



Australian programs and workforce initiatives for children and their families where a parent has a mental illness

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Abstract

The aim of this study was to review the child, parent and family programs and workforce initiatives in Australia that target children and families where a parent has a mental illness. Fifty two individual telephone interviews were conducted with facilitators responsible for 60 child, parent, family and workforce programs across Australia. Interviewees were asked to describe (i) the program provided, (ii) the evidence framework of the program, and (iii) evaluation strategies employed. To supplement this data, three consumers and one carer were interviewed regarding their involvement in programs. Participants were identified through websites, e-discussion lists and snowball recruiting. Audio transcripts from the interviews were qualitatively analysed, using thematic analysis, alongside inter-rater reliability and member checks. Of the 60 identified programs, there were 26 child and adolescent programs, six programs for parents with a mental illness, four family programs and 24 workforce training initiatives. Program facilitators typically drew on their clinical experiences, rather than research, when developing programs. Generally, evaluation strategies were non standardised and/or measured participant satisfaction of programs. There was no systematic way of involving and supporting consumers and carers. Recommendations are made regarding evaluation training, a participation framework for consumers and carers, funding for programs, and the establishment of a formal network for sharing resources and facilitator experiences.

Keywords

children of parents with a mental illness; parental mental illness; programs; children; families; consumers; carers; evaluation

Introduction

Families where a parent has a mental illness experience many adversities compared to other families. As 21-23% of Australian families have, or have had, at least one parent with a mental illness (Maybery, Reupert, Patrick et al., 2009),

it is important to develop effective and multifaceted interventions for family members. A snapshot of Australian programs and workforce initiatives for such families is presented as well as the perspectives of carers and consumers involved in these programs, to highlight current practice strengths and issues.

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While risk varies depending on a range of contextual and individual variables, children whose parents have a mental illness are more likely to be taken into care, develop a mental health problem, and/or substance abuse issue (Lescheid, Chiodo, Whitehead & Hurley, 2005; Mowbray & Oyserman, 2003). Oyserman, Mowbray, Meares and Firminger (2000) found that mothers with a serious mental illness have significantly less adequate parenting skills than other mothers in the community. Such families tend to have poor communication patterns and a low sense of cohesion (Warner, Mufson & Weissman, 1995). Finally, a review paper has highlighted various workforce barriers for working with family members, including gaps in worker attitude, knowledge and skill, lack of clear organisational policy and difficulties with interagency collaboration (Maybery & Reupert, 2009). Collectively, such research highlights the need for a multifaceted approach that targets the children, parents who have a mental illness, the family as a whole, and the workforce (Reupert & Maybery, 2007).

Given the prevalence and associated risk for families living with parents who have a mental illness, it is essential that appropriate interventions are developed. However, in a critique of 26 published intervention programs for children whose parents have a mental illness, Fraser, James, Anderson et al. (2006) highlighted the lack of rigorous evaluation methods, with nearly half (46%) of these programs failing to explicitly state a theoretical framework (James, Fraser & Talbot, 2007).

In order to ascertain services across Australia, the *Children of Parents Affected by a Mental Illness Scoping Project* (AICAFMHA, 2001) distributed questionnaires across Australian agencies that were likely to have a role in supporting children, parents and families affected by parental mental illness. Of the 44 programs identified, 34 provided programs to different family members (e.g., parenting programs or school holiday programs for children), while four targeted workforce change, and the remainder involved research/policy development. Since that time, several key Australian documents have been developed — *Pathways to Resilience: Children of Parents with a Mental Illness Project Report* (Smith &

Nicholls, 2002); *Principles and Actions for Services and People Working with Children of Parents with a Mental Illness* (AICAFMHA, 2004); and *Families Where a Parent has a Mental Illness* (Mental Health Branch, 2007) — highlighting the need to embed family sensitive practices into agency services. It remains to be seen whether these guidelines have resulted in changed service delivery. Additionally, given that the field has a limited evidence base (Fraser et al., 2006; James et al., 2007) identifying common themes across programs has the potential to ‘provide *reasonable hypotheses*, and suggest sufficient starting points for more rigorous research and the development of an evidence base for the treatment of parents with a mental illness and their families’ (Hinden, Biebel, Nicholson et al., 2006, p. 24). Rather than the traditional science to service pathway, which traces the development of interventions from academic settings into community practice, identifying current practice models can highlight the program elements that can then be studied in more detail (Nicholson, Hinden, Biebel et al., 2007).

