Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services

Summary  The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services aims to:
1) Foster the continuing development of Area Mental Health Services for children of parents with a mental illness and their families; and
2) Assist Area Mental Health Services in the ongoing development of collaborative approaches with key partners and agencies working with children and their families.

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Distributed to  Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres
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NSW CHILDREN OF PARENTS WITH A MENTAL ILLNESS (COPMI)
FRAMEWORK FOR MENTAL HEALTH SERVICES
2010 – 2015

PURPOSE
The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services is a new publication that aims to:

1. Foster the continuing development of Area Mental Health Services for children of parents with a mental illness and their families.
2. Assist Area Mental Health Services in the ongoing development of collaborative approaches with key partners and agencies working with children and their families.

MANDATORY REQUIREMENTS
The NSW COPMI Framework identifies and sets out strategic directions for an integrated approach for Area Mental Health Services in collaboration with NSW Health partners to improve the mental health and well being of children and young people in NSW who have a parent with a mental illness. The four key strategic directions are:

1. Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.
2. Identify and provide responsive services for families where a parent has a mental illness.
3. Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.
4. Support the workforce to provide appropriate family focused interventions and care to parents with a mental illness, their children and families.

IMPLEMENTATION
Area Mental Health Services are required to provide a range of services consistent with the strategic directions to foster and improve the mental health and wellbeing of children whose parents have a mental illness, their parents and families. The major focus of the NSW COPMI Framework is on reducing the impact of parental mental illness on all family members through a timely, coordinated preventative, family focused approach.

The NSW COPMI Framework identifies some key outcomes associated with the implementation of COPMI framework for mental health services. These include:

- Early and better identification of the difficulties parents may face when they have mental illness and of the possible or actual risks for their children.
- Assessment of level and type of need and appropriate interventions required to enhance optimal functioning for the children, parents and families.
Support and intervention and recovery that is multi-faceted, targeting the children, the parent experiencing mental health problems and the family to promote resilience, coping skills and improve parental mental health and parenting capacity to meet their children’s need and ensure their safety.

Part Two of the NSW COPMI Framework is a Support Document that provides information and resources to support the framework and to facilitate the implementation of the framework process.

REVISION HISTORY

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<th>Approved by</th>
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<td>June 2010</td>
<td>Director-General</td>
<td>New policy</td>
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ASSOCIATED DOCUMENTS

1. NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015
2. NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015 - Support Document
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Foreword

The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010 –2015 consists of two parts. Part One sets out the strategic directions for the continuing development of Area Mental Health Services for children of parents with a mental illness and their families. The COPMI Framework also aims to assist Area Mental Health Services in the ongoing development of collaborative approaches with other human service agencies working with the children and their families.

Part Two (COPMI Framework Support Document) provides information and resources to support the Framework and to facilitate the implementation process.

We want our children to have the best start in life and positive outcomes throughout their lives, no matter what their circumstances, and for families to be supported and able to access the services that they need. The COPMI Framework promotes a family-sensitive approach to working with children whose parents have mental health problems and disorders. It highlights the need for mental health services to advocate for and enhance the associations between child mental health, child development and adult mental health services. The mental health and wellbeing of parents, carers and their children is everyone’s responsibility.

The COPMI Framework has been developed by MH-Kids, an Area-hosted unit of the Mental Health and Drug & Alcohol Office, in consultation with the Child & Adolescent Mental Health Subcommittee (Mental Health Program Council), Area Health Services and other key stakeholders. The COPMI Framework has been developed in the context of a national movement to promote mental health, prevent the development of mental disorders and reduce their impact on individuals and their families.

The COPMI Framework aligns with relevant National and State initiatives including:

- A New Direction for NSW: The State Health Plan (2006)
- NSW: A New Direction for Mental Health (2006)
- The NSW Interagency Action Plan for Better Mental Health (2005)
- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness (AICAFMHA, 2004).

The COPMI Framework identifies and sets out strategic directions for an integrated approach for Area Mental Health Services in collaboration with NSW Health partners to improve the mental health and wellbeing of children and young people in NSW who have a parent with a mental illness. The four key strategic directions are:

- Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.
- Identify and provide responsive services for families where a parent has a mental illness.
- Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.
- Support the workforce to provide appropriate family focused interventions and care to parents with a mental illness, their children and families.

