



Guest editorial

Children aged 0-5 with a parent who has a mental illness: The need for early intervention

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Keywords

children of parents with a mental illness; infants; parents; early intervention; evaluation

Background

Considerable evidence from the fields of neuroscience, social psychology, developmental psychology and preventive science indicates that targeting interventions in the early years of a child's life can prevent long-term adverse outcomes and, in addition, improve parents' functioning (Shonkoff & Phillips, 2000). Although not all children whose parents have mental health problems will experience difficulties themselves, their risk of having a mental illness is two to three times higher than the general population (Worland, Weeks & James, 1987). A combination of factors including psychosocial adversity, children's age and developmental status, family relationships, the severity and chronicity of the parental psychiatric disorder, and the involvement of other carers in the child's life, all impact on the child's risk of psychopathology (Fudge, Falkov, Kowalenko & Robinson, 2004). Furthermore, families affected by parental mental illness are also more likely to experience poverty and social isolation (Reupert & Maybery, 2007) and are more likely to have children taken into care (Leschied, Chiodo, Whitehead & Hurley, 2005).

Other research has sought to quantify the problems experienced by families where a parent

has a mental illness. In a survey of clients of an adult mental health service, 50% of children of parents with a mental illness experienced significant mental health problems (Mathai, Jespersen, Bourne et al., 2008). Anywhere between 20-35% of mental health service clients are female parents of dependent children and have young children (less than 6 years old), 70% of whom are living with them, and about 30% of these mothers also have a history of alcohol and other drug use (Mathai, et al., 2008). Following a census of current adult mental health clients, between 28-33% of those who were parents had dependents aged 0-5 years (Howe, Batchelor & Bochynska, 2009).

Rates of common child psychiatric disorders and the patterns of co-morbidity in preschoolers are similar to those seen in later childhood (Egger & Angold, 2006). I argue that a similar prevalence of difficulties can be anticipated for very young children. Mental health problems in Scandinavian young children aged 18 months can be reliably identified, and the prevalence of disorders in this age group is between 16-18% (Skovgaard, Houmann, Christiansen et al., 2007). The prevalence of social-emotional and behavioural problems in a community sample of one and two year old children is 11.6% in a representative sample of infants in the US

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- Citation:** Kowalenko, N. (2009). Children aged 0-5 with a parent who has a mental illness: The need for early intervention. *Australian e-Journal for the Advancement of Mental Health*, 8(3), <http://amh.e-contentmanagement.com/archives/vol/8/issue/3/article/3470/children-aged-05-with-a-parent-who-has-a-mental>
- Published by:** *Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)*
www.auseinet.com/journal

population (Briggs-Gowan, Carter, Skuban & Horwitz, 2001). This suggests a community prevalence of disorders of between 11.6% and 18% in international samples. If such data can be extrapolated to young children in Australia, then 23-50% of children whose parents are affected by mental illness may be experiencing significant mental health problems, assuming their risk of experiencing a mental health problem is two to three times higher than the general population (Worland et al., 1987).

What is being done?

An Australian survey in 2001 (AICAFMHA, 2001) found that only four programs addressed the needs of parents with young children aged 0-5 years. A recent 'snapshot' of Australian programs to support young people whose parents have a mental illness demonstrates a similar disparity (Reupert & Maybery, 2009). The vast majority of programs catered for 8-18 year olds and only three catered for 5-8 year olds. In the main, program facilitators were not able to report on information pertaining to parents' mental illness, although many stated that substance abuse with co-occurring psychiatric diagnosis was common (Reupert & Maybery, 2009).

Given that 21-23% of Australian children live with a parent who has or had a mental illness (Maybery, Reupert, Goodyear et al., 2009), this is an insufficient response. There appears to be a considerable service gap for children under the age of eight and for those living in rural and remote areas of Australia (Reupert & Maybery, 2009). Specific programs for particular demographic groups, such as Indigenous children and those from culturally and linguistically diverse backgrounds, have not been developed, representing major gaps in service delivery. Moreover, the recent snapshot found, in terms of program evaluation strategies, that facilitators found it difficult to identify the theory that drives their practice and hence program evaluation strategies were limited (Reupert & Maybery, 2009).

Evaluation

I believe that sound evaluation strategies are underpinned by program logic. Program logic provides a rationale which links outcomes with the key activities of a program. In other major public mental health initiatives, the implementation of program logic has been a

crucial step in developing an evaluation framework, and for identifying the key components of effective interventions (Penrose-Wall & Kowalenko, 2000). The salience of articulating program logic (sometimes referred to as program modelling) for prevention programs has also recently been highlighted (Martin, Krysinska & Swannell, 2008). Should a public mental health approach achieve its aims, the factors responsible for success must be identified to ensure they can be sustained, further refined and generalised. This process is dependent on a comprehensive evaluation framework (Martin, 2007).