The aim of this study was to provide a snapshot of current child, parent, family and workforce programs in Australia for children and families where a parent has a mental illness. As infant-mother psychiatric units have been extensively reviewed and/or studied internationally (Glangeaud-Freudenthal & Barnett, 2004; Joy & Saylan, 2007), in New Zealand (Wilson, Bobier & Macdonald, 2004) and in Australia (Buist, Minto, Szego et al., 2004; Fisher, Feekery & Howe, 2004), these were excluded from the current study. Thus, overall this study sought to identify from program facilitators:

- (i) key components of programs (e.g., program goals, delivery strategies, participant demographics, carer and consumer involvement);
- (ii) evidence base for the interventions employed, including theoretical framework; and
- (iii) evaluation strategies employed.

To supplement the data collected from facilitators, consumers and carers were interviewed regarding their involvement in programs.

Method

Overall, 52 program facilitators (including workforce providers) were interviewed regarding 60 programs, along with four consumers/carers. Program facilitators were identified in three ways; first, via a national public database established in 2004 that provides a list of programs across Australia for families where a parent has a mental illness (see http://www.copmi.net.au/jsp/copmi_programs/index.jsp). This list has been promoted widely across Australia [Fudge, E: personal communication, 2008]. Second, facilitators were identified via a public e-list, which is regularly promoted on the *Children of Parents with a Mental Illness* (COPMI) website home page, through state and territory mental health networks and at conferences [Fudge, E: personal communication, 2008]. Finally, a snowballing process was undertaken, whereby interview participants were asked to identify others that work in the area (Kitton, Chesters & Grbich, 2008). Once identified, program facilitators and workforce providers were emailed information and consent forms about the study and invited to participate. The one to two hour interviews were audio-taped, with participant permission, using questions focusing on the three aims of the study.

In the interviews, facilitators were also asked about the nature and extent of consumer/carer involvement in their programs, *and* asked to identify a consumer/carer who might be available for an interview. With permission of the consumer/carer, the facilitator released his/her name to the researcher at which point the researcher contacted the consumer/carer and invited him/her to an interview about the nature of their involvement in various programs. Ethics approval for the study was provided by the relevant university ethics committee.

Results

Data analysis

Sixty programs were identified, including 26 child and adolescent programs, six programs for parents with a mental illness, four for families and 24 workforce initiatives. Audio transcripts from the individual telephone interviews were transcribed and data analysed within each of the

three research questions, for each of the program areas. One researcher reviewed each individual transcript and identified arising themes. To enhance validity, member checks were implemented, whereby interview participants were invited to review and critique the identified themes from their original interview transcripts (Kitton et al., 2008). After feedback was incorporated, the interviewer and another member of the research team independently identified themes across transcripts, within the three research questions. The two researchers subsequently met and finalised the themes reported here (inter-rater reliability) (Kitton et al., 2008). At this point, analysis consisted of qualitative theme identification plus frequency counts. Of the nine consumers/carers contacted, three consumers and one carer were available. Interview data were also analysed by content theme analysis, member checks and inter-rater reliability.