Professor Debora Picone AM
Director-General
1.1 Introduction

The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010–2015 sets out strategic directions for Area Mental Health Services in collaboration with NSW Health partners to foster and improve the mental health and wellbeing of children and adolescents in NSW who have a parent with a mental illness.

Not all children of parents with a mental illness will experience difficulties as a result of their parents’ illness. Many parents who have a mental health problem are capable parents and cope very well. However, parents with a mental illness are at greater risk of relationship and parenting difficulties, social isolation and poverty (Rutter, 1986). The child-parent interaction can be compromised by factors related to the illness such as severity, chronicity or phase of the illness, and by the environment, such as the degree of support from the family and community (Falkov, 1998). Each of these factors increases a child’s vulnerability to various physical, cognitive, social, behavioural and mental health difficulties (Murray, Cooper & Hipwell, 2003).

Appendix A provides examples of the relationship between mental illness in parents and outcomes for children and young people and includes information on the impacts and protective factors.

Services may struggle to recognise and respond in a timely and appropriate way to the needs of families where parents have a mental illness. However, providing family support and intervention at the earliest stage, from the antenatal period and throughout the course of development is important. Early identification and intervention are likely to reduce the impact of mental illness on the family unit by building resilience and reducing risk factors.

The COPMI Framework aims to make children of parents with a mental illness and their families a priority for mental health services, as well as other key services and agencies, by:

- Maximising the collaborative approach with all sectors and agencies to address the needs of children and their families. Mental health services have a significant role to play in providing direct services, building on cross-sector collaboration and minimising fragmentation of services.
- Supporting parents with a mental illness.
- Where needed, protecting the safety and wellbeing of children of parents with a mental illness.
- Identifying areas for improvement and ensuring programs and services meet the needs of the Aboriginal and Torres Strait Islander communities and the culturally and linguistically diverse (CALD) population (such as through research and effective communication strategies).
- Promoting a family-focused service model that enables a comprehensive assessment of the care needs of the client and their family.

The COPMI Framework also acknowledges comorbidity and the growing awareness of the impact of parental substance abuse on children and families. This includes specific impacts of alcohol, a range of licit and illicit drugs, and the interplay between substance abuse and mental disorder.

1.2 Family focus and parenting

Figure 1 illustrates the relationships between important factors influencing child and parent mental health and wellbeing.

COPMI is about prevention and early intervention that incorporates a parenting perspective into mental health services and a mental health perspective into parenting and children’s services. Improvements in both mental ill health and parenting not only provide opportunities for more rewarding family life, but can also reduce the proportion of parents who are unable to meet their children’s needs and ensure their safety. Earlier intervention will help to reduce the number of children with emotional and behavioural problems who will require specialist children’s services as well as the proportion who will need mental health and other services in adulthood (Falkov & Cowling, 2009).
The mental health and wellbeing of children and adults within families in which an adult carer is mentally ill, are closely linked in at least four ways (Falkov, 1998):

Parental mental illness can affect the development and in some cases the safety of children (a parent to child influence).

Growing up with a parent with a mental illness can have an influence on the quality of that person’s adjustment in adulthood, including their transition to parenthood (a childhood-to-adulthood-lifespan influence).

Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental illness health in their parents/carers (a child-to-parent influence).

Adverse circumstances (poverty, single parenthood, isolation, stigma) can influence both parent and child mental health (an environment-to-person influence).

These principles highlight the key areas of relevance and the inter-connections between mental illness, parenting, and children. They also demonstrate the links over time (childhood to adulthood) and across generations. Mental illness has profound implications for the affected individual and for that individual’s network of family and social relationships. Given the prevalence of mental illness, there are major implications not only for individuals and families but also for society as a whole (Falkov, 1998).

Working with parents requires clinicians to balance hope for the future with realistic approaches to assessment, treatment and recovery. Clinicians must be aware of and able to respond appropriately to the ways in which these processes affect and are influenced by parenting tasks and the implications for children.

‘…We never spoke about mum getting sad when I was younger. It was only later when someone came to our school and told us about depression and mental illness that I realised that was what mum and dad had been hiding from us. Because I felt I couldn’t tell anyone and dad had always kept it quiet I just didn’t know what support was out there…’

A boy’s story

1.3 Key principles

- Prevention of mental disorders in children enhances their development and wellbeing as well as their transition to adulthood. As adults, they are then more likely to experience good mental health and to become parents who can meet the needs of their children in the next generation and contribute to rewarding family and community life.