The relative paucity of research, evaluation and workforce development in the area of children of parents with a mental illness has been noted (Nicholson & Denevey, 2009) and this particularly applies to the needs of young children aged 0-5 years. Perhaps the exception to this in the Australian context has been perinatal depression, a topic I will return to.

A public health approach informs the National COPMI Initiative and has been funded by the Australian Government Department of Health and Aging (Fudge & Robinson, 2009). The initiative has developed materials specifically for parents in the perinatal period (AICAFMHA, 2004). Materials for parents with toddlers, preschoolers and young school aged children aged 2-7 years have recently been launched (AICAFMHA, 2009a) while other educational material specifically targeting early childhood workers has also been developed (AICAFMHA, 2009b).

The pilot information materials were carefully evaluated by 18 consumers or carers, and then 19 parent consumers participated in focus groups in two states to test the parents' booklets for children aged 2-7 years. Feedback was also sought on the early childhood workers' resources and focus group comments from 32 early childhood and 10 infant mental health workers were analysed. The qualitative feedback regarding both resources was considered by the reference group and then incorporated into subsequent drafts, prior to their launch in October, 2009 (Fudge, E. personal communication).

Obtaining feedback from stakeholders on resources is critical, given that qualitative

evaluation methods have identified that parents with a mental illness experience stigma and fear losing custody of their children and of being discriminated against by service providers, resulting in a reluctance to seek help for parenting difficulties (Alakus, Conwell, Gilbert et al., 2007; Fudge & Mason, 2004). There are pilot programs for parents that appear to have overcome some of these difficulties, in the US (Nicholson, Albert, Gershenson et al., 2009) and in Australia, where for example, the average age of children of parents who attended one program was 4.75 years (Phelan, Lee, Howe & Walter, 2006).

In sum, comprehensive descriptions of the processes that underlie early intervention in young children are available (Erickson & Kurz-Riemer, 1999) but rigorous process and outcome evaluations in Australian initiatives for children of parents affected by mental illness in the 0-5 year old age group are rare.

Perinatal and infant mental health

In comparison, however, in the perinatal period, there are significant policy, service and practice initiatives underway, mostly focusing on primary care. Part of the foundation for this ongoing work flows from the policy development process for Promotion, Prevention & Early Intervention in Mental Health (Commonwealth Department of Health and Aged Care, 2000a,b). In a related development, beyondblue: The National Depression Initiative, has begun a national implementation of the *National Action Plan for Perinatal Mental Health 2008-2010* (beyondblue, 2008). This Plan has been built on a wide evidence base, including research conducted by beyondblue (Buist, Bliszta, Milgrom et al., 2006), the scope of practice in perinatal psychiatry (Austin, 2003), the evidence base for early intervention in the perinatal period (Kowalenko, Barnett, Fowler & Matthey, 2000), the feasibility of routine perinatal screening within an integrated care model (Barnett, Glossop, Matthey & Stewart, 2005), psychosocial risk assessment models (Priest, Austin, Barnett & Buist, 2008), policy developments in some states (NSW Department of Health, 2009), the results of acceptability of screening to consumers (Buist, Condon, Brooks et al., 2006) and a review of international guidelines.

The Plan provides a population health approach to improving the perinatal mental health and wellbeing of women and their relationship with their infant. While the long-term goal is to also improve the mental health and wellbeing of infants, fathers/partners and families, the Plan does not provide recommendations to address their particular needs, or elaborate an evaluation strategy that might demonstrate these outcomes.

There is an emerging evidence base for interventions that meet the needs of fathers and of infants. The impact of paternal depression on child development (Ramchandani, Stern, O'Connor et al., 2008), tools for case identification (Matthey, Barnett, Kavanagh & Howie, 2001) structured approaches to the psychosocial assessment of expectant fathers (Fletcher, Vimpani, Russell & Sibritt, 2008) and early evaluation approaches (Friedewald, Fletcher & Fairbairn, 2005), are all available for fathers in the Australian context. Thus, along with the *National Action Plan for Perinatal Mental Health*, there is a need for matching initiatives targeting fathers that could, for example, involve a routine psychosocial assessment and identification of depression and other risks, such as alcohol and drug use. Given the paucity of practice in this area, it is reasonable to predict that the mental health of fathers will emerge as a major public health initiative in the near future as the evidence base develops further.

