



Taking a closer look: A cross-sector audit of families where a parent has a mental illness

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Abstract

A growing number of studies over the past decade have identified the needs of families where a parent has a mental illness (FaPMI) and the responsibility of organisations to provide adequate services to effectively support them. This article describes the development and implementation of a cross-sector audit between mental health and family support services in a catchment area in Melbourne, Australia. The audit gathered information about the number, demographics, supports and potential needs of FaPMI clients and their dependent children (aged 0-18 years). Selected results are presented here. Across ten teams, the audit identified 223 FaPMI clients (including ten shared clients across organisations) with a total of 400 children. The audit provided insight into gaps in knowledge about FaPMI and possibilities for service development for participating agencies.

Keywords

children of parents with a mental illness; families; children; consumers; mental health services

Introduction

A growing number of studies over the past decade have identified the needs of families where a parent has a mental illness (FaPMI) and the responsibility of organisations to provide adequate services to effectively support these families. The Victorian FaPMI Strategy (Department of Human Services; DHS, 2007) provides the framework for mental health services in the state of Victoria to increase service provision in order to more adequately address the needs of these families.

It has been established that children of parents with mental illness are at higher risk of developing their own mental health problems (Farrell, Handley, Hanke et al., 1999; Leschied, Chiodo, Whitehead & Hurley, 2005), with the mental wellbeing of up to 40-60% of these

children at risk and 25-50% of children likely to experience some psychological disorder in childhood, adolescence or adulthood (DHS, 2007). Children of parents with mental illness may also experience heightened vulnerability towards physical, learning and behavioural issues.

Families affected by parental mental illness are more likely to experience poverty, housing problems or homelessness, family disruption or disorganisation, relationship conflict and/or family violence, substance abuse, reduction of social and leisure activities, disruption of children's schooling, and isolation. (Feldman, Stiffman & Jung, 1987).

In response to a growing awareness of the disadvantages faced by these families and the increased risk to dependent children, various

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mental health and support agencies have developed local intervention programs of support and education for parents and children over the last decade. These include PATS (*Paying Attention to Self*; Hargreaves, O'Brien, Bond et al., 2005) and CHAMPS (*Children And Mentally ill ParentS*; Goodyear, Cuff, Maybery & Reupert, 2009) peer support groups. Recently the Victorian Government has further supported this work by funding FaPMI coordinators in 11 area mental health services to implement the Victorian FaPMI Strategy (DHS, 2007).

It has been estimated that 21-23% of Victorian children (approximately 250,000) live in a household where a parent has a mental illness (Maybery, Reupert, Patrick et al., 2009). Of these, 34,666 children live in 18,502 households where a parent has a severe mental illness, and these parents would likely qualify for a clinical mental health service. Although simple population level data such as these exist, there has been little systematic study of the prevalence and needs of such families at a local level that can assist service planning and support the work of FaPMI coordinators to better address the needs. While Victoria's FaPMI strategy aims to increase support to families, adult mental health services (clinical and Psychiatric Disability Support Services) are not required to collect data on dependant children and inconsistencies exist.

Neither adult mental health services nor local family support services, by themselves, are likely to be able to assess or address the range of mental health and support needs of parents and children (Fudge & Mason, 2004). Within geographic catchment areas, better information about the numbers and needs of such families is required across agencies to enhance service collaboration and program planning. Basic information such as the numbers of children who have a parent with a mental illness, the age range of children and their respective developmental needs, and the service location of children and their families will inform service provision planning. The extent to which families are shared across agencies will inform planning to enhance collaborative partnerships and practices in working to better address their needs. In addition, risk and protective factors provide rich information for services that seek to address

support needs for families prior to a crisis occurring.

The audit reported here aimed to better understand the needs of FaPMI in a catchment area in Melbourne, Victoria. The specific aims of the audit were:

- To collate demographic information about families in the area;
- To discover gaps in knowledge and/or service provision that may inform future planning;
- To gain understanding about how many clients are shared between organisations in the catchment;
- To investigate the need for specific services, in particular, intervention support groups for children and young people; and
- To increase understanding across agencies about each other's client groups and their needs.

Method

An audit of the number and needs of FaPMI parents and their children was undertaken in late 2008 as a collaborative project between a group of services in a geographic catchment area in Melbourne (the catchment area covers a population of around 260,000 people). For the purpose of this audit 'FaPMI' families constituted an adult who is a registered client of any of the participating agencies (or teams) who had a mental illness (or a suspected mental illness) and was either pregnant or had a child 0-18 years old.