- The stigma of mental illness can affect all family members, not just the identified person, and may result in disadvantage and inequality. Clinicians can incorporate positive approaches into their practice and positively inform and influence community attitudes towards people with a mental illness.

- A focus on families highlights that all individuals have the right to services which meet their needs. Race and ethnicity, culture, religion, linguistic background, gender, physical, intellectual or psychological ability and sexual orientation should not be a barrier to service access.

- Responsive, accessible and integrated services need to take account of the social context in which people experience mental ill health and of the contextual factors which facilitate effective intervention.

- The family is a focus for service design and a key target for integrated service delivery.
1. Focus on individuals within a family context highlights that there is diversity of need and the requirement for collaboration and support within and between services and agencies. No single service can meet the needs of all family members.

2. Area Mental Health staff should provide a range of services following a comprehensive assessment and provide evidence based (informed) interventions in collaboration with key partners. Principles and guidelines for collaboration are outlined in the NSW Interagency Guidelines for Child Protection Intervention (NSW Department of Community Services, 2006).

3. Targeted interventions to meet the needs of priority groups, for example, Aboriginal and Torres Strait Islander Communities and Culturally and Linguistically Diverse Communities (CALD).

4. Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.

1.4 Strategic directions

Informed by National and NSW State policies and guidelines, the following four strategic directions have been identified for the NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010–2015:

1. Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.

2. Identify and provide responsive services for families where a parent has a mental illness.

3. Strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.

4. Support the workforce to provide appropriate family focused interventions and care to parents with a mental illness, their children and families.

1.5 Renewed focus on young carers

In Australia, ‘young carers’ is the term used to refer to children and young adults aged up to 24 years who have caring responsibilities for parents, grandparents, siblings or other relatives who have chronic illness, disability, mental health problems or other conditions connected with, a need for care, support or supervision. They carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility which would usually be associated with an adult.

One in eight people in Australia identify themselves as carers, which represent around 750,000 people in NSW (NSW Health, 2007). Research shows that supporting families and carers contributes to reducing relapse rates and psychotic symptoms for people with a mental illness (Dixon & Lehman, 1995) and increased family/carer sense of control and their ability to manage situations (Smith & Birchwood, 1987).

Whilst caring can have positive outcomes and protective factors for children and their families, it can sometimes come at a price. As a result of their caring roles many young carers have restricted opportunities for social, recreational and extra-educational participation.

One of the most commonly identified elements of best practice in programs and service delivery to support young carers is to involve young carers in their parents’ care plan with mental health services. A ‘whole family approach’ is central for responding to children and young carers needs. Services need to be family-focused, flexible, reliable, high quality, coordinated and non-stigmatising. An assessment of the needs of young carers and those they support is a key gateway to information, services and support for all family members. Additional support for young carers can be obtained through referral to NGOs such as Carers NSW who provide support programs to young carers.

See the COPMI Framework Support Document (Section 1 – Prevalence and Significance) for additional information on young carers or go to: http://www.youngcarersnsw.asn.au/StoryView.aspx?PageID=588

‘Hi I’m Kasey. I’m 17 and am a young carer. I have looked after my mum since the age of 12. My mum sees people that aren’t there, she hears voices coming from the fridge and thinks I’m going to poison her when I give her the pills. It’s hard being only 17 and working 38 hours a week I used to wish I was like normal kids and have no one to care for but I would be bored as, I’m grateful that god gave me the mum he did I love her so much and even though she kicks me out she calls me when there is washing and cleaning to do.’ http://www.youngcarersnsw.asn.au/StoryView.aspx?PageID=588
The following National and State strategic policy and planning documents directly align with or are relevant to NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010–2015:

**Principles and Actions for Services and People Working with Children of Parents with a Mental Illness (AICAFMHA, 2004)**

This document is seen as complementary to the implementation of the National Practice Standards for the Mental Health Workforce (2002) in relation to the provision of care, protection and information for children of parents with a mental illness and their families. The following Action Areas were identified for service providers to enhance protective factors and reduce risk factors in parents with a mental illness and their children:

- Promotion of wellbeing and risk reduction
- Support for families and children
- Addressing grief and loss issues
- Access to information
- Education and decision making
- Care and protection of children
- Partnerships and cross-agency processes
- Workforce development
- Research and evaluation


The State Plan is a long term plan to deliver the best possible services to the people of NSW. It sets out the main areas where the community expects improvements, and shows how those improvements will occur. About 75 percent of the priorities and targets have been retained from the State Plan launched in 2006, but changes have been made to; strengthen targets and drive local delivery.

