordinate their activities, with the support of identified agencies, for the whole family and not just the parent. Plans were considered an important way for children’s needs to be acknowledged and addressed more generally, and not just in crisis times.

Key Finding

The development of care plans provides an opportunity for families to focus on their long and short-term goals.

Components of family care plans

The family care plans, as implemented in the North East of Victoria, comprised distinct but interrelated components, namely a crisis and a care or treatment component.

Key Finding

Care plans should include both crisis and care components.

The crisis component

Workers and parents still considered it important to have a crisis component to the plan, particularly if the parent had severe, recurrent symptoms and/or there was a likelihood of hospitalization. There was some concern about the length of many of the existing plans however, and parents considered it important to tailor and refine plans for individual families. One parent suggested that the crisis component of the plan needed to be summarised in one page, and that this be laminated with a magnet to stick on the fridge, so that children might easily access it. Children also identified the need to have phone numbers on hand that they could ring, if they felt in danger or were concerned.

Key Finding

Plans should have a crisis component, especially if the parent has severe, recurrent symptoms and there is a likelihood of hospitalization.

The care component

Parents, children and workers suggested that the care plan needed to identify what was important for the family in both the short and long term. Short-term goals might include organising to have the house cleaned, getting school lunches made, and making an appointment with a counsellor. Longer term goals that some families nominated included meeting their children’s future educational costs, identifying the children’s recreational activities, enhancing parenting skills and identifying possible employment/study options.

Case Study

A family care plan was undertaken by a VicChamps worker with a family whose mother had been diagnosed with bipolar disorder, and had been previously hospitalized on one occasion due to her illness²⁸. The family consists of a mother, an adolescent boy (aged 14) and his six year old stepsister. The father was not living in the local area, and is estranged from the mother. The adolescent boy has acted as a carer for his six year old sister during a previous period of the mother's hospitalization, and helped care for the mother on her return. The mother identified her strengths as being caring, sensible and organized, while her children reported being caring, helpful and friendly, all attributes that the plan drew on.

Crisis planning: Potential crises centered on the mother being hospitalized and/or becoming very ill. The boy was provided with information regarding early warning sign, and a plan of what he could do. Contact names and telephone numbers were provided to him (two different organisations), and alternative accommodation was identified (grandparents). The different organisations and supports were contacted, and their permission sought for the family to access them in a crisis. Another issue was raised by the son, when staying with his grandparents. He reported that they 'took over' rather than fitting in with the existing family routine. Well-defined roles and tasks for the children and grandparents were discussed with the grandparents, the family and VicChamps worker and then recorded.

When the mother was ill and/or hospitalized, another issue was dealing with ongoing domestic responsibilities (e.g. cleaning, clothes washing), and having access to money for things such as school excursions. Within the crisis plan, different family members were allocated specific 'jobs', with the six year old girl most keen to maintain her share of tasks. Again, this information was recorded and discussed with the grandparents. Upper Murray Family care and the Salvation Army were contacted regarding their willingness to provide short-term funds for additional expenses. Again, all information was discussed with the grandparents and recorded.

Case Planning: In the short-term, the issues identified were that when mum gets home from hospital or is ill, she is tired and not able to make lunches and be with her children in the morning. It was consequently written into the care plan that mum make lunch in the evening, so that she could just get up and sit there while the children get ready for school. Another related need was for the family to 'regroup' after the mother returns home from hospital. On the son's recommendation, it was recorded that, when mum gets home, he and his sister have a couple of days off school, for a 'bit of a rest'. The family was clear that they did not want the school to know about their family situation, and this was recorded.

Longer term goals centered on the mother asking for help sooner, when she was not feeling well, an issue that was highlighted for the mother and her mental health worker to work on. The mother also wanted to enhance her parenting skills, and was subsequently referred to a community-based parenting education and support group.

²⁸ While this family exists, additional information, sourced from other family care plans is included here, in order to outline more detailed issues.

In the North East, this process has been undertaken with five families. Due to limited numbers, there has been no formal evaluation undertaken at this time (except for different family case studies, such as that highlighted here).

Key Finding

Family care plans have been undertaken with five families in the North East of Victoria.

Issues involved in implementing care plans

The first of the several issues involved in implementing care plans was that children were incidentally educated about their parent's mental illness. Children's growing awareness of their parent's mental illness prompted workers to provide them with age appropriate information about their parent's mental illness in an ongoing manner (for example, Falkov, 2004).

Another incidental benefit in facilitating family care plans was that it provided family members with an opportunity to talk to each other in new and functional ways. It was found that listening and respecting the wishes and opinions of each other was essential to the smooth functioning of family care plans. Thus, families found new ways of conversing, listening and respecting each other. Tools such as the Bear Cards and Strengths Card (St Luke's, 1992) helped facilitate these conversations.

Key Finding

The planning process had incidental benefits, including improving family knowledge about mental illness, providing an opportunity to talk and discuss needs, and for the parent to develop new skills.

As the project is a three year funded project only, another important issue was to identify appropriate staff members who could assume the role of initiating family care plans when the Vic Champs project was finished. However, there appears to be problems in the current workforce to respond appropriately to families affected by parental mental illness. Previous research has found that service providers usually work with just the child (e.g. in terms of child protection) *or* the adult (in terms of his or her mental health needs) (Nicholson, Biebel, Kinden, Henry, & Stier, 2001). Additionally, workers report a lack of skills and knowledge when working with children and their mentally ill parents (Maybery & Reupert, 2005).

At the same time, however, adult mental health workers see a significant number of clients, who are also parents with a severe mental illness (and hence more likely to be hospitalized) (Maybery, Reupert, Patrick, Goodyear & Crase, 2005). Thus, it would appear appropriate that professionals who are already in contact with parents who have a mental illness, such as adult mental health workers, are best placed to facilitate the types

of care plans described here. A reduction in case load and appropriate training would first be required for this to occur. There currently exists no training for workers in supporting a family through this process.

Key Finding

With consideration for training and resources, adult mental health agencies are best placed to implement Care Plans.

Issues for further discussion

The following provides a brief discussion of issues in relation to family care plans. As raised earlier, raising these issues seeks to prompt discussion about the findings in order to be instructive to policy makers and programmers about work force development and policy, with suggestions for how current evidence about family care plans might influence future practice.

Engaging families in care and support

While there has been no formal evaluation of the five families in the North East, who now have family care plans, it would appear that this planning serves a number of ancillary and important functions. Overall, family care plans appear to play a significant role in engaging families with mental health/welfare services, and enhance engagement and support within the family. Further evaluation data is required to confirm this hypothesis. Additionally, at this point of time, there is no available training for workers to facilitate this process, and this gap might need to be considered in future training packages.

Recommendation: If provided with appropriate training and resources, adult mental health agencies are seen as the most appropriate agency to assume responsibility for the implementation of family care plans.

Recommendation: Family care plans should incorporate a plan for managing potential crises, as well as identifying short and long-term goals for the care of family members.

Recommendation: Further development and evaluation should be undertaken before substantive claims are made regarding the efficacy of family care plans.

Chapter 8: Community education: SKIPS, pamphlets and website

This section details three aspects of community education that were undertaken by the VicChamps program team. The details of the primary school-based education, website and promotional and educational pamphlets are outlined below, including any evaluation that accompanied the activities.

