



CHAMPS: A peer support program for children of parents with a mental illness

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Abstract

Having a parent with a mental illness can create considerable risks in the mental health and wellbeing of children. While intervention programs have been used effectively to reduce children's psychopathology, particularly those whose parents have a specific diagnosis, little is known about the effectiveness of these early interventions for the wellbeing of children of parents who have a mental illness from a broad range of parents. Here we report on an evaluation of CHAMPS (*Children And Mentally ill ParentS*), a pilot intervention program offered in two formats (school holiday and after school peer support programs) to children aged 8-12 whose parents have a mental illness. The wellbeing of 69 children was evaluated at the beginning of the programs and four weeks after program completion, on instruments examining self-esteem, coping skills, connections (total, within and outside the family) and relationship problems (total, within and outside the family). Post intervention, there were significant improvements in self-esteem, coping and connections within the family, and reductions in relationship problems. The impact on children's wellbeing differed according to the intensity of the program (consecutive days or weekly program). The results are discussed in the context of providing interventions for children whose parents have a mental illness and the implications for service provision generally.

Keywords

children of parents with a mental illness; parental mental illness; children; early intervention; peer support; evaluation; resilience; wellbeing

Introduction

Strengths-based interventions for at-risk children have the overarching aim of improving resilience in young people and children. Resilience is the ability to bounce back or rebound from adversity (Werner & Smith, 1982). Fostering positive outcomes in young people is especially important in those individuals experiencing adversity in the face of abuse, neglect and/or trauma and is emerging as a powerful tool for the prevention of future mental health and substance abuse issues (Fuller, McGraw & Goodyear,

2002). Resilience involves both inner strengths (e.g., optimism, self-esteem and adaptive coping techniques) and relational strengths (e.g., connectedness) (Grotberg, 1995). Relations with others are thought to be very important, including quality family connections (Resnick, Harris & Blum, 1993) and support from such things as positive educational institutions and experiences whilst there (Fuller, McGraw & Goodyear, 1999; Resnick et al., 1993). This paper reports on the impact of CHAMPS (*Children And Mentally ill ParentS*) - a strengths-based peer support pilot intervention -

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Citation: Goodyear, M., Cuff, R., Maybery, D., & Reupert, A. (2009). CHAMPS: A peer support program for children of parents with a mental illness. *Australian e-Journal for the Advancement of Mental Health*, 8(3), <http://amh.e-contentmanagement.com/archives/vol/8/issue/3/article/3479/champs>

Published by: *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)*
www.auseinet.com/journal

Received 4 September 2009; Revised 18 November 2009; Accepted 18 November 2009

on building resilience factors such as coping, connectedness and self-esteem in children of parents with a mental illness.

Peer support groups utilise a peer setting to promote individual growth where children learn by interacting with, observing and listening to peers in similar circumstances (Rose & Edleson, 1987). Other advantages include instilling a sense of belonging through group membership, and addressing children's needs and issues collectively while conducting this intervention in a cost effective manner (Geldard & Geldard, 2001). Children utilise this format to enhance their emotional and social development, as the formation of peer relationships can have a strong influence on the regulation of children's behaviour and attitude formation (Cuff & Pietsch, 1997). These peer support groups often utilise a strengths-based approach that enhances resilience using a model of preventative and early intervention to modify risk and protective factors (Fraser, James, Anderson et al., 2006).

Between 21-23% of Australian families are living, or have lived, in a household where at least one parent has a mental illness (Maybery, Reupert, Patrick et al., 2009). Children living with parental mental illness are more likely to be taken into care (Leschied, Chiodo, Whitehead & Hurley, 2005), develop their own mental health issues (Leschied et al., 2005) and/or substance abuse issues (Mowbray & Oyserman, 2003), and experience adjustment problems or behavioural difficulties (Farahati, Marcotte & Wilcox-Gök, 2003). At the same time, however, young people can develop resilient strengths such as resourcefulness, and greater knowledge, confidence and maturity when growing up in a household where a parent has a mental illness, as reported by adult offspring in a retrospective study (Kinsella, Anderson & Anderson, 1996).