Children and adolescent programs

Program description

Eighteen facilitators responsible for 26 programs were identified, with some providing different programs for children of various ages¹. Of the 26 programs, 12 targeted children aged 8-13 years, seven programs targeted adolescents (12/13-18 years) and three programs targeted children under eight years of age. Four programs targeted children across developmental stages (e.g., 8-18 years of age). Parents' mental illness diagnoses were broad and included bipolar disorder, depression, dual diagnosis (substance abuse with co-occurring psychiatric diagnosis), schizophrenia and anxiety. According to 15 facilitators, children's inclusion in programs was primarily on the basis of their parent having a mental illness, with 15 facilitators stating that children were excluded from programs if they had significant physical or emotional issues, including a psychological diagnosis such as ADHD. Facilitators did not target any specific cultural group and children's socio-economic and cultural background was dependent on the program's locality. Facilitators reported multiple program goals including peer support (16 of the 18 facilitators), education about mental illness (15), respite from caring responsibilities (10), to have fun (7), to learn ways of coping (7) and to enhance resilience (7). There was considerable

overlap in the type of interventions employed including formal and informal discussion groups (all facilitators), psycho-educational sessions (13 of the 18 facilitators), fun activities such as cooking and craft (10), and specific exercises to enhance coping and resilience (4). Funding was drawn from state and federal governments. Some needed to reapply for funding regularly, for example, yearly, and many spoke about what one facilitator summarised as *'the constant scramble for funding'*. Ten facilitators provided programs in urban areas with transport being an issue for all localities.

In terms of consumer/carer involvement, five facilitators involved young people as peer support leaders, another three involved parents with a mental illness on a steering committee and one included a parent as a guest speaker in the program. Support and/or remuneration for consumers and carers ranged from nonexistent to being fully paid for the time involved (though not including planning time). Facilitators who did not include consumers/carers stated that they did not have the time, staff or resources to include them, while one reported *'I haven't really thought about it'*.

Evidence base

Most facilitators (17) drew on their clinical experiences of working with young people, when developing programs. Seven facilitators described needs analysis conducted by their organisation as evidence for program development. Program facilitators found it difficult to articulate the theoretical basis for their program but some mentioned strength-based theory, resilience and/or attachment theory.

Evaluation

Thirteen of the 18 facilitators indicated that they evaluated their programs. Ten employed non-standardised measurement tools they had developed themselves. Three facilitators did not evaluate their programs, with one facilitator reporting that this was because *'kids plan the activities and drive the planning of activities'*. A further two facilitators were in the process of developing an evaluation strategy. Dropout rates were measured by three facilitators, though data was not consistently maintained. According to these facilitators the main reason for drop out was the young person having moved away from

the program's geographical area or being placed in foster care. (Data and discussion related to the young people's programs are provided in greater detail in Reupert & Maybery, 2009).

Programs for parents with a mental illness

Program description

Of the six programs, five provided group programs for parents with a mental illness, and of these, four also provided individual support (such as home visiting or case management). The remaining program provided a mentoring support group for parents, where mothers were matched to other mothers with similar interests and mental illness diagnosis. Parents were predominately mothers, though one facilitator stated *'any parent is accepted but to date only mothers have participated'*. No specific cultural groups or mental illness diagnosis were targeted, and facilitators reported that while parents came from a wide spectrum of demographics they were predominately from lower socio-economic groups. Most programs aim to improve social and community connectedness and peer support (5) and enhance parenting skill (6). Managing mental illness was a key but not sole focus as one facilitator reported:

'[We aim to...] place parenting centrally in the recovery process so that their treatment and support options are not just about the management of their illness but the management of its impact on their relationships, their self-concept and role identity.'

All programs employed interventions that emphasised education with four of these specifying that the information was parent led; *'[the] group is consulted on what areas they would like to address and learn more about'*. Funding came from multiple sources, most commonly from state governments, though was typically short lived. One program was offered in both urban and rural areas, two were offered in rural areas, and three were run in urban localities.

Consumers/carers were involved in all six programs in some way; five involved consumers/carers in the planning of their programs, and three involved consumers/carers in program delivery either as a co-facilitator or as a guest speaker. Facilitators reported that their organisation did not have a consistent system of remuneration or support for consumers/carers.

Evidence base

Facilitators' experiences of working with parents and previous program evaluations were the main sources of evidence used to develop programs. There was some mention of systems theory, attachment theory, feminist theory and strength-based theory.

Evaluation

All six programs were evaluated, typically measuring participant satisfaction (4). Five also used a pre and post evaluation strategy on a variety of mostly self-developed scales. Five facilitators measured dropout rates though there did not appear to be a systematic way of doing this, with anecdotal reasons for participant dropout including child care issues or participants gaining employment.