Supporting Kids in Primary Schools (SKIPS)

In total, it is estimated that there are between 21.73 and 23.52 percent of children living in Australian and Victorian households, where at least one parent has a mental illness. This means that there are just over one million children in Australia, and just over a quarter of a million in Victoria. Many of these children are in primary schools. SKIPS is a component of community education providing a universal approach to mental health promotion and literacy for a whole school community, giving schools straightforward information about mental illness.

SKIPS is a unique program that deals directly and honestly with the issue of mental illness in families, and how primary schools support the children in those families. The project has two main objectives:

- addressing the roles of schools and teachers in supporting children and families affected by the mental illness of a parent, and
- reducing stigma through classroom education about mental illness.

The program consists of two workshops for the whole school staff, and three classroom sessions for grade 5 and 6 children run by a team of two presenters, a consumer and a speaker who talk of their own experience of growing up with a parent with a mental illness. The workshops for teachers provide:

- an understanding of the impact that mental illness in the family has on children,
- confidence in supporting those families and children, and
- practical strategies.

In addition the classroom sessions give children:

- an understanding of mental health and illness, and
- appropriate language for talking about mental illness.

A parent information session is also offered, so that parents know what their children are learning.

Programs delivered

In the Eastern region, there were three SKIPS programs run during the period. In the North East, there was a train the trainer session (evaluation detailed below) with mental health and school welfare workers to enable them to run SKIPS in future within their region.

Evaluation

While an evaluation of the SKIPS program was initially proposed, it was not undertaken as part of this project. A comprehensive peer-reviewed evaluation of SKIPS has been undertaken previously by Joyce, Alchin, Malmberg, Candy and Cowling (2003). Those authors concluded that SKIPS is a program that reduces prejudice and addresses "...the role of schools and teachers in supporting student and families affected by mental illness" (2003, p 218). Instead of undertaking a further evaluation here, it was decided (after negotiation with the funding committee) to reassign evaluation resources toward obtaining the large normative data collection outlined in the 8-12 year old chapter earlier described. However, a brief evaluation of the level of satisfaction of participants with a SKIPS Train the Trainer program is outlined below.

Key Finding

SKIPS reduces prejudice and supports students and families affected by mental illness in primary schools.

SKIPS Train the Trainer program

Fifteen participants in a SKIPS train the trainer presentation in the North East in October 2005 anonymously responded to a single page questionnaire immediately following the program. The evaluation focused upon three general areas including: the presentation, participant perceptions of their readiness to run SKIPS training in future; and open-ended responses regarding the quality of the training.

In terms of the presentation, participants responded to four questions regarding their level of agreement on a five point scale from 1 = strongly disagree to 5 = strongly agree to the following: The figure below shows the mean responses of the participants²⁹ for these four questions.

²⁹ Note that there is missing data on some items.



Figure 8.1: Level of agreement regarding quality of training of presenters, setting and manual.

The figure shows that participants agreed with the three statements ‘Today I found ...’ ‘The presenters were clear and easy to follow’, ‘The manual to be clear and flow logically’, ‘The manual to be easy to use’. This shows strong support for the quality of the program delivered. One further statement regarding the level of comfort with the setting was lower in agreement (though almost to the agree level). However, additional comments by eight respondents indicated this was associated with acoustics of the venue (e.g. “Except for the acoustics in the big room”).

Key Finding

Participants rated the SKIPS Train the Trainer presenters as clear and easy to follow and the manual to be clear, logical and easy to use.

The participants then responded to the question, ‘After today do you feel able to run a SKIPS program?’. Ten responded that they were ready, and five that they were not quite ready. No participants indicated that they were not ready. This suggests that the training was valuable in equipping at least two-thirds of the participants to run training programs future.

Key Finding

Two-thirds of the SKIPS Train the Trainer participants considered themselves ready to run a SKIPS program at the end of training.

Finally, participants were asked to respond to four questions (see Table 8.1 below). Their responses are shown below, including a summary of core content to some of the questions.

Table 8.1: Participant responses to questions regarding SKIPS Train the Trainer session.

Question	Content and/or Verbatim responses
What did you gain from the training?	Participants gained three main things from the training. The first involved improved knowledge by the participants of the problem for such children (e.g. more understanding), recognition of the quality of the program (e.g. ‘Great resource and the encouragement to work with a colleague’) and the knowledge and enthusiasm to get started (e.g. ‘Ideas about presentation to teachers and class rooms’).
What else would you want to see as part of the training?	While several thought the training was very good, others suggested that it might be better spread over two days, the program needed to be ongoing and set up to establish networks between participants. Most of these comments appeared to be aimed at extending the current training further.
What, if any, anticipated barriers are there to you running the SKIPS program?	While several participants indicated their discomfort with running future training (e.g. ‘I would need help to start off with’), the focal anticipated barrier centred upon access, including time and resources to schools. Many responses centred on this concern (e.g. ‘Principals willing to embrace the program - but we have ways and means!!’; ‘Getting into the school - class time’ and ‘time funding access’)
Any other suggestions?	A central core of comments focused upon thanks to the presenters. Such comments included ‘Thank you so much it was great’ ‘I really enjoyed speakers’ and ‘well done’. Other comments included: ‘We need help to start promoting positive images of people who have mental illness’ ‘Drawings for explanation of symptoms of mental illness for 5 + 6 classes.’

Key Finding

The SKIPS Train the Trainer program improved participants’ understanding of problems for COPMI children and enhanced their enthusiasm to get started.

Key Finding

The central barrier for participants running SKIPS programs in future was gaining access (including time) to schools.

Promotional and Educational pamphlets

Promotional and educational materials (pamphlets) were distributed widely in the Eastern and North Eastern communities. These outlined the range of supports available to COPMI families, with the aim of reducing their isolation. Additionally, information conveyed non-discriminatory messages about mental health issues targeting all children, parents, family members and community. The messages contained in the information gave children 'permission' to speak to someone, such as phoning Kids Helpline or speaking to a teacher, which they may have been previously reluctant to do.

The information gave parents, service providers and the community the opportunity to become more aware of the needs of the children in general, and to be more attuned to the difficult issues that some children face, including the need for children to know and understand their parent's mental illness and treatment, while simultaneously emphasising their normative developmental needs. This approach provided general information to all children and families about a group of illnesses labelled 'mental illness', using affirmative and non-discriminating language.

The materials were made widely available in places where families with children naturally congregate, including schools, libraries and community houses, and distributed to General Practitioners through GP Divisional networks. Posters were prepared and made available to primary schools in the government, independent and Catholic education sectors, and to community centres, community health centres and libraries. The process of distribution also served to inform agencies and service providers about children of parents with mental illness and their families. Examples of such material are shown on the pages that follow.

Talking to Children

- Parents may experience difficulty discussing their mental illness with their children. They might think that if they talk openly about their illness and how it makes them feel, their children will be confused or won't understand.
- However, children worry less about something if they understand it and know they are not alone in their experiences.



- Answering questions and providing honest explanations to children helps to stop them from filling in gaps with wrong information. *Accurate* information can reassure them that they are not at fault as they may also feel that they are somehow to blame for their parent's condition.
- Providing opportunities for children to talk with their parent or other trusted adults about mental health issues might help reduce their worries.
- If you need some encouragement and some guidelines for talking to your children, check out www.champsworldwide.com or refer to other resources over leaf.