Given the prevalence and associated risks for children where a parent has a mental illness, several preventative interventions for young people and children have been developed. Many of these have been developed for children whose parents have a specific mental illness diagnosis, typically an affective disorder. For example, Beardslee and colleagues (1997, 2003) reported on a family-based psycho-educational intervention that was successful for children of parents with depression in gaining a better

understanding of their parent's illness and demonstrated decreases in children's internalising symptomatology. Ginsburg (2009) reports on an intervention, for children whose parents have an anxiety disorder that involved targeted family therapy sessions (coping and promoting strengths). At one year follow-up, significant reductions were seen in children's levels of anxiety, compared to the waitlist control group. For another intervention with adolescents of parents with depression, a randomised controlled trial demonstrated that a weekly intensive group program with monthly follow-up sessions targeting problem solving skills and cognitive restructuring techniques, resulted in a reduction in depressive episodes and symptomatology, compared to a control group (Garber, Clarke, Weersing et al., 2009). Interestingly however, the prevention program was only effective when the parent was not currently experiencing symptoms of depression, possibly due to the fact that the adolescents of parents currently depressed tended to show higher incident depression themselves.

In Australia, three programs for children of parents with a mental illness have been recently evaluated, targeting young people whose parents have varied mental illness diagnoses. The *Paying Attention to Self* (PATS) program for teenagers aged 12-18 years involves eight weekly sessions that focus on coping strategies and knowledge of mental illness within a peer setting (Hargreaves, Bond, O'Brien et al., 2008). The PATS program showed significant reductions in depressive symptoms, the risk of homelessness, and stigma at 12-month follow-up (Hargreaves, O'Brien, Bond et al., 2005). Another program, the *Koping Adolescent Group Program* (KAP), showed modest effects for adolescents with a parent with a mental illness (Fraser & Pakenham, 2008). No significant differences were observed when the program was compared to a waitlist control group; however, clinically significant improvements were seen in mental health literacy, symptoms of depression and life satisfaction (Fraser & Pakenham, 2008). The *Simplifying Mental Illness and Life Enhancement Skills Program* (SMILES) involved a three consecutive day program for children aged 8-16 years where a parent or sibling has a mental illness (Pitman & Matthey, 2004). The program saw significant improvements in children's

knowledge of mental illness and enhanced life skills using a peer support model. Whilst these three studies outline the effectiveness of their interventions for the children, especially in regards to symptomatology, mental health literacy and/or life satisfaction or skills, the effect of these interventions on targeted aspects of wellbeing, including self-esteem, coping styles and connectedness, are not thoroughly explored. This is particularly important given that promoting coping skills and resilience are central to the aims of many interventions for children of parents with a mental illness. It must be noted that Fraser and Pakenham (2008) did include an examination of social connectedness and coping styles but did not find any effect of the intervention on these elements of wellbeing. The impact of parental mental illness extends over and above the development of a mental illness in the children themselves, and includes other areas where adjustment may be affected, such as social competence and education (Seifer, Sameroff, Dickstein et al., 1996). Thus, it would be beneficial to evaluate the impact of interventions on multi-faceted elements of wellbeing in more detail.

This paper outlines the evaluation of strengths-based peer support pilot program for 8-12 year old children, with a particular focus on multiple wellbeing outcomes. The evaluation component aimed to establish whether changes occurred in the wellbeing of children following their involvement in the CHAMPS program. Changes were explored according to program type (school holiday and after school) at pre to post (four week post program) intervention points. The study design did not incorporate a control group. While overall generalisability of the data are limited in this research design, pilot testing of a program can nonetheless provide useful data that refines an intervention program and identifies crucial implementation issues before offering the program as a full scale intervention (Chen, 2005). Thus, this paper seeks to extend the evidence base for the effectiveness of peer support programs for children whose parents have a range of diagnosed mental illnesses, utilising outcome measures targeting self-esteem, coping styles, connectedness and relationship problems, both within and outside the family unit.