The project was initiated by the Northern Area Mental Health Service (NAMHS); a clinical mental health service providing treatment to people aged 16-64 in the Cities of Darebin and Whittlesea in Melbourne's north. NAMHS has worked collaboratively with local agencies in providing a range of services to families affected by mental illness over the past decade. The development of the audit was part of the work of an interagency steering group, which oversees peer support groups for such families. This collaborative group also includes a consumer-parent and a young carer representative.

The audit was undertaken as a quality improvement project and therefore formal ethics approval was not sought; however, confidentiality was upheld and no identifying

information was shared between organisations. Individual staff members were contacted when clarification of the client's details was required. Approval was provided by the Clinical Director of NAMHS and a directive memorandum about the audit was sent to staff of the relevant teams. This approach had the benefit of providing 100% participation by staff members. Had the audit been conceptualised as a research project, the methodology would have needed to be changed, as staff participation would have been voluntary and a file audit would have been required in order to gather information on all registered FaPMI clients.

Census date

20 October 2008 was agreed as the census date and managers from each participating team generated a list of all persons who were registered clients on this date.

Participating agencies/teams

NAMHS decided that community based teams would participate in the audit and that both acute teams (Crisis Assessment Team and Psychiatric Inpatient Unit) would be excluded. This decision was based on the fact that clients of the acute mental health services do not necessarily become ongoing clients of the service; equally, due to the acute state of mental illness of clients who access these services, information in relation to their children and parenting status is likely to be less available.

The total number of teams participating in the audit was ten (see Table 1). Within NAMHS, four teams participated in the audit (Darebin Community Mental Health Centre, Whittlesea Community Mental Health Centre, the Mobile Support and Treatment Team, and the Community Care Unit). An additional program within NAMHS (Youth Early Psychosis Program) was approached but they had no current FaPMI clients. Two Family Support Services (FSS) participated with two teams each (Anglicare Plenty Valley and Anglicare Preston; CPS Thomastown and CPS Heidelberg). Anglicare Plenty Valley also included clients from their group program in the audit. The Psychiatric Disability Rehabilitation Support Service (PDRSS) participated with two teams (Neami Darebin and Neami Whittlesea).

Developing an inclusive audit tool

The audit tool comprised a set of 19 questions about the parent and 29 questions about each of the children. It was divided into three sections: basic information about the staff member (team and contact details); information about the parent (demographic information, organisations that are involved in supporting the family, and specific issues such as family violence, alcohol and other drugs, living arrangements, attendance of specific support groups). The third section gathered information on children, including the number of parents with a mental illness, child protection or other support service involvement, current living arrangements, attendance of peer support programs. Questions could be answered by ticking the appropriate answer, or by ticking other options, 'not available', 'other' or 'don't know'. A 'missing' category was created in data analysis for coding when information was not provided. The audit tool was developed in relation to known (potential) risk factors for FaPMI (such as the level of support available, level of isolation, having two parents with mental illness) as well as potential protective factors (level of support, supportive partner, having one parent without a mental illness). Issues of particular relevance to the wellbeing of families, and more specifically to children, namely family violence and drug and alcohol issues, were asked both about current and past history in order to help determine service development directives.

The audit tool went through several consultation processes with key personnel across sectors. Within NAMHS this included team managers and the dual diagnosis consultant; family services consulted with managers and senior staff. The audit tool was accompanied by supporting material, which consisted of:

- a list of abbreviations;
- an auditor information sheet clarifying what constitutes FaPMI and who to include/exclude;
- a staff information sheet containing information about the audit, who to contact with any questions and some background information; and
- scenarios that were developed and supplied to auditors during the training session.

Undertaking the audit

Early in the project it was decided that the audit would be undertaken by final year social work students on placement in the mental health service, for reasons of time management (three people undertaking the audit rather than one) and consistency (three auditors versus individual staff members filling out forms). Students who demonstrated an interest in increasing their knowledge about FaPMI were engaged and thus it was hoped that this experience would foster expertise in the future workforce. Furthermore, as students have access to client files and are familiar with confidentiality about the information they gain during their placement, no additional ethical or confidentiality issues were raised.

The audit was accompanied by a communication strategy for NAMHS; this included discussions with senior staff in the lead-up to the audit, team visits and brief presentations. Managers were consulted about the best way to communicate about and undertake the audit within each team to ensure participation of all staff members. Auditors participated in a training session that covered the rationale for the audit and an explanation of the questions, followed by familiarisation with the audit tool and practice in its implementation. This intensive training session along with the supporting material was conducted to address inter-rater reliability issues.