Where to go for further information?

- Local councils provide a range of services for children, families and people with disabilities including mental illness.
- Talk to your GP about support services.

Key Resources

Below are some contact numbers and websites that may provide useful information.

Telephone Numbers

Parent Line: 13 22 89
Life Line: 13 11 14
Kids Help Line: 1800 55 1800
Mental Illness Fellowship: 9482 4199
ARAFEMI (Association of Relatives & Friends of the Mentally Ill): 9889 3733
24 hour Telephone Assistance:
Psychiatric Triage: 1300 721 927

Websites

Mental Health Information (General)

www.sane.org
www.health.vic.gov.au/mentalhealth/services/index (Vic. Government website)
www.beyondblue.org.au (National depression initiative)
www.easternhealth.org.au

Family Specific

www.mifellowship.org.au (Families and Carers)
www.copmi.net.au (Tips for families)

Young People 12-18

www.ybblue.com.au
www.rch.org.au/pats

For Children 5-12

www.champsworldwide.com

VicChamps is a project that has been funded for 3 years by Vic Health, Beyond Blue and the Department of Human Services, Mental Health Branch to develop a model of best practice for parents and children aged 5-12 who have a parent with a mental illness. VicChamps is a partnership project between the Eastern Health Mental Health Program and Upper Murray Family Care. Evaluation will be conducted by Charles Sturt University in Wagga Wagga.

Protecting Your Privacy

Our staff are committed to respecting your confidentiality and preserving your privacy. We will keep your personal information secure and protected from unauthorised access or improper use, and we will only disclose information about you if it is authorised by you or mandated by law.

All our services comply with the relevant information and privacy legislation.

If you would like a copy of our Privacy Policy please ask a member of staff

or visit our website on www.easternhealth.org.au



Supporting children and families where a parent has a mental illness



Human Services



VicHealth

PROMOTING MENTAL HEALTH & WELLBEING

Clive Ward Centre, 18 Arnold Street,
Box Hill Victoria 3128 Australia
PO Box 84, Box Hill 3128
Tel: (03) 9895 4888 Fax: (03) 9895 4844
Email: info@easternhealth.org.au

Mental Illness is Common

In fact...

- 20% of adults are affected by some form of mental health disorder every year.
- 3% of adults have a severe mental disorder.
- Anxiety disorder and depression are the most common mental health disorders.



- **Anyone** can be affected by mental illness.
- Most people with a mental illness recover when they receive ongoing treatment and support.



Stigma

- Mental health, and in particular mental illnesses, are commonly misunderstood, leading to stigma.
- Stigma attached to mental illness can make it difficult for people to ask for help and can lead to isolation from family, friends and community.
- It can prevent families and the person with the illness from getting support when it is most needed.
- Stigma is often a result of inaccurate representations in the media or general community.
- The effects of stigma can be as distressing as the illness.



What can we do?

- Try talking about mental illnesses openly with people that you meet - it is surprising how many people are affected by mental illness but have been too afraid of rejection to discuss it openly.

Being a Parent who has a Mental Illness

- Parenting is hard work.
- All parents struggle at times. Most families need help from time to time from friends and relatives or professionals.
- **It's OK to ask for help.**
- Parents who have a mental illness may be afraid that by asking for help, they will be judged as 'bad parents'. Yet many people with a mental illness successfully raise their families.



You Matter Too!

- As a parent, it is important to look after yourself.
- This may mean arranging regular breaks from your role as a parent such as spending time with friends or family.
- Respite care can be a useful option to explore as part of a self-care plan.
- Children and parents benefit from space apart as well as times together. This assists children to discover and explore the world around them safely and independently.

Supporting Kids

VicChamps



*Promoting the health and well-being of children
who have a parent with a mental illness.*

Who are we?

Supporting Kids Program is a service that aims to provide support & recreational activities to children of a parent or carer who has a mental illness. We also provide information to agencies and organisations, such as schools and health services, in order to promote greater understanding and community support.

Why is this service needed?

It was recognised that children who have a parent with a mental illness have unique challenges that have traditionally been unsupported.

Who can use this service?

Recreational and support services are for children aged 5 to 12 years, and their families.

For more information or to make a referral please contact:

Kirsten Green Wangaratta Ph: 03 5723 4000

Natalie Greene Wodonga Ph: 02 6022 8000



Evaluation

Due to the reassignment of evaluation resources toward obtaining the large normative data collection outlined in the 8-12 year old chapter, no formal evaluation of this aspect of the program was undertaken

Website

Initially, the 'Champsworldwide' website was funded from a separate source, but the completion has been facilitated through VicChamps. The site provided age appropriate information for children and young people about mental illnesses, having links with an enjoyable activity pages and other relevant sites. The site was continually updated, and could be viewed at: www.champsworldwide.net. In recent times, a new site is nearing completion, and can be viewed at: <http://www.easternhealth.org.au/mental/champs/>

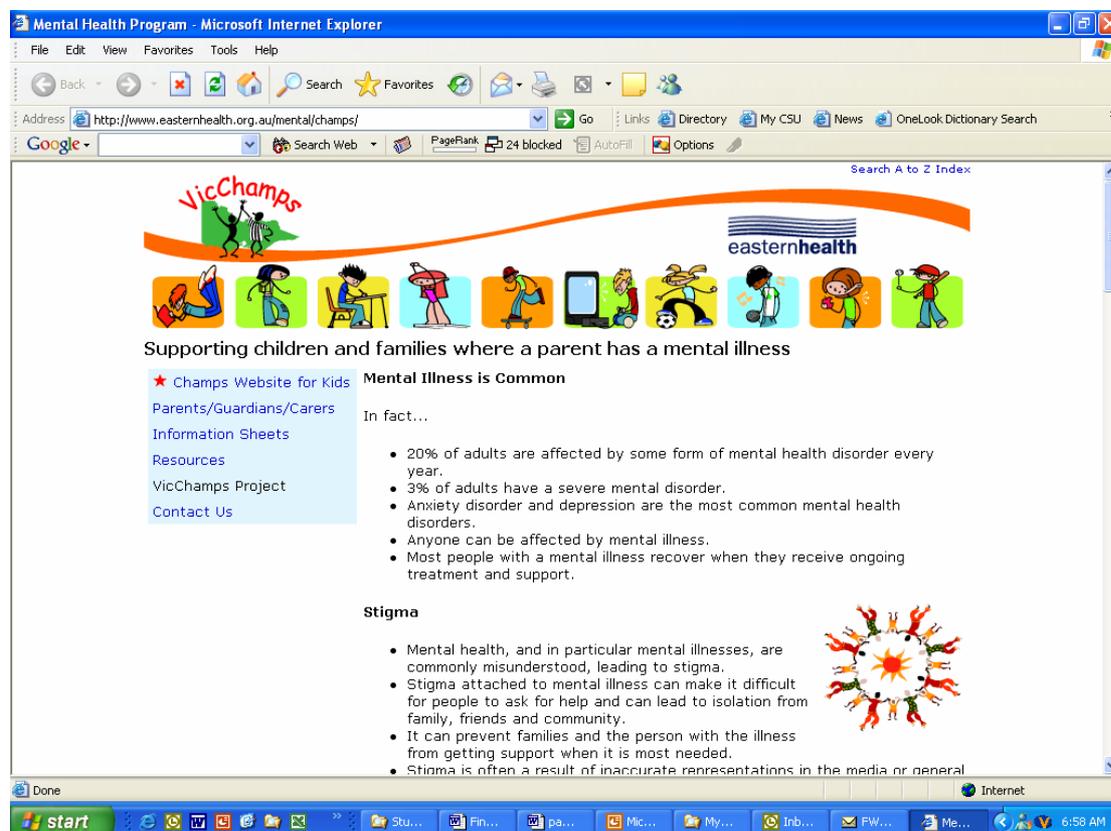


Figure 8.2: Newly created VicChamps website.