Programs for families

Program description

One of the four identified family programs was a playgroup for the parent and his/her children, one provided services to families in their homes, another provided 'a space and place for the families to get together, a place where families can come together to make sense of the issues in their lives' and the fourth offered a support program for children concurrently with a separate program for their parents. While all identified as family programs, one facilitator indicated that her program had a dominant focus on parents, while another focused more on the needs of children: *'our program is a child centred program that has the capacity to offer support for the parents as well'*. Two were for families with children aged between two and five, and two were for families with children aged 0-18 years. Programs were open to parents with various mental illness diagnoses. All offered flexible services, with one facilitator reporting that *'families can come to the group as long as they need'* and another suggesting that *'we might re-engage with families when there is a crisis or when changes occur, for example, developmentally'*. No specific cultural or demographic group was targeted. The main goals for family programs were to improve social connectedness within as well as outside of the family (including linking in to other services), improve child outcomes and provide mental health education. Funding came from a

combination of state, federal and philanthropic sources. All four programs were offered in urban areas. All involved consumers/carers in the planning of the program with two also involving consumers/carers in program delivery. There was no consistent method of remuneration or support offered to consumers and carers.

Evidence base

Facilitators' own experiences of work with families, research (early childhood and attachment research was most commonly cited) and government reports were reported as the evidence base for programs. Theories most commonly reported included strength-based, systems and attachment theory.

Evaluation

Three of the four programs were evaluated (the fourth had plans for evaluation) using self-developed measures, with two also employing standardised measures including the Strengths and Difficulties Questionnaire (SDQ: Goodman, 2001) and the Family Assessment Device (FAD: Ryan, Epstein, Keitner et al., 2005) pre and post program. Three facilitators report that they measure dropout rates, but two qualified this by suggesting that participants rarely dropped out once they started the program. Anecdotal reasons provided for participant dropout included the child no longer living with the parent or a parent's anxiety about attending.

Workforce

Program description

Twenty four workforce training facilitators were interviewed; five ran prescribed training programs, two were involved with tertiary training, and the remainder (17) were in delegated positions to enhance workforce capacity. Eight targeted both rural and urban areas, 13 focused on rural and three focused on urban areas. Most programs were state funded and half were time limited and did not have ongoing funding. Training dealt with a broad range of diagnosis as the focus was on supporting families and the effects on children. Most commonly, facilitators aimed to increase workers' capacity to respond to the needs of children, carers and families where a parent has a mental illness (13), raise awareness of these issues (12), and enhance workforce collaboration (5). Across facilitators, the content of programs

involved the impact of the mental illness on children and parenting capacity, how to work with families, and collaborative practices.

The target audience was mostly adult mental health workers (12), followed by generalist mental health workers and community-based health workers (8) and child and adolescent mental health workers (7). There was also a range of one-off training programs provided to workers from other agencies, such as juvenile justice. All training involved face to face sessions that ranged from full day, half day to one hour sessions. Format was dependent on whether the facilitator provided formal training, or if the facilitator was embedded in a workplace and provided informal training through collaboration and mutual sharing of information.

Seven programs employed consumers/carers as guest speakers or as a co-presenter, five used video to portray the lived experience of consumers, four involved consumers in planning, while eight out of the 24 programs had no consumer/carer involvement.

Evidence

Participants indicated that workforce change initiatives were based on previous research (14), government and state policy documents (11), prior work experiences (9), other professional guideline documents (4), and consultations with others in the field, such as other workforce trainers (5).

Evaluation

Nine workforce respondents measured changes in workers' skill and knowledge, pre and post training, using self-developed measures, while five others used post program satisfaction questionnaires. The remaining ten did not evaluate at all. Two respondents measured participant dropout rates.