At an arranged time, the auditors met with each case manager, who had their client's files with them. The auditor went through the audit form with the individual staff member, asking questions about each client who is a parent and each of their children.

Results

Characteristics of FaPMI clients

Across the 10 teams, 213 FaPMI clients were identified. The majority was female (81.2%, $n = 173$) and there were a slightly greater proportion of female FaPMI clients registered with FSS compared to NAMHS and PDRSS. The average age of FaPMI clients was 37.0 years (with the youngest client 17 years of age and the eldest 59 years of age). The mean age was similar for mothers and fathers, and there were no age differences across teams/agencies.

A total of 400 children were identified across the 213 FaPMI clients, the majority of families having one or two children. Fifty-four percent (53.5%, $n = 214$) of children were male and 42.8% ($n = 171$) were female; sex was unknown for 15 (3.8%) children. The average age of the children was 8.9 years. There were large proportions of children in the 0-5 ($n = 130$) and the 13-18 age bracket ($n = 126$). Ninety-nine children were in the 8-12 age bracket and only 39 children were aged 6-7 years of age. Age was unknown for 6 children.

FaPMI clients per team/agency

There were 10 registered shared clients identified across services, using date of birth and family characteristics to match clients. These shared clients were between NAMHS and PDRSS ($n = 7$), NAMHS and FSS ($n = 1$), and between PDRSS and FSS ($n = 2$). When including these shared clients, the majority ($n = 118$, 52.9%) of FaPMI clients were from NAMHS, 38 (17.1%) were from FSS, and 67 (30.0%) were from PDRSS.

Table 1 shows the number and percentage of FaPMI clients per agency/team. The two NAMHS community mental health teams had higher proportions of FaPMI clients compared to the two NAMHS rehabilitation teams (in terms of percentage of total FaPMI clients). Amongst FSS, Anglicare Plenty Valley had the most FaPMI clients; however, this service included additional clients in the audit who were not case managed but participating in group programs. The two PDRSS teams had a similar percentage of the total FaPMI clients. FaPMI clients incorporated a major proportion of the total client load for FSS. NAMHS and PDRSS were similar in their lower proportions of FaPMI clients per client load.

Diagnoses of FaPMI clients

Figure 1 shows the distribution of FaPMI clients' primary diagnoses across NAMHS, PDRSS and FSS. The most common diagnosis was schizophrenia (and other psychoses) ($n = 93$, 41.7%), followed by major depression ($n = 52$, 23.3%) and bipolar disorder ($n = 28$, 12.6%). A third of the FaPMI clients ($n = 71$) had a mental health issue additional to the 'diagnosed' mental illness. The majority were from NAMHS ($n = 46$), 21 were from FSS and 4 were from PDRSS.

Table 1. Number and percentage of FaPMI clients per agency/team

Agency/team	n FaPMI clients in agency/team	% of total FaPMI clients (N = 223) ^a	Total n clients in agency/team	% clients in agency/team who are FaPMI
Northern Area Mental Health Service (NAMHS) (n = 118)				
Darebin Community Mental Health Centre	63	28.3%	401	15.7%
Whittlesea Community Mental Health Centre	45	20.2%	248	18.2%
Mobile Support & Treatment Team Darebin/Whittlesea	7	3.1%	72	9.7%
Community Care Unit	3	1.3%	19	15.8%
Family Support Services (FSS) (n = 67)				
Anglicare Plenty Valley ^b	35	15.7%	58	60.3%
Anglicare Preston	14	6.3%	37	37.8%
CPS Thomastown	13	5.8%	26	50.0%
CPS Heidelberg	5	2.2%	6	83.3%
Psychiatric Disability Support Service (PDRSS) (n = 38)				
Neami Darebin	22	9.9%	169	13.0%
Neami Whittlesea	16	7.2%	80	20.0%
TOTAL	223	100.0%	1116	20.0%

a. This number includes 10 shared clients across agencies/teams.

b. Anglicare Plenty Valley included clients who were case managed and/or involved in group programs; 18 of the total 58 clients (31.0%) were case managed.