The new site is situated within the Eastern Mental facility, and is maintained by the regions webmaster. On completion of the site (May 2006), its availability will be widely publicised through the local networks, and will be consolidated over coming years. This will occur through SKIPS school presentations, through AMHS and CAMHS case managers, and as other opportunities arise. Website promotion through national networks, such as the COPMI project, will also occur.

The website is an innovative service for children of parents with mental illness with, at present, no precedent in its format and content. The site will be linked to community education material, and contain mental health information accessible to children in different age groups. Similarly, the activities will appeal to different age groups.

Issues for discussion

A considerable amount of advertising and education of the general public and target groups (e.g. COPMI) was undertaken by way of the VicChamps website, and through promotional and educational pamphlets, during the 2003 to 2005 period. In addition, a central focus of community education focused upon the SKIPS primary school-based education program. The SKIPS Train the Trainer program improved participants' understanding of problems for COPMI, and their enthusiasm to get started. The central barrier to for participants running SKIPS programs in future was gaining access (including time) to schools. The following recommendations are made regarding community education.

Recommendation: Pamphlets, flyers and websites should be regularly employed to advertise and educate about the range of issues regarding families with a parental mental illness.

Recommendation: The SKIPs manual should be made readily available to organizations across the state, with accompanying training to run the program.

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Appendices

Appendix 3.1

8-12 year old pre and post intervention program data, total and subscale SDQ (parent report) pre and post intervention data comparisons according to region and type of program.

SDQ Total Difficulties

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	14.2	8.2	9
		north east	14.1	8.8	21
		Total	14.1	8.5	30
	after school	eastern	8.7	4.6	6
		north east	16.0	6.6	22
		Total	14.4	6.9	28
	Total	eastern	12.0	7.3	15
		north east	15.1	7.8	43
		Total	14.3	7.7	58
Post	school holiday	eastern	15.4	10.7	9
		north east	11.7	8.6	21
		Total	12.8	9.2	30
	after school	eastern	6.5	3.6	6
		north east	16.0	7.8	22
		Total	14.0	8.1	28
	Total	eastern	11.9	9.5	15
		north east	13.9	8.4	43
		Total	13.4	8.6	58

SDQ Emotional Difficulties

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	4.0	2.3	9
		north east	3.3	2.7	21
		Total	3.5	2.6	30
	after school	eastern	3.5	1.8	6
		north east	4.4	2.9	22
		Total	4.2	2.7	28
	Total	eastern	3.8	2.0	15
		north east	3.9	2.8	43
		Total	3.8	2.6	58
Post	school holiday	eastern	5.7	4.4	9
		north east	2.6	2.8	21
		Total	3.5	3.6	30
	after school	eastern	2.2	1.9	6
		north east	3.7	3.0	22
		Total	3.4	2.8	28
	Total	eastern	4.3	4.0	15
		north east	3.2	2.9	43
		Total	3.5	3.2	58

SDQ Conduct Problems

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	3.1	2.9	9
		north east	2.8	2.4	21
		Total	2.9	2.5	30
	after school	eastern	1.5	1.5	6
		north east	3.3	2.1	22
		Total	2.9	2.1	28
	Total	eastern	2.5	2.5	15
		north east	3.0	2.2	43
		Total	2.9	2.3	58
Post	school holiday	eastern	2.9	2.8	9
		north east	2.4	2.4	21
		Total	2.5	2.5	30
	after school	eastern	1.2	1.2	6
		north east	4.1	2.3	22
		Total	3.5	2.4	28
	Total	eastern	2.2	2.4	15
		north east	3.3	2.5	43
		Total	3.0	2.5	58

SDQ Hyperactivity

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	5.2	3.4	9
		north east	4.9	3.0	21
		Total	5.0	3.0	30
	after school	eastern	2.3	2.2	6
		north east	4.5	2.3	22
		Total	4.0	2.4	28
	Total	eastern	4.1	3.2	15
		north east	4.7	2.6	43
		Total	4.5	2.8	58
Post	school holiday	eastern	4.6	3.0	9
		north east	4.3	3.1	21
		Total	4.4	3.0	30
	after school	eastern	1.8	1.5	6
		north east	4.7	2.7	22
		Total	4.1	2.7	28
	Total	eastern	3.5	2.8	15
		north east	4.5	2.8	43
		Total	4.2	2.8	58

SDQ Peer Problems

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	1.9	1.2	9
		north east	3.2	2.3	21
		Total	2.8	2.1	30
	after school	eastern	1.3	0.5	6
		north east	3.8	2.1	22
		Total	3.3	2.1	28
	Total	eastern	1.7	1.0	15
		north east	3.5	2.2	43
		Total	3.0	2.1	58
Post	school holiday	eastern	2.3	1.9	9
		north east	2.4	1.9	21
		Total	2.4	1.8	30
	after school	eastern	1.3	0.5	6
		north east	3.5	1.9	22
		Total	3.1	2.0	28
	Total	eastern	1.9	1.5	15
		north east	3.0	2.0	43
		Total	2.7	1.9	58

SDQ Prosocial behaviour

	PROGRAM	REGION	Mean	Std. Deviation	N
Pre	school holiday	eastern	7.7	2.3	9
		north east	8.0	1.6	21
		Total	7.9	1.8	30
	after school	eastern	9.5	0.8	6
		north east	8.0	2.2	22
		Total	8.3	2.1	28
	Total	eastern	8.4	2.1	15
		north east	8.0	1.9	43
		Total	8.1	1.9	58
Post	school holiday	eastern	7.8	2.7	9
		north east	7.6	1.7	21
		Total	7.6	2.0	30
	after school	eastern	9.3	1.0	6
		north east	7.0	2.4	22
		Total	7.5	2.4	28
	Total	eastern	8.4	2.3	15
		north east	7.3	2.1	43
		Total	7.6	2.2	58

Connections, Problems, Coping and Self Esteem (child report) pre and post intervention mean score comparisons according to region and type of program

Connections (total)

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	1.3	0.5	30
		north east	1.3	0.5	25
		Total	1.3	0.5	55
	after school	eastern	1.4	0.4	35
		north east	1.7	0.6	28
		Total	1.5	0.5	63
	Total	eastern	1.3	0.4	65
		north east	1.6	0.6	53
		Total	1.4	0.5	118
Post	school holiday	eastern	1.4	0.4	30
		north east	1.6	0.5	25
		Total	1.5	0.5	55
	after school	eastern	1.4	0.4	35
		north east	1.6	0.6	28
		Total	1.5	0.5	63
	Total	eastern	1.4	0.4	65
		north east	1.6	0.6	53
		Total	1.5	0.5	118