Method

The CHAMPS program

CHAMPS programs first began in 1995 as part of a federally funded project to develop interventions for children whose parents have a serious mental illness (Cuff & Pietsch, 1997). The CHAMPS program, targeting children aged 8-12 years, living with parental mental illness, provides information about a range of mental illnesses in an age appropriate way and promotes healthy coping strategies using a strengths-based approach. Peer support programs for this age group have been widely implemented in a variety of settings. It is also considered that an approach utilising peer support is developmentally appropriate for this age group. The program 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 wellbeing to children;
- develop and establish a strong collaborative role for health professionals and family workers; and
- build on children's strengths and promote resilience by bolstering protective factors.

In 2003, as part of a government funded project addressing a model of best practice for children of parents with a mental illness (the VicChamps Project), a comprehensive evaluation of the effectiveness of two types of CHAMPS peer support interventions was conducted (school holiday and after school programs). School holiday programs were run over four consecutive days and aimed to provide the opportunity for children to meet regularly and offer a sense of belonging and acceptance. The program also aimed to increase independence from parents and other adults, accompanied by a parallel connectedness with peers. After school programs were similar in content but were undertaken as shorter sessions (two hours) over regular time intervals (weekly over one school term or

fortnightly over two school terms). The after school program included a mid-term information session and both programs included an end-of-term graduation ceremony for parents/guardians and family members. The key aims of both programs are to be supportive, educative, build on peer connections and create connectedness to the community beyond the province of mental illness.

Participants

Data were collected from 69 children who participated in school holiday programs ($n = 31$) or after school programs ($n = 38$) in a metropolitan region of Melbourne Victoria. One hundred and twenty-nine children attended eight school holiday and 16 after school programs over a three year period, but participants were only included in this analysis if they had completed both the pre and post intervention measures. Thirty-four children attended both programs (i.e., a school holiday program and an after school program). Analyses were conducted to compare children who had attended both intervention programs compared to children who attended only one program to determine the possible impact of multiple interventions. No significant effects of multiple program attendance were found on any of the wellbeing factors measured. For the purposes of this study, the children are included in the group that they attended first.

Table 1. Age, gender and parental mental illness of participants who completed both pre and post measures for the interventions

	School holiday ($n = 31$)	After school ($n = 38$)
Mean age (years)	9.0	9.4
Gender	7M, 24F	13M, 25F
Parental mental illness (n % of children)		
Schizophrenia	7 (22.6%)	3 (7.9%)
Bipolar Disorder	6 (19.3%)	9 (23.7%)
Depression	5 (16.1%)	6 (15.8%)
Depression & Schizoaffective Disorder	4 (12.9%)	-
Borderline Personality Disorder (BPD)	2 (6.5%)	5 (13.1%)
BPD & Depression	2 (6.5%)	9 (23.7%)
Anxiety & Depression	2 (6.5%)	2 (5.3%)
Depression & PTSD	2 (6.5%)	1 (2.6%)
Bipolar & Depression	-	2 (5.3%)
Bipolar & Depression & Social Phobia	1 (3.2%)	1 (2.6%)

Table 1 shows the age and gender of the children, as well as the parents' mental illness diagnoses. More females than males participated in the evaluation of the intervention programs, but this was similar for both programs. The mean age of the children was also similar for both programs (overall mean 9.3 years). Even though 8-12 years was the target age group, there were a small number of 6, 7 and 13 year olds included in the evaluation, based on a clinical decision by the program facilitator to include siblings in the program. Three children (4.3%) had a mother and a father with a mental illness.

Taking into consideration the limited financial and physical resources available and the perceived benefit of providing a peer support 'space', the program design did not target a particular diagnosis in the parent. Instead, the program developers recognised that across parental diagnosis, children's experiences were more similar than dissimilar and sought to assist the children to explore themes around the impact of hospitalisation, children taking on caring responsibilities, and living with stigma. Parental mental illness included anxiety, depression, bipolar disorder, borderline personality disorder, post-traumatic stress disorder, schizoaffective disorder and schizophrenia. The number of parental disorders was essentially similar across both programs with the exception that slightly more children in the school holiday program had a parent with schizophrenia whereas slightly more children in the after school programs had a parent with borderline personality disorder (see Table 1).