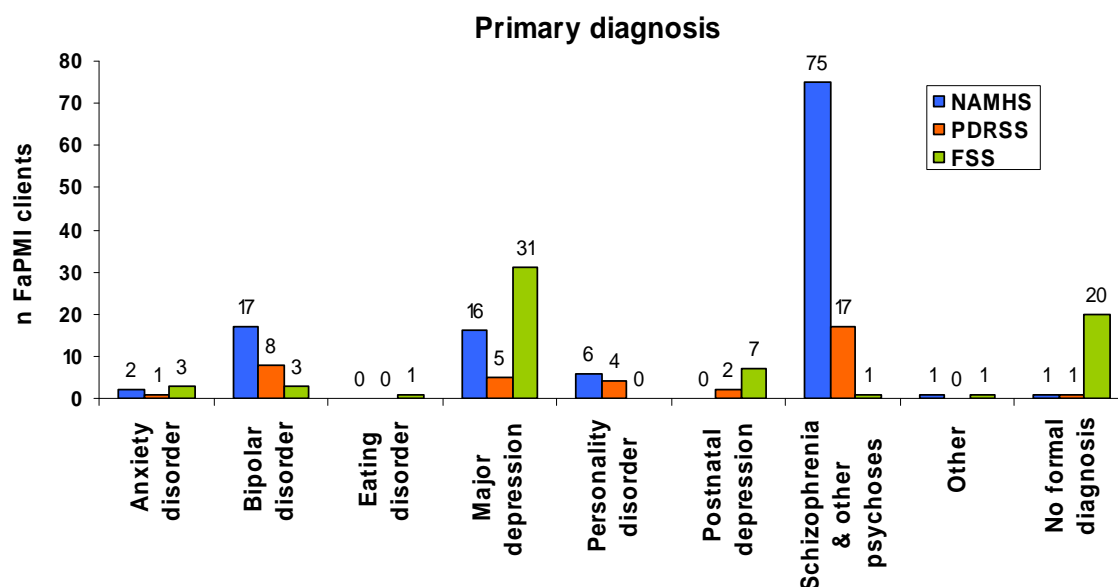


Figure 1. Distribution of primary diagnoses across service sector

Twenty-two clients had no formal diagnosis but support workers considered that the client had a mental health ‘issue’. Of these clients, 20 were from FSS (10 Anglicare Plenty Valley, 5 CPS Thomastown, 4 Anglicare Preston and 1 CPS Heidelberg), one was from NAMHS (Darebin) and one was from PDRSS.

The majority of clients with schizophrenia or other psychoses ($n = 75$, 33.6% of total FaPMI) and bipolar disorder ($n = 17$, 7.6% of total FaPMI) were from NAMHS, while the majority of clients with major depression ($n = 31$, 13.9% of total FaPMI) were from FSS.

Table 2. Relationship status and living arrangements of FaPMI clients across service sectors

	NAMHS (n = 118)		PDRSS (n = 38)		FSS (n = 67)		Total (n = 223) ^a	
	n	%	n	%	n	%	n	%
Relationship status^b								
Married	29	(24.6)	8	(21.1)	19	(28.4)	56	(25.2)
Partnered	21	(17.8)	4	(10.5)	13	(19.4)	38	(17.0)
Single	66	(55.9)	25	(65.8)	35	(52.2)	126	(56.8)
Other	1	(0.9)	1	(2.6)	0	(0.0)	2	(0.9)

a. These figures include shared clients; hence total is 223.

b. No information was recorded for one NAMHS client

Relationship status and living arrangements

Table 2 shows the relationship status of the FaPMI clients across the three service sectors. More than half of the clients identified by the audit were single, a quarter were married and about one in five were otherwise partnered. Minimal differences were seen between the service sectors in marital status, with the exception of slightly more married FaPMI and fewer single FaPMI involved with family support services.

There were 40.4% of FaPMI clients ($n = 86$) living either with their child or another family member. More FaPMI clients from NAMHS resided with the child's other parent (36.4%) compared to the other service sectors. More FSS FaPMI clients resided with other family members or the child, or the child's other partner, compared to NAMHS and PDRSS.

Discussion

The results of this audit show that within the geographic catchment area of this mental health service, which covers a population of around 260,000, the level of potential need is high; over 200 families where a parent has a mental illness, with 400 children, were identified. These numbers constituted just those parents who were currently known to participating services; the actual prevalence is likely to be significantly greater.

The greatest proportion of the families was identified within the public mental health services. This is unsurprising, given the relative size of the clinical services versus other service types involved in the audit. However, it would be a mistake to suggest that case identification should only occur through mental health services

– the families identified through the other services were rarely shared clients with mental health services. Given that these agencies were more likely to be working with clients who had high prevalence disorders, and that high prevalence disorders are not a priority group for public mental health services, the finding suggests that case identification of FaPMI and mental health support can be expanded through collaboration with such support agencies.