Connections – within the family

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	1.3	0.6	30
		north east	1.4	0.6	25
		Total	1.4	0.6	55
	after school	eastern	1.1	0.4	35
		north east	1.5	0.7	28
		Total	1.3	0.6	63
	Total	eastern	1.2	0.5	65
		north east	1.5	0.7	53
		Total	1.3	0.6	118
Post	school holiday	eastern	1.4	0.5	30
		north east	1.4	0.6	25
		Total	1.4	0.5	55
	after school	eastern	1.2	0.5	35
		north east	1.4	0.6	28
		Total	1.3	0.6	63
	Total	eastern	1.3	0.5	65
		north east	1.4	0.6	53
		Total	1.4	0.6	118

Connections – outside the family

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	1.3	0.6	30
		north east	1.3	0.7	25
		Total	1.3	0.7	55
	after school	eastern	1.7	0.5	35
		north east	2.0	0.6	28
		Total	1.8	0.6	63
	Total	eastern	1.5	0.6	65
		north east	1.7	0.8	53
		Total	1.6	0.7	118
Post	school holiday	eastern	1.4	0.5	30
		north east	1.8	0.6	25
		Total	1.6	0.6	55
	after school	eastern	1.6	0.5	35
		north east	1.9	0.7	28
		Total	1.7	0.6	63
	Total	eastern	1.5	0.5	65
		north east	1.8	0.7	53
		Total	1.7	0.6	118

Problems (total)

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	0.7	0.3	27
		north east	0.7	0.6	22
		Total	0.7	0.4	49
	after school	eastern	0.8	0.5	34
		north east	0.9	0.5	24
		Total	0.8	0.5	58
	Total	eastern	0.7	0.4	61
		north east	0.8	0.6	46
		Total	0.8	0.5	107
Post	school holiday	eastern	0.4	0.3	27
		north east	0.8	0.8	22
		Total	0.6	0.6	49
	after school	eastern	0.7	0.5	34
		north east	1.2	0.5	24
		Total	0.9	0.6	58
	Total	eastern	0.5	0.5	61
		north east	1.0	0.7	46
		Total	0.7	0.6	107

Problems – within the family

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	0.8	0.4	27
		north east	0.8	0.6	22
		Total	0.8	0.5	49
	after school	eastern	0.8	0.6	34
		north east	0.9	0.7	24
		Total	0.9	0.6	58
	Total	eastern	0.8	0.5	61
		north east	0.9	0.7	46
		Total	0.8	0.6	107
Post	school holiday	eastern	0.5	0.5	27
		north east	0.8	0.5	22
		Total	0.6	0.5	49
	after school	eastern	0.6	0.6	34
		north east	1.2	0.6	24
		Total	0.9	0.7	58
	Total	eastern	0.5	0.5	61
		north east	1.0	0.6	46
		Total	0.7	0.6	107

Problems – outside the family

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	0.6	0.5	27
		north east	0.7	0.6	22
		Total	0.7	0.5	49
	after school	eastern	0.8	0.6	34
		north east	0.9	0.6	24
		Total	0.8	0.6	58
	Total	eastern	0.7	0.6	61
		north east	0.8	0.6	46
		Total	0.7	0.6	107
Post	school holiday	eastern	0.4	0.4	27
		north east	0.9	1.6	22
		Total	0.6	1.1	49
	after school	eastern	0.7	0.7	34
		north east	1.2	0.7	24
		Total	0.9	0.7	58
	Total	eastern	0.5	0.6	61
		north east	1.0	1.2	46
		Total	0.7	0.9	107

Problems Focused Coping

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	1.2	0.4	29
		north east	1.4	0.3	22
		Total	1.3	0.4	51
	after school	eastern	1.4	0.4	35
		north east	1.4	0.4	27
		Total	1.4	0.4	62
	Total	eastern	1.3	0.4	64
		north east	1.4	0.4	49
		Total	1.3	0.4	113
Post	school holiday	eastern	1.5	0.3	29
		north east	1.3	0.4	22
		Total	1.4	0.3	51
	after school	eastern	1.4	0.4	35
		north east	1.3	0.4	27
		Total	1.4	0.4	62
	Total	eastern	1.4	0.4	64
		north east	1.3	0.4	49
		Total	1.4	0.4	113

Emotion Focused Coping

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	0.9	0.4	29
		north east	1.2	0.4	22
		Total	1.0	0.4	51
	after school	eastern	1.1	0.6	35
		north east	1.1	0.5	27
		Total	1.1	0.5	62
	Total	eastern	1.0	0.5	64
		north east	1.2	0.4	49
		Total	1.1	0.5	113
Post	school holiday	eastern	0.9	0.4	29
		north east	1.0	0.6	22
		Total	1.0	0.5	51
	after school	eastern	1.2	0.4	35
		north east	1.2	0.4	27
		Total	1.2	0.4	62
	Total	eastern	1.1	0.4	64
		north east	1.1	0.5	49
		Total	1.1	0.5	113

Seeking Social Support (Coping)

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	0.9	0.4	29
		north east	1.2	0.4	22
		Total	1.0	0.5	51
	after school	eastern	1.0	0.4	35
		north east	1.4	0.5	27
		Total	1.2	0.5	62
	Total	eastern	1.0	0.4	64
		north east	1.3	0.5	49
		Total	1.1	0.5	113
Post	school holiday	eastern	1.1	0.4	29
		north east	1.1	0.5	22
		Total	1.1	0.4	51
	after school	eastern	1.2	0.5	35
		north east	1.4	0.5	27
		Total	1.3	0.5	62
	Total	eastern	1.1	0.5	64
		north east	1.3	0.5	49
		Total	1.2	0.5	113

Self-esteem

	program	region	Mean	Std. Deviation	N
Pre	school holiday	eastern	6.1	2.3	31
		north east	5.8	2.0	24
		Total	6.0	2.2	55
	after school	eastern	5.4	2.2	38
		north east	6.3	1.8	26
		Total	5.8	2.1	64
	Total	eastern	5.7	2.3	69
		north east	6.1	1.9	50
		Total	5.9	2.1	119
Post	school holiday	eastern	6.9	1.9	31
		north east	6.9	2.0	24
		Total	6.9	1.9	55
	after school	eastern	6.1	2.4	38
		north east	5.2	1.8	26
		Total	5.7	2.2	64
	Total	eastern	6.4	2.2	69
		north east	6.0	2.1	50
		Total	6.3	2.1	119

Appendix 4.1

OUTLINE FOR YOUNGCHAMPS CHILDREN'S PROGRAM, OCTOBER 2004 Fiona and Rose, Facilitators

This outline is designed as a guide only. The program will be very flexible due to the age of the children.

- Session 1: Getting to know you/Games
Evaluation (painting, kids connections/problems)
- Session 2: Construction, 'Your neighbourhood' (making buildings etc out of boxes, reverse garbage materials etc, paint, tape etc)
- Session 3: Dramatic Play/Dress ups (may use a theme eg family situations, characters from TV, books. Include music)
- Session 4: Puppets (possibly use felt glove puppets/finger puppets/cone puppets)
- Session 5: Masks (suggest half masks made out of cardboard)
- Session 6: Christmas Prezies (eg. Chocolates, bathbombs, cards)
- Session 7: Claybake (make clay to bake in the oven, use it to make figures, dolls, mobiles, decorations etc, and paint the following week)
- Session 8: Finish Claybake and final Evaluation painting and other evaluations
- Session 9: Final party/Presentation of certificates/Resources

- Other: At end of each session there will be 5 minutes of reading aloud, of a book which discusses feelings/families etc

There will be lots of other resources at hand to assist with children who need time out/different activities, eg play dough, cars and dolls, toys and games, sports equipment, soothing activities.