Procedure

Children were referred to the program by community mental health agencies or by a parent. A home visit by the CHAMPS group facilitator was undertaken to engage the family, to provide information and to obtain informed parental consent for the child's participation in the program and in the program evaluation. Ethics approval was sought and gained for the evaluation by the relevant university and health service.

On the first day of each program, each child was asked to complete measures of Kids Problems, Kids Connections, Kids Coping and the Self-esteem scale. Approximately four weeks after

the program, the child measures (problems, connections, coping and self-esteem scales) were sent to the participants with reply paid envelopes. Whilst it might be advisable to obtain post scores immediately upon completion of the program, we believed they were best provided some time after, given that many of the wellbeing measures require a longer reflective time frame. All information collected was given to the researchers in a de-identified condition.

Instruments

Kids Connections and Kids Problems

Two recently developed measures were utilised to tap into all of the possible relationships that might exist for 8-12 year old children. 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; Headley & Wearing, 1989; Zautra & Reich, 1983). Given the increasing support for dual affectivity dimensions, it was important to use measures that reflected the key positive relationships for children (Kids Connections) and the key negative relationships for children (Kids Problems). The items were developed to reflect a child's key possible relationships and included such items as 'time spent with your mum' and 'time spent with your best friend'. The 11 items were grouped together to form a total connections/problems score or broken down into a subscale for 'within family' connections/problems which included mum, dad, siblings and grandparents, and a subscale for 'outside family' connections/problems which included friends, teachers, and other important adult like a sporting coach. Both measures asked children to respond on a four-point scale ('smiley faces' for the connections scale and 'sad faces' for the problems measure), from 'none' (0) (did not happen), 'happened some' (1), 'happened a lot' (2), to 'happened all the time' (3). The total connections/problems and respective subscales were calculated by summing responses to all the items and averaging by the number of the items to form the final score. Reliability of the subscales has been calculated as follows: within Family Connections (0.57 Cronbach's Alpha), Outside Family Connections (0.67), Within Family

Problems (0.52) and Outside Family Problems (0.72) (Maybery, Reupert, Steer & Goodyear, 2009).

Coping

The Kids Coping scale is designed to have three clear factors representing problem-focused coping, emotion-focused coping and social support (Maybery et al., 2009). The measure is used as a brief, 9-item general measure of activities important for this age group on a three-point Likert scale, from 'never' (0), 'sometimes' (1), to 'a lot' (2). The items were designed to reflect distinct cognitive and behavioural coping actions such as 'you tried to think of different ways to solve the problem'. Scores for each item were summed and averaged by the number of items to form the total score. The measure has low to moderate levels of internal consistency with reliabilities calculated at 0.58 for Problem-Focused Coping and 0.30 for Emotion-Focused Coping (Maybery et al., 2009).

Self-esteem

The Rosenberg-Simmons Self-Esteem Scale (RSSSES) is used as an indicator of global self-esteem. The 6-item scale is modified from the 10-item Rosenberg Self-Esteem Scale for adolescents (Rosenberg, 1979). Responses are generally scored on a three point scale (0-2), with higher numbers signifying high self-esteem. Rosenberg (1979) report internal reliability for the RSSSES of 0.90.

Results

Table 2 presents pre and post mean scores for self-esteem, coping, connections and relationship problems. A 2 x 2 mixed design ANOVA was conducted to examine the impact of the two types of intervention programs (school holiday and after school) on children's wellbeing measures at pre and post intervention.

There was one significant interaction found between program type and time (pre to post intervention) for problem focused coping (Wilks Lambda = .89, $F(1, 62) = 7.948$, $p = .006$, partial eta squared = .114), with the school holiday program showing large improvements in problem focused coping relative to the after school program (see Table 2). Reductions in relationship problems were also noted for the school holiday program; however, these changes were not significant.