Consumers and carers

The consumers and carers interviewed reported that they were mainly involved to 'tell their story' at training programs, though there was some involvement in the development of materials, providing feedback on materials already developed, advocacy roles and raising children's issues in various forums. Three of the four received formal wages for their role and/or received remuneration for lunch, photocopying,

consultancy fees, with child care arrangements offered, though it was stressed that this was not standard practice for many organisations. Preparation time was usually not remunerated. Some also described receiving gifts rather than money. Participants had various levels of support ranging from no support to one consumer receiving support from a mentor. When asked why they thought they were involved, one interviewee suggested that she was involved so that the organisation '*could tick the box, it's all about ticking the box*'. Others believed that their involvement was genuinely valued.

Discussion

In Australia, programs for children and families where a parent has a mental illness primarily focus on supporting children and adolescents of parents with a mental illness (26) as well as enhancing workforce capacity (24). Comparatively fewer programs target parents with a mental illness (6) and the family as a unit (4). In the 2001 Scoping Project (AICAFMHA, 2001), the largest proportion of programs also targeted children and adolescents of parents with a mental illness but at that time only a very small proportion of programs (four of 44 programs) reported targeting the workforce. The increase in emphasis on workforce development may be related to the inclusion of children of parents with a mental illness in key areas of the *National Practice Standards for the Mental Health Workforce* (Commonwealth Department of Health and Ageing, 2002). The overall increase from 44 to 60 programs over the period from 2001 to 2009 is significant; however, given the prevalence of such families (Maybery et al., 2009) and the emphasis parental mental illness has received nationally (e.g., AICAFMHA, 2004) and in state and territory mental health plans (Australian Health Ministers' Conference, 2008) the comparative increase in programs is inadequate to influence the ongoing transmission of mental illness and associated problems in families with a parent who has a mental illness.

In terms of young people's programs, many target children aged 8-13 years, followed by programs for adolescents. It is also interesting to note that many programs exclude children with behavioural and/or emotional difficulties, indicating that programs focus on health

promotion and illness prevention, rather than on treatment. Parent programs focused predominately on providing peer support and enhancing parenting skill, with managing mental illness being only one aspect of the intervention. Family programs focused on enhancing connectedness within and outside of families, in a flexible manner. Across intervention programs, there appears to be a lack of specifically developed programs for indigenous and culturally and linguistically diverse populations, for fathers and for families in rural and remote areas. Overall, connectedness in various forms (e.g., peer support for either children or parents; attachment between parent and child; connections with outside services and within the family), as well as education about mental illness, are common intervention goals in programs targeting children, parents and families. In respect to workforce programs, most programs aim to enhance the capacity and awareness of the workforce in this area, with some also focusing on workforce collaboration. The often repeated content areas across the 24 workforce respondents indicate a duplication of resources across states/territories and organisations. Finally, according to facilitators and the consumers and carers interviewed, consumers and carers are mostly involved in 'telling their story' as well as providing feedback on materials for programs. There does not appear to be a consistent framework of involving and supporting (including remunerating) consumers and carers in programs.

Many programs focus on individual rather than key environmental factors, such as housing and schooling. Another common issue across child, parent, family and workforce programs, is a lack of comprehensive and rigorous evaluation tools and methodologies, with few measuring participant dropout rates, and many employing self-developed as opposed to standardised outcome measures, similar to the finding of Fraser and colleagues (2006), highlighting an Australian training priority for those working in the field. Furthermore, a sound theoretical and/or evidence base for programs appears to be lacking, again consistent with another study (James et al., 2007), with program facilitators relying on their own clinical experiences and/or the evaluation reports of others. Finally, funding

for many programs is often short term and reliant on multiple sources.