Appendix 4.2

Approach taken in the North East regarding incorporating younger children with the older group program.

The following details the approach taken and aims for how the North East group worked with the combined ages 5-12 within groups:

- Age appropriate activities were chosen or developed. These activities were flexible and easily adapted to the different age groups as well as having a number of open ended tasks so that children could work at their own level. Many of these activities were visual, creative and hands on.
- Discussions about mental illness often occurred in small groups and in different age groups. A leader or volunteer was in each group facilitating the conversation. In one School Holiday Program the group worked as a whole during the discussion about mental illness and everyone was able to contribute in their own way. No contribution was seen as less important than another.
- A benefit of having the two age groups together was that the older children were able to share their knowledge with the younger children 'peer teaching'. Thus the older children had an opportunity to reinforce their own knowledge about living with a parent who experiences mental illness and the younger children were able to gain this knowledge through a medium and using a language in which they would understand.
- Previous research has also supported the combination of sibling groups (e.g. Maybery, Ling and Szakacs, 2002) and is also part of the Upper Murray Family Care philosophy to be family orientated.

Appendix 4.3

Possible questions and issues when discussing the pictures of children in the 5-7 year age group.

Here are some suggestions when implementing and interpreting the drawings. The rationale for this process is drawn from the aims and objectives of the program.

Directions:

Ask the child to draw a picture of his or her house and in the same picture to draw a picture of his or her family, including him/herself and the parent with a mental illness. The child is to do this at the beginning and end of the program. Whatever process you currently use is fine, and might include a collage, a painting or whatever you consider to be most appropriate. It is however important to be consistent over the two occasions, that is, if you ask for a collage at the beginning of the program, then you will also need to ask for another collage at the end of the program. Consistency in materials also needs to be maintained over the two occasions, so, for example, if you ask the child to paint his or her family, then ensure that the same colour paints are made available over the two occasions.

Questions:

These questions have been developed in order to get some measure about how the child sees his or herself, and the child's perception of his or her family functioning. Consequently, the questions asked and the subsequent interpretations of the drawings need to be focused on these two general areas.

Some of the following questions may prove potentially upsetting. Please do not use these particular questions if you consider there is a risk of unnecessarily upsetting the child. If the child becomes upset, then please disregard this process and use your counselling skills to comfort and support the child.

The child might prefer to talk about him or herself in the third person, and refer to his or her pictorial representation of him or herself in this way. Alternatively, the child might just prefer to talk about him or herself, and you could then just use the drawing as a prompt or guide to direct further questions.

Questions are grouped into themes and are as follows:

General open-ended questions to start:

- Tell me about your picture.
- What is happening in your picture?
- What are you doing in this picture?
- How do you feel in this picture?
- Is this person happy or sad? (It is important to ask the child rather than assume a certain emotional state on the basis of the drawing alone).

Specific questions related to self-perception:

Self esteem:

- How would you describe yourself (or ‘that person’ and point to child’s representation of him or herself)?
- How do you think your friends would describe you?
- Is there anything that you would like to change about yourself?
- Do you like yourself? (or ‘this person’)?
- What is it that you like about yourself (or ‘this person’)?
- What is it that you don’t like about yourself (or ‘this person’)?

Resilience and coping:

- Are you [or ‘is this person’] strong? In what ways?
- Can you [or ‘this person’] manage difficult or tricky situations? In what ways?
- What do you [or ‘what does this person’] do when in a difficult or tricky situation?

Connectedness:

- Who do you [or ‘who does this person’] turn to when things aren’t going so well?
- Who do you [or ‘who does this person’] talk to when you have a problem?
- Who do you [or ‘who does this person’] have the most fun with, in your family?
- Who looks after you [or ‘this person’] in this family?

Family functioning:

Try to get some gauge of how the child functions in his or her family, level of conflict, how problems are resolved (or not resolved), the relationship between different members of the family and the child, and the type and frequency of good/bad times that occur in his or her family.

General:

- Who are the different people in your picture?
- What are they doing?
- What are they saying?
- What do the different people do together?
- What do the different people in this family do with you [or say, 'with this person' and point to the child's representation of him or herself].
- What are some of the good times that this family has?
- What are some of the bad times that this family has?

Level of conflict:

- What happens in this family when someone is angry?
- How do arguments get fixed?

Problem solving capacity of the family:

- What happens in this family when there is a problem?
- How are problems fixed?
- Who in this family helps you, if you have a problem [or 'this person' and point to the child's representation of him or herself]?

Interpretation of the drawings and evaluation of the program:

Try to record the main themes and issues that arose from your conversation (both pre and post program) with the child.

You might like to show the children both of their pictures, that is, from the start of the program and at the conclusion of the program, and ask the children to point out the differences themselves, in terms of how they feel about themselves, and their family.

Record as faithfully as possible, the child's words on both occasions. Also record your overall assessment of where the child is functioning in terms of self-perception (self esteem, resilience, coping) and family functioning. Note also anything of significance about the picture that you consider important, such as someone who might be missing.

No names or other identifiable features to be included in the pictures. If they are, please do not send these pictures to the evaluation team.

Please keep pre and post drawings together, along with your interpretative notes. Send these as a package to the evaluation team.

Please circle: Pre program post program

Please indicate the number of times this child has been involved in the program:

Facilitator's interviewing sheet:

	Sample questions	A record of the child's responses:
General open-ended questions	Tell me about your picture. What is happening in your picture? What are you doing in this picture? How do you feel in this picture? Is this person happy or sad?	

General issue	Sub issue	Sample questions	A record of child's responses:
Child self-perception	<p data-bbox="304 331 461 405">Self esteem</p> <p data-bbox="304 1025 461 1099">Resilience and coping</p> <p data-bbox="304 1391 461 1464">Connectedness</p>	<p data-bbox="481 331 938 367">How would you describe yourself?</p> <p data-bbox="481 405 975 479">How do you think your friends would describe you?</p> <p data-bbox="481 517 995 591">Is there anything that you would like to change about yourself?</p> <p data-bbox="481 629 767 665">Do you like yourself?</p> <p data-bbox="481 703 987 739">What is it that you like about yourself?</p> <p data-bbox="481 777 1062 813">What is it that you don't like about yourself?</p> <p data-bbox="481 851 887 887">Are you strong? In what ways?</p> <p data-bbox="481 925 932 999">Can you manage difficult or tricky situations? In what ways?</p> <p data-bbox="481 1037 1054 1111">What do you do when in a difficult or tricky situation?</p> <p data-bbox="481 1178 1067 1252">Who do you turn to when things aren't going so well?</p> <p data-bbox="481 1290 962 1364">Who do you talk to when you have a problem?</p> <p data-bbox="481 1402 1058 1476">Who do you have the most fun with, in your family?</p> <p data-bbox="481 1514 943 1550">Who looks after you in this family?</p>	

General issue	Sub-issue	Sample questions	A record of child's responses:
Family functioning	General	<p>Who are the different people in your picture?</p> <p>What are they doing?</p> <p>What are they saying?</p> <p>What do the different people do together?</p> <p>What do the different people in this family do with you?</p> <p>What are some of the good times that this family has?</p> <p>What are some of the bad times that this family has?</p>	
	Level of conflict	<p>What happens in this family when someone is angry?</p> <p>How do arguments get fixed?</p>	
	Problem solving capacity of family	<p>What happens in this family when there is a problem?</p> <p>How are problems fixed?</p> <p>Who in this family helps you, if you have a problem?</p>	

Kids Connections

Name _____

Some people have a lot of friends others have few. Think about your friends now.
How many friends do you have? _____

In the last month, how many times have you done the following:

- (a) gone to a friend's house to play _____
- (b) had a friend over to play _____

If you had a problem, how many of your friends (including adults) would be able to help you with that problem? _____

We want to know how often you had good times with other people in the last few weeks.