Table 2. Subscale means and standard deviations for pre and four week post time frames in the school holiday and after school programs

	School holiday			After school			Total		
	n	Pre (Mean, SD)	Post (Mean, SD)	n	Pre (Mean, SD)	Post (Mean, SD)	n	Pre (Mean, SD)	Post (Mean, SD)
Connections									
Total	30	1.29 (0.49)	1.40 (0.42)	35	1.36 (0.39)	1.41 (0.37)	65	1.33 (0.44)	1.40 (0.39)
Within family	30	1.34 (0.57)	1.45 (0.46)	35	1.09 (0.42)	1.21 (0.51)	65	1.21 (0.50)	1.32 (0.50)
Outside family	30	1.28 (0.61)	1.36 (0.49)	35	1.67 (0.49)	1.63 (0.46)	65	1.49 (0.58)	1.51 (0.49)
Problems									
Total	27	0.68 (0.31)	0.38 (0.32)	34	0.76 (0.47)	0.66 (0.55)	61	0.73 (0.41)	0.53 (0.48)
Within family	27	0.80 (0.36)	0.45 (0.45)	34	0.79 (0.57)	0.61 (0.61)	61	0.79 (0.49)	0.54 (0.55)
Outside family	27	0.62 (0.50)	0.35 (0.38)	34	0.77 (0.65)	0.69 (0.71)	61	0.71 (0.59)	0.54 (0.61)
Coping									
Problem-focused	29	1.20 (0.41)	1.48 (0.30)	35	1.39 (0.44)	1.39 (0.43)	64	1.30 (0.43)	1.43 (0.37)
Emotion-focused	29	0.92 (0.41)	0.92 (0.36)	35	1.11 (0.56)	1.16 (0.45)	64	1.02 (0.51)	1.05 (0.43)
Social support	29	0.90 (0.44)	1.06 (0.42)	35	1.05 (0.44)	1.19 (0.49)	64	0.98 (0.45)	1.13 (0.46)
Self-esteem									
	31	6.07 (2.32)	6.90 (1.87)	38	5.43 (2.29)	6.08 (2.41)	69	5.72 (2.29)	6.45 (2.21)

Significant main effects for time were found for self-esteem (Wilks Lambda = .92, $F(1, 67) = 5.791$, $p = .019$, partial eta squared = .08), social support coping (Wilks Lambda = .92, $F(1, 62) = 5.689$, $p = .020$, partial eta squared = .084), connections within the family (Wilks Lambda = .935, $F(1, 63) = 4.363$, $p = .041$, partial eta squared = .065), total problems (Wilks Lambda = .818, $F(1, 59) = 13.091$, $p = .001$, partial eta squared = .182), within family problems (Wilks Lambda = .806, $F(1, 59) = 14.233$, $p = .0001$, partial eta squared = .194), and outside family problems (Wilks Lambda = .915, $F(1, 59) = 5.449$, $p = .023$, partial eta squared = .085). In each variable, participants showed changes in the expected direction from pre to post intervention for both the school holiday and after school programs.

There were also significant between group differences in emotion focused coping ($F(1, 62) = 5.381$, $p = .024$, partial eta squared = .08), within family connections ($F(1, 63) = 4.958$, $p = .030$, partial eta squared = .073) and connections outside the family ($F(1, 63) = 9.977$, $p = .002$, partial eta squared = .137). For children attending the after school program, participants showed lower levels of within family connectedness and higher levels of emotion-focused coping) compared to children attending the school holiday program. For connections outside the family, children attending the school

holiday program scored lower than children in the after school program.

In summary, there were improvements on a number of wellbeing factors, with specific improvements in self-esteem, problem-focused coping, social support coping, connections within the family, as well as total, within family and outside family problems.

Discussion

At four weeks post intervention, children who attended the school holiday and/or the after school CHAMPS programs demonstrated improvements in self-esteem, social support coping, and connections within the family. Reductions were recorded in total relationship problems including within and outside family subscales, again for both the school holiday program and the after school program. The school holiday program had the additional benefit of improving problem-focused coping.