A limitation of the present study is that only those facilitators identified via a network predominately orientated towards the public health sector were interviewed, which might have missed those working in the non government or community sectors. There was only a small number of consumers and carers available to be interviewed and the views presented here might not be representative. At the same time, based on the results of the present study as well as previous research, several recommendations can be made to policy makers and program developers:

1. *Funding.* In order to establish a sound and rigorous evidence base for programs in this area funding for program development, implementation and evaluation needs to be long term. Goodman and Steckler (1989) argued that funding for a three year period is too short for program developers to demonstrate evidence, and instead urged governments to invest in a plan of at least five years to gather substantive data.
2. *Program evaluation.* Program evaluation needs to be built into program implementation from the outset. Programs need to move from employing participant satisfaction measures to also including a comprehensive evaluation plan based on clearly articulated program goals. Evaluation needs to address program efficacy (the extent to which a program produces the desired outcomes) as well as program effectiveness (the transferability of the program) (NSW Department of Health, 2003). Participant dropout rates need to be consistently measured and the reasons for participant dropout identified.
3. *Theoretical framework.* Even though theory can assist program developers to think broadly about areas of intervention (James et al., 2007), facilitators reported various and often disparate theories. As program theory and evaluation are interrelated, evaluation training packages need to incorporate a theoretical framework for those working with families where a parent has a mental illness. Such a theoretical framework would

need to consider the various pathways of risk for such families, incorporating the social and biological as well as individual factors that programs might subsequently target.

4. *Needs analyses.* This study showed that programs target a broad range of mental illnesses. However, not all families where a parent has a mental illness are the same, and the level of risk for families varies, according to a variety of moderators (Maybery et al., 2009). Thus, it is important that program facilitators undertake a comprehensive needs assessment of program participants, including individual as well as environmental variables (such as housing, poverty and so on). This process would assist in program development and delivery and ensure that resources are deployed in the most effective manner.
5. *Consumer and carer involvement.* Facilitators need to genuinely value consumer and carer participation and have the time, resources and training to provide adequate, appropriate support. Consumers and carers need to have access to training, remuneration and practical support structures that underpin flexible participation.
6. *Formal networking.* A formal sharing network of resources, information, evaluation data and experiences is required for program facilitators to provide a basis for comparison and to avoid the duplication of resources.

Given the issues for families where a parent has a mental illness, it is essential that appropriate and effective interventions are developed. The issues in program development and evaluation and gaps in service delivery identified here provide a direction for future program developers as well as policy makers and agency administrators.

Note

1. For children's programs the unit of analysis is the facilitators while for the other programs it is the programs themselves. Some of the facilitators for children's programs were responsible for more than one program (e.g., delivering one program for younger and another for older children). This meant that some programs had similar/identical goals and interventions, though pitched at

different ages. Thus, the focus on facilitators as opposed to programs more clearly represents the themes as a whole for children's programs.

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References

- AICAFMHA (2001). *Children of Parents Affected by a Mental Illness - Scoping Project*. Stepney, (SA): Australian Infant, Child, Adolescent and Family Mental Health Association Ltd.
- AICAFMHA (2004). *Principles and Actions for Services and People Working with Children of Parents with a Mental Illness*. Adelaide: Australian Infant Child Adolescent and Family Mental Health Association Ltd. Available at http://www.copmi.net.au/files/PrinciplesandActions_final.pdf
- Australian Health Ministers' Conference (2008). *Council of Australian Governments National Action Plan for Mental Health 2006-2011: Progress Report 2006-07*. Canberra: Australian Health Ministers.
- Buist, A., Minto, B., Szego, K., Samhuel, M., Shawyer, L., & O'Connor, L.O. (2004). Mother-baby psychiatric units in Australia - the Victorian experience. *Archives of Women's Mental Health*, 7(1), 81-87.
- Commonwealth Department of Health and Ageing (2002). *National Practice Standards for the Mental Health Workforce*. Canberra: National Mental Health Education and Training Advisory Group, Commonwealth Department of Health and Ageing.
- Fisher, J., Feekery, C., & Howe, H. (2004). Treatment of maternal mood disorder and infant behaviour disturbance in an Australian private mothercraft unit: a follow-up study. *Archives of Women's Mental Health*, 7(1), 89-93.
- Fraser, C., James, E.L., Anderson, K., Lloyd, D., & Judd, F. (2006). Intervention programs for children of parents with a mental illness: A critical review. *International Journal of Mental Health Promotion*, 8(1), 9-20.
- Glangeaud-Freudenthal, N. & Barnett B.E.W. (2004). Mother-baby inpatient psychiatric care in different countries: Data collection and issues - Introduction. *Archives of Women's Mental Health*, 7(1), 49-51.