For the people shown below please put a cross through "None" if you were not with them during that time (or you were but you did not have a good time).

If the person did make you happy please put a cross through one of the smiley faces. Remember, the bigger the face the more often you had a good time.

<i>Person</i>	Did not happen	Happened Some	A lot	All the time
1. Time spent with your mum	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
2. Time spent with your dad	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
3. Good times spent with your brothers	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
4. Good times spent with your sisters	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
5. Time spent with a special grandparent (or other relative)	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
6. Time spent with your friend	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 
7. Another grown-up? Please write their name here.....	<input type="radio"/> None	<input type="radio"/> 	<input type="radio"/> 	<input type="radio"/> 

Kids Problems

Name _____

At times people have arguments, problems or fights with other people. We want to know how bad any problems were with others during the last few weeks.

For the people shown below please put a cross through "No" if that thing did not happen or was no problem.

If you did have a problem that made you sad, upset or angry then put a cross through one of the sad faces below. Remember, the bigger the face the bigger the problem and the more unhappy or sad you felt.

	No Problem	A Little	A lot	Major Problem
<i>Person</i>				
1. You had problems with your mum	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. You had problems with your dad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. You had problems with brothers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. You had problems with your sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. You had problems with a grandparent (or other relative)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. You had problems with a friend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. You had problems with another person (other than above) Please write their name here	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Strengths and Difficulties Questionnaire

Parents completed the Strengths and Difficulties questionnaire pre and post intervention. This measure is outlined in detail in the 8-12 year old section.

Parent support and education program.

Two measures were developed, pre and post program. These measured the ability of parents to access further community support, and to what extent they felt supported and better educated as a result of participating in the parent support program. See below.

Pre program questionnaire

Questions relating to parenting and mental illness

A. General information.

1.
 - a) How did you find out about the group?
 - b) What information were you given at the time?
 - c) Did the information provide you with clear and sufficient information about the program?
2. What would you like to achieve by attending the group?

B. Parenting support. (Please circle your response)

1. How confident are you as a parent?

Not at all		Moderately		Very confident
1	2	3	4	5

2. How understood do you feel as a parent with a mental illness?

Not at all		Moderately		Very much understood
1	2	3	4	5

3. How supported do you feel as a parent with a mental illness?

Not at all		Moderately		Very much supported
1	2	3	4	5

4. How often do you talk generally to other parents about your children?

Not at all		Sometimes		Often
1	2	3	4	5

5. How often do you discuss your mental health/illness concerns with other parents?

Not at all		Sometimes		Often
1	2	3	4	5

6. How often do you discuss parenting concerns with community, health and/or educational workers?

Not at all		Sometimes		Often
1	2	3	4	5

7. How confident are you about accessing parenting support and information?

Not at all		Moderately		Very confident
1	2	3	4	5

8. How much knowledge do you have about mental illness and parenting?

None		Some		A lot
1	2	3	4	5

9. How often do you positively interact with your children (for example, read to your child, play a game, cook together, watch sport and so forth)?

Not at all		Sometimes		Often
1	2	3	4	5

10. How would you describe your family environment?

Negative		Sometimes positive, sometimes negative		Always positive
1	2	3	4	5

11. Please make any other general comments about your needs as a parent with a mental illness.

Post program questionnaire

Questions relating to parenting and mental illness

A. Parenting support. (Please circle your response)

1. How confident are you as a parent?

Not at all		Moderately		Very confident
1	2	3	4	5

2. How understood do you feel as a parent with a mental illness?

Not at all		Moderately		Very much understood
1	2	3	4	5

3. How supported do you feel as a parent with a mental illness?

Not at all		Moderately		Very much supported
1	2	3	4	5

4. How often do you talk to other parents about your children?

Not at all		Sometimes		Often
1	2	3	4	5

5. How often do you discuss mental health/illness concerns with other parents?

Not at all		Sometimes		Often
1	2	3	4	5

6. How often do you discuss parenting concerns with community, health and/or educational workers?

Not at all		Sometimes		Often
1	2	3	4	5

7. How confident are you about accessing parenting support and information?

Not at all		Moderately		Very confident
1	2	3	4	5

8. How much knowledge do you have about mental illness and parenting?

None		Some		A lot
1	2	3	4	5

9. How often do you positively interact with your children?

Not at all		Sometimes		Often
1	2	3	4	5

10. How would you describe your family environment?

Negative		Sometimes positive, sometimes negative		Always positive
1	2	3	4	5

11. Please make any other comments about the program here.

12. Please make any other general comments about your needs as a parent with a mental illness.

Thank you for your responses.

Appendix 5.1.

Worker questionnaire second phase.

CONSENT TO PARTICIPATE

Project title: Evaluation of mental health agency professional development and interagency/sector collaborations in relation to children of parents with a mental illness.

“I on / /04 have read and understood the information above, and any questions I have asked have been answered to my satisfaction. I agree to participate in the project realising that I may withdraw at any time. I agree that research data provided by me or with my permission during the project may be used in a report, for student research purposes, presented at conferences and/or published in journals at a later time, on the condition that neither my name nor any other identifying information is used.”

I also consent (please tick) to receiving two email reminders in relation to the 12 month follow up questionnaire (please provide your email address – below – *only if you agree* to receiving reminders by email). My email address is as follows:

_____@_____

Signature.....

Agency Name:.....

Mailing Address:.....

.....

Did you complete this questionnaire as part of the “Getting there Together’ training program? Please circle **Yes** **No**

1. What percentage of your clients/patients is younger than 13 years of age?

Please circle don’t know or the approximate percentage

Don’t Know None 10 20 30 40 50 60 70 80 90 100

2. What percentage of these children has a parent with a mental illness?

Please circle don’t know or the approximate percentage

Don’t Know None 10 20 30 40 50 60 70 80 90 100

3. How much **knowledge** do you have about children whose parents have a mental illness? (please circle below).

	None	A Little	Some	A Lot
Don’t Know	0	1	2	3

4. Over the last 12 months, what percentage *of your clients/patients with a mental illness* were also parents with at least some of their children living in their home?