These findings support a small body of knowledge that interventions targeting the mental wellbeing of children of parents with a mental illness are successful in creating positive outcomes in this cohort. The majority of studies have reported that interventions lead to reductions of the onset of child psychopathology, and/or mental health literacy (Beardslee et al., 1997, 2003; Fraser & Pakenham, 2008; Garber et al., 2009; Ginsburg, 2009; Hargreaves et al.,

2005). Peer support interventions have also been found to be particularly effective for this cohort (Fraser & Pakenham, 2008; Hargreaves et al., 2005; Pitman & Matthey, 2004). The present study supports the benefits of the peer support model for the target age cohort and demonstrates significant gains in positive wellbeing outcomes for children of parents with a mental illness. The model of peer support has several advantages, including an effective process to learn about mental illness and to assist children to discover other children in similar circumstances and benefit from the 'shared' experience (Cuff & Pietsch, 1997). Utilising the peer support framework for pre-pubescent upper primary school aged children appears a powerful tool at this developmental stage to promote gains in emotional and social development (Geldard & Geldard, 2001). The shared experience underpinning the peer support model aids participants in gaining alternative perspectives and problem solving skills and encourages them to formulate their own coping skills (Turner, 1999).

At four weeks follow-up, the school holiday program and the after school program both showed significant changes to children's wellbeing. The school holiday program had the additional benefit of leading to improvements in problem-focused coping, a coping style aimed at changing the environment or oneself in order to overcome a problem (Folkman, Chesney, McKusick et al., 1991). Whilst the content of both programs was essentially the same, differences lie in the particular focus of each program and the intensity of the delivery of the program. The school holiday program had a particular focus on recreation in addition to education and building resilience, and was conducted over four consecutive days. The after school program met weekly or fortnightly, and for shorter blocks of time (2 hours each session). Thus the added intensity of the school holiday program appears to have led to greater change at four week follow-up. It must also be noted that just under half of the children attended multiple programs and this might have been expected to have an influence on the pre to post changes found in these measures. However, no significant effect was found as a result of the number of programs the children attended and hence the pre to post changes most likely reflect

attendance at an intervention per se irrespective of the amount of times the intervention is applied. This finding is noteworthy for child-focused interventions and has important implications for service delivery in that the delivery of multiple programs of a similar nature may not be an effective use of resources for this cohort.

The evaluation reported here indicates that connectedness outside the family was not shown to improve for either program, which is surprising given the peer support focus of the intervention. However, this finding may be explained by the post evaluation being timed four weeks after their involvement in the program and thus those relationships may not have been sustained. This lack of change in outside family connections, including peer connections, does support the lack of effect reported by Fraser and Pakenham (2008) in their evaluation of KAP. Even though the target group differed with the present study, no change was seen in social connectedness as a result of their intervention. Hargreaves et al. (2008) note that there are potential risks in utilising the peer support model for children of parents with a mental illness, and for the PATS peer support program these included young people increasing their peer connections with other participants at the expense of external social networks. In future, CHAMPS and other approaches might examine ways to increase outside family networks.

The present study reports improvements in key wellbeing variables for children one month after completion of the program. However, further studies are needed in this area to assess their long-term impact of such programs. A major weakness in this study is that changes observed over the course of the intervention were not compared to a control group. The decision not to include a control group was based on ethical grounds to ensure that children had access to these interventions as early as possible, though it is acknowledged that this form of research design is problematic in terms of generalisability and rigor. Ongoing evaluations should be undertaken by future programs with standardised measures to allow for comparisons with other programs or groups (such as a wait list control), and to develop further research knowledge

regarding families with a parent with a mental illness. Nonetheless, the current exploratory study highlights a potentially promising new program for children living in these families.

In summary, the results of the present study suggest that the CHAMPS program is an effective and useful model for building strengths and protective factors in children of parents with a mental illness, and provides an opportunity for establishing sustained mental wellbeing. Future developments could investigate strategies to improve outside family networks.

Acknowledgements

This article would not have been possible without the considerable support and input from Eastern Health Mental Health, and the funding provided by *beyondblue: the national depression initiative*, the Mental Health Branch of the Victorian Department of Human Services, and Victorian Health Promotion Foundation (VicHealth). Finally, we thank the families who gave their time and knowledge to this study.

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