- ▶ Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child & Adolescent Psychiatry*, 40, 1337-1345.
- Goodman, R.M. & Steckler, A. (1989). A model for the institutionalization of health promotion programs. *Family & Community Health*, 14(4), 63-78.
- ▶ Hinden, B.R., Biebel, K., Nicholson, J., Henry, A., & Katz-Leavy, J. (2006). A survey of programs for parents with mental illness and their families: Identifying common elements to build the evidence base. *Journal of Behavioral Health Services & Research*, 33(1), 21-38.
- ▶ James, E.L., Fraser, C., & Talbot, L. (2007). Vulnerable children in families affected by parental mental illness: The role of theory in programme development. *Vulnerable Children and Youth Studies*, 2, 142-53.
- Joy, C.B. & Saylan, M. (2007). Mother and baby units for schizophrenia. *Cochrane Database of Systematic Reviews*, 24(1):CD006333.
- Kitton, S.C., Chesters, J., & Grbich, C. (2008). Quality in qualitative research. *Medical Journal of Australia*, 188(4), 243-246.
- ▶ Leschied, A.W., Chiodo, D., Whitehead, P.C., & Hurley, D. (2005). The relationship between maternal depression and child outcomes in a child welfare sample: Implications for treatment and policy. *Child & Family Social Work*, 10(4), 281-91.
- ▶ Maybery, D. & Reupert, A. (2009). Parental mental illness: A review of the barriers and issues for working with families and children. *Journal of Psychiatric and Mental Health Care Nursing*, 16(9), 784-791.
- ▶ Maybery, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of children whose parents have a mental illness. *Psychiatric Bulletin*, 33, 22-26.
- Mental Health Branch (2007). *Families Where a Parent has a Mental Illness*. Melbourne: Victorian Government Department of Human Services.
- ▶ Mowbray, C.T. & Oyserman, D. (2003). Substance abuse in children of parents with mental illness: Risks, resiliency, and best prevention practices. *Journal of Primary Prevention*, 23(4), 451-482.
- ▶ Nicholson, J., Hinden, B., Biebel, K., Henry, A., & Katz-Leavy, J. (2007). A qualitative study of programs for parents with serious mental illness and their children: Building practice-based evidence. *Journal of Behavioral Health Services & Research*, 34(4), 395-413.
- NSW Department of Health (2003). *NSW Parenting Partnerships. A Framework for Mental Health Service Involvement in Promotion, Prevention, and Early Intervention Through Parenting Initiatives. Strategies for 2002-2004*. Sydney: NSW Department of Health.
- ▶ Oyserman, D., Mowbray, C.T., Meares, P.A., & Firminger, K.B. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry*, 7(3), 296-315.
- ▶ Reupert, A. & Maybery, D. (2007). Families affected by parental mental illness: A multiperspective account of issues and interventions. *American Journal of Orthopsychiatry*, 77(3), 362-369.
- ▶ Reupert, A. & Maybery, D. (2009). A 'snapshot' of Australian programs to support children and adolescents whose parents have a mental illness. *Psychiatric Rehabilitation Journal*, 33(2), 125-132.
- Ryan, C.E., Epstein, N.B., Keitner, G.I., Miller, I.W., & Bishop, D.S. (2005). *Evaluating and Treating Families: The McMaster Approach*. New York: Routledge.
- Smith, W. & Nicholls, D.S. (2002). *Pathways to Resilience: Children of Parents with a Mental Illness Project Report*. Perth: Health Department of Western Australia.
- ▶ Warner, V., Mufson, L., & Weissman, M. (1995). Offspring at high and low risk for depression and anxiety: Mechanisms of psychiatric disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(6), 786-797.
- ▶ Wilson, D.A., Bobier, C., & Macdonald, E.M. (2004). A perinatal psychiatric service audit in New Zealand: Patient characteristics and outcomes. *Archives of Women's Mental Health*, 7(1), 71-79.