Please circle don't know or the approximate percentage

Don't Know None 10 20 30 40 50 60 70 80 90 100

5. With that percentage of your clients, how often do you focus on their needs (or role) as a parent?

Never One Case A Few Cases Some Cases Many Cases All Cases
0 1 2 3 4 5

6. Also with those clients, how often do you discuss or focus upon the needs of their children?

Never One Case A Few Cases Some Cases Many Cases All Cases
0 1 2 3 4 5

7. What percentage of your *clients/patients who have children living at home* could you discuss the problems that those children might have related to the parent's mental illness?

Please circle don't know or the approximate percentage

Don't Know None 10 20 30 40 50 60 70 80 90 100

8. For those that you *could not* discuss the problem/s, what would be the barriers to you doing so? Using the following scale as a guide, circle the number that best represents your answer to each of the barriers/issues below. Please indicate your level of agreement or disagreement as to how much each barrier/issue applies to you?

Not applicable	Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	
n/a	0	1	2	3	4	
a. The client's mental illness is too active or they are too medicated	n/a	0	1	2	3	4
b. The client denies that they have a mental illness	n/a	0	1	2	3	4
c. The client does not see their illness as being a problem for their child/ren	n/a	0	1	2	3	4
d. The client just does not want to talk about their children	n/a	0	1	2	3	4
e. The client doesn't want to talk about it because they are concerned it will make things worse for their children	n/a	0	1	2	3	4
f. You don't think your clients illness is a problem for their child/ren	n/a	0	1	2	3	4
g. You don't have time to spend on the issue of the children	n/a	0	1	2	3	4
h. It is not part of your role to get involved with the issues of your client's children	n/a	0	1	2	3	4
i. You have limited <i>knowledge</i> about working with <i>children</i> and the issues involved for them	n/a	0	1	2	3	4
j. You have limited <i>knowledge</i> about working with <i>adult</i> clients regarding the issues for their children (ie impact of the problem on children, advising parents regarding parenting issues etc)	n/a	0	1	2	3	4
k. You have limited <i>skills</i> in working with such <i>children</i>	n/a	0	1	2	3	4
l. You have limited <i>skills</i> to work with <i>adult</i> clients regarding their children	n/a	0	1	2	3	4
m. If it would jeopardise the relationship you were trying to build with the adult client (ruining rapport, client becomes defensive)	n/a	0	1	2	3	4
n. You think that it will burden and be detrimental to the children	n/a	0	1	2	3	4
o. The children are not able to (e.g. they are in foster care) or do not want to be involved	n/a	0	1	2	3	4
p. There are problems of distance and transport for doing things with the child/ren	n/a	0	1	2	3	4
q. Your organisation does not have the resources (including time) to involve the children	n/a	0	1	2	3	4

9. We are also interested with how many of your clients/patients, during the last 12 months, you provided support, information or education to a child/ren or about the child (e.g. helping the parent) whose parent has a mental illness? Please indicate your activity below for the following:

	Never 0	One Case 1	A Few Cases 2	Some Cases 3	Many Cases 4	All Cases 5
a. Met with the family together	0	1	2	3	4	5
b. One to one contact with the child/ren	0	1	2	3	4	5
c. One to one counselling to the parent about the children	0	1	2	3	4	5
d. Emotional support to the child/ren	0	1	2	3	4	5
e. Emotional support to the parent about the child/ren	0	1	2	3	4	5
f. Provided education or information to the child/ren about the parent's mental health problem	0	1	2	3	4	5
g. Provided education or information to the parent to educate child/ren about mental health problem	0	1	2	3	4	5
h. Made a referral regarding the child/ren to another agency or practitioner	0	1	2	3	4	5
i. Other: please detail _____	0	1	2	3	4	5

10. Who have you consulted (including referrals) during the last 12 months about children whose parents have a mental illness? Indicate using the following scale.

	Never 0	One Case 1	A Few Cases 2	Some Cases 3	Many Cases 4	All Cases 5
a. A General Practitioner	0	1	2	3	4	5
b. Mental Health Service Psychiatrist	0	1	2	3	4	5
c. Adult Mental Health Service Worker (e.g. Psychologist, nurse, social worker, O.T.)	0	1	2	3	4	5
d. Private Psychiatrist	0	1	2	3	4	5
e. Private Psychologist	0	1	2	3	4	5
f. Psychiatric Inpatient staff	0	1	2	3	4	5
g. Child protection worker	0	1	2	3	4	5
h. Supporting kids/VicChamps project worker	0	1	2	3	4	5
i. Education department personnel (e.g. school teacher, social worker, psychologist)	0	1	2	3	4	5
j. Health and welfare sector worker (e.g. community health worker)	0	1	2	3	4	5
k. Other Professional (please indicate title) _____	0	1	2	3	4	5

11. In the last 12 months how often have you referred a child/ren in such circumstances to another agency/practitioner or program for counseling, treatment or support?

Never	One Case	A Few Cases	Some Cases	Many Cases	All Cases
0	1	2	3	4	5

12. To the best of your knowledge how beneficial has the VicChamps or Supporting Kids program been during the last 12 months? Please circle below using the following scale. Circle Don't Know if you only recently learnt of the program or you have no knowledge of the program.

	None	A Little	Some Benefit	A Lot	Very Beneficial
Don't Know	0	1	2	3	4

13. If you indicated above that VicChamps-Supporting kids has been beneficial please indicate (tick) in the appropriate square below what has been helpful to you. Also provide any additional comments in the spaces provided.

	Don't Know d/k	None 0	A Little 1	Some Benefit 2	A Lot 3	Very Beneficial 4
a. Provided information/knowledge about children whose parents have a mental illness (e.g. from 'Getting There Together' workshops etc)	d/k	0	1	2	3	4
b. Improved my skills regarding children whose parents have a mental illness	d/k	0	1	2	3	4
c. Improved my skills regarding working with parents	d/k	0	1	2	3	4
d. Provided secondary consultation/s regarding children whose parents have a mental illness	d/k	0	1	2	3	4
e. Provided programs for children whose parents have a mental illness	d/k	0	1	2	3	4
f. Provided (improved) resources (e.g. materials, books etc)	d/k	0	1	2	3	4
g. Other skill development in working with parents/children (please specify)_____	d/k	0	1	2	3	4

Please comment on any of the above or anything else that you would like to add?

Are there any resources that you require in relation to children whose parents have a mental illness?

Thanks for supporting children whose parents have a mental illness

Dear Rose's Boss

3/4/05

I went to champs because my dad had Depression and the doctor said champs would help me to cope understand.

Champs was good because it helped me cope and handle dad's yelling and bad moods. I learnt that I don't always have to go and do on dad to mum because I know how to handle things better now.

I also learnt how to make more friends and not get into so many fights because if I am stressed I get upset and start yelling and get into fights so Rose and Carmine taught me how to handle things but not everything. I learnt not to stress so much and have to remember how to have fun.

Kids Club is really fun and I'm always excited before I go. I like going to Kids Club because it helps me with my stress and anger.

Other kids should go to champs because it will help them all deal with problems they have when there mum or dad has a mental problem and it will help them deal with all the anger and stress in there parents body.

Rose and Carmine have been doing a good job and teaching me that I don't have to go and cry all the time and I don't have to be embarrassed all the time either.

Lauren and Lisa are the leaders at Kids Club. They help to look after us and organise for us to do fun things.

I think they all do a really good job and I just thought you should know all that, but sometimes Lauren is silly because she broke her leg.

From Ashleigh (9 yrs old)