Diagnoses suggest that the parents in contact with the clinical mental health service, in the main, have serious and enduring mental disorders (predominantly schizophrenia). This has implications for the nature of service provision, especially the need for services to be available over time and to adapt to phases of illness and recovery.

The development of a cross-sector audit tool that addresses the needs of organisations that work with FaPMI was not without its challenges. Different services and sectors work from different paradigms and provide different aspects of support, treatment and care to the families. Discussions within the steering group about how to ask questions of parents, which language to use, who constitutes 'FaPMI' and what it means to have a mental health issue, problem or diagnosed mental illness, all contributed towards better understanding between service sectors and those individuals involved in the discussions.

Differences existed across service sectors relating to the client group, and the purpose and focus of the services. Clinical mental health services, for example, worked with those with 'low prevalence disorders', particularly schizophrenia, while family support services tended to work with those with 'high prevalence

disorders'. Auditing using the language of clinical diagnosis was also challenging in the non-clinical services, where a formal diagnosis had not necessarily been given or such information was not necessarily known. For these reasons, 'suspected mental health issue' was included in the audit tool as an option to ensure that family support service clients who did not have a known formal diagnosis but who appeared to have 'mental health problems', were included.

Other key learnings from undertaking the audit included that client registration processes varied between the sectors. While family support agencies were found to register one parent only, mental health services will register both parents if they both receive a service. Hence, the number of FaPMI clients accessing family support agencies found in this audit is likely to be an underestimation.

The audit was undertaken with case managers and support workers. Using a structured interview-based format rather than a file audit had the advantage of engaging staff members in thinking about the needs of FaPMI. It raised awareness about the gaps in their own knowledge and skills in working with this client group; it furthermore provided the opportunity to discover organisational gaps (such as routinely asked questions of FaPMI clients).

While the clinical mental health service and the participating PDRSS share many clients and all three service types have been involved in collaborative work for some years, the audit provided a surprising result in relation to the number of FaPMI clients that were identified as shared between the organisations. The small number could be attributed to different registration processes across sectors; or equally it may be the case that the families are adequately supported within their respective services and across sector service provision is not necessary. This is, however, speculative and warrants further investigation. Even when taking these possibilities into account, it appears that much work still needs to be done in addressing the low number of shared clients. The NAMHS and Neami organisations – the two specialist mental health services – share many non-FaPMI clients and have developed shared plans to support clients better. In this context, it is

surprising that in the area of FaPMI this collaboration has not been replicated. Future service development work between the organisations is needed to address this gap and ensure adequate service provision. It would be expected that families would benefit from a more holistic model of care through cross-sector collaboration, to better address their potential mental health and family support needs.

The audit's aims included investigating the number of children and young people who fall into age groups for which evidence-based intervention groups can be provided. The results of the audit show that there was a large cohort of children in the 0-5 year old and 13-18 year old brackets. While the participating organisations have run a CHAMPS program for 8-12 year olds for some years, these results suggest a need to also attend to the other two age groups. NAMHS has begun to address these service system gaps through obtaining funding for the development of a facilitated playgroup. Preliminary discussions between agencies have been held to work towards the development of a support group for adolescents. These programs are expected to be run collaboratively across the service sectors; thus, there is potential to further increase collaboration in order to better support families where a parent has mental illness.

Conclusion

The FaPMI audit aimed to identify gaps in service provision and knowledge; we believe the audit raises several issues, both internally and across service sectors, to address these gaps. The work following the audit, which includes feedback sessions to service sites about the results, provides the opportunity to increase awareness among clinicians/support workers (and managers) about risk and resilience factors for families affected by parental mental illness, as well as organisational responsibilities to address them.

The results of the audit furthermore provide the opportunity to address some of the gaps by increasing organisational responsiveness, so that working with the families is more supported and becomes increasingly 'embedded' for staff in all participating sectors. The Victorian FaPMI Strategy (DHS, 2007) aims to increase the capacity of specialist mental health services and

partnership organisations to provide a more family-focused response. The strategy furthermore aims to increase the capacity of clinical mental health services to recognise and respond appropriately to the families. We believe that finding out about the current level of knowledge about families affected by parental mental illness across service systems will ultimately contribute towards implementing the aims of the strategy.

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