For infants, toddlers and preschoolers of depressed mothers, interventions that improve outcomes (particularly for infants) involve not only treating maternal depression and other risk factors, but also providing parenting interventions that enhance the parent/infant relationship (Van Doesum, Riksen-Walraven, Hosman & Hoefnagels, 2008). Limiting treatment to parental depression alone may not be sufficient to improve infant wellbeing (Nylen, Moran, Franklin & O'Hara, 2006).

While I view the beyondblue *National Action Plan for Perinatal Mental Health 2008-2010* as limited in scope, it is nonetheless a major national public mental health achievement for mothers and possibly infants. The Plan enhances the opportunity for the identification of vulnerable parents (systematically and routinely for mothers and opportunistically for fathers).

Moreover, implementation of the Plan could provide a framework for the early identification of young children affected by their parents' mental illness and the opportunity to provide preventive interventions in pregnancy and in the early years.

There has been some, albeit little, documented research regarding interventions for specific parental illness diagnoses. A strong case for focussing on borderline personality disorder as a parental mental illness that confers significant risk for socio-emotional development of children has been made (Newman, Stevenson, Bergman & Boyce, 2007; Royal College of Psychiatrists, 2002). Infants in refugee and asylum-seeker families have also been identified as a group at particular risk of trauma (Mares & Powrie, 2008) as too are infants of parents who misuse drugs (Coombs, 2008). More generally, the contribution of attachment theory and practice to enhancing parent-child relationships and development has been reviewed (Newman & Mares, 2007) and evidence for effective interventions in this area is scant, but emerging (Hoffman, Marvin, Cooper & Powell, 2006).

Workforce development and organisational change

Workforce development and the development of collaborative practice models are other ways that might result in families being appropriately supported. Workforce barriers that impede mental health clinicians from working with patients about parenting and child related issues have been systematically analysed (Maybery & Reupert, 2006). Strategies that aim to promote collaborative practice have been documented, following the implementation of a multi-component service intervention involving a trial interagency protocol, allocation of designated project workers and cross-agency training; and were positively evaluated (Clark & Smith, 2009). The development of an Australian COPMI workforce development resource titled *Keeping Families and Children in Mind* (AICAFMHA, 2009c) also represents a significant opportunity for workforce development, though it needs to be rigorously evaluated to determine its efficacy for systems change and as a professional development tool.

Specifically related to the needs of young children, developing the capacity and skills of

preschool and day-care staff has been the target of a web-based education program to enhance confidence and skill in working with infants and preschoolers whose parents are depressed (Family Connections Materials, 2008).

An Australian research project into change processes affecting the organisational systems servicing children of parents with mental illness and their families has been undertaken (Owen, in press), and provides an overview of the characteristics of sustainable organisational change in this area. The processes identified could inform a national evaluation strategy.

Policy and practice

Policy priorities will continue to drive the development of interventions for young children (NSW Government, 2009). A public health approach to child protection also needs to include a focus on parental mental illness, substance abuse and domestic violence (Scott, 2009). One example of policy change comes from the Royal Australian & New Zealand College of Psychiatrists (RANZCP). In this instance, the RANZCP collaboratively developed a position paper titled *Children of Parents with Mental Illness* (RANZCP, 2009) that aims to ensure professional psychiatric practice includes identifying the children and their needs. It also has implications for training. Developments such as these should be evaluated in terms of practice change, with the implications of developing such position statements (or similar) for psychiatric and other professional bodies' practice clarified.

Inherent in the development of intervention programs are longitudinal and rigorous evaluation strategies, to ensure the effectiveness of preventive interventions. Practice informed science can be useful, in addition to rigorous and traditional evaluation methodologies, as one way to build an evidence base in this area (Nicholson, Hinden, Biebel et al., 2007), and a process that could, I believe, be readily implemented in Australia. For example, in Australia we have a national system of outcome measurement for all young people aged 4-17 who attend specialist Child and Adolescent Mental Health Services. In conjunction with some changes to the National Minimum Data Set, adding routine outcome measures for 0-48 month old children to the existing data collection system in the context of

their parents experiencing mental illness could readily allow for the comparison of variations in outcomes due to the type of interventions provided, and other factors.

It is not particularly new to suggest that investing earlier and more intensively may alter the trajectory of a life course for children who are at risk of poorer outcomes than other children in the community. But how this might work, who might do it best, what partners will be required, who might benefit most, what works best, what is the most cost-effective and equitable course of action, and what might cause the least harm, are the sort of questions that deserve answers based in science, reason and creative evaluation. Hopefully our younger children and their parents will begin to derive some benefit from the answers to these questions.

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