Relevant change areas and priorities for COPMI include:

a) Healthy Communities: priority is improved outcomes in mental health

b) Stronger Communities: priority is improved child wellbeing, health and Safety.

**NSW: A New Direction for Mental Health Services (2006)**

This Plan sets out a five-year plan for the enhancement of mental health services. The Plan focuses on

1. promotion, prevention and early intervention
2. integration of the care system
3. increasing participation in employment and community
4. enhancing workforce capacity.

**The NSW Interagency Action Plan for Better Mental Health (2005)**

This Plan acknowledges that improvement of mental health requires a whole of government approach which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice, with mental health services. The Plan sets out three Strategic Directions:

1. prevention and early intervention;
2. community support services; and,
3. coordination of emergency responses.

**Draft building a secure base for the future: NSW mental health service plan for children, adolescents and the people who care for them (2008)**

This document outlines a Child and Adolescent Mental Health Service Plan for the enhancement of child and adolescent mental health services in NSW. The Plan aims to improve the mental health of children and adolescents, to help them, their families and others caring for them to optimise their development and to build a secure base for their futures. COPMI is a priority area based on consideration of risk and protective factors and identification of vulnerabilities for this group.

**SAFE START Strategic Policy 2007–2010**

The SAFE START Strategic Policy (as part of the NSW Health/Families NSW Supporting Families Early package) provides direction for the provision of coordinated and planned mental health responses to primary health workers involved in the identification of families at risk of, or with, mental health problems, during the critical perinatal period. It outlines the core structure and components required by NSW Mental Health services to develop and implement the SAFE START model.
**NSW Community Mental Health Strategy 2007 – 2012**

This Strategy describes the model of community mental health services to be developed and delivered by 2012. This model covers the spectrum of mental health care and provides a framework for improving responses to the needs of people with mental illness or disorder, their families and carers across NSW, across the age range, and across diverse communities. The strategy is intended to inform consumers, their families and carers and other stakeholders about directions in community mental health and about what they can expect from community mental health services.

The COPMI Framework is also aligned with the following National and State strategic policy and planning documents:

- National Practice Standards for the Mental Health Workforce (2002)
- The NSW Aboriginal Mental Health and Wellbeing Policy 2006–2010
- Getting in Early: A Framework for Early Intervention and Prevention in Mental Health for Young People in New South Wales (2001)
- The NSW Health/Families NSW Supporting Families Early package
- The SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants 2007–2011
- The NSW Multicultural Mental Health Plan 2008–2012

The COPMI Framework is also informed by several other key documents including:

- United Nations Convention on the Rights of the Child
- NSW Children and Young Persons (Care and Protection) Act 1998
- Universal Declaration of Human Rights, and the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care
- Position Paper – Improving the Mental Health of Infants, Children and Adolescents in Australia (AICAFMHA, 2005)
- First and Final Reports of the Senate Select Committee on Mental Health – A national approach to mental health–from crisis to community (2006)
- The Royal Australian and New Zealand College of Psychiatrists Position Statements:
  - #56 Children of Parents with a Mental Illness
  - #57 Mothers, Babies and Psychiatric Inpatient Treatment.

Section 2 in the COPMI Framework Support Document provides additional information on relevant policies and documents.
The COPMI Framework outlines strategic directions for Area Mental Health Services staff to foster and improve the mental health and wellbeing of children whose parents have a mental illness, their parents and families. The major focus of the COPMI Framework is on reducing the impact of parental mental illness on all family members through a timely, coordinated preventive, family-focused approach.

Monitoring and improving mental health services for families experiencing mental health problems will in turn increase the understanding of the needs of and interventions for families and the associated risks for families, their children and young people for NSW Health interagency partners.

Some key achievements of the implementation of COPMI framework for mental health services include the following:

**Early identification**
The COPMI Framework should assist in promoting a greater awareness and understanding in all mental health sectors working with children and families of the difficulties parents may face when they have a mental illness, and of the possible or actual risks for their children. This will lead to better identification and development or enhancement of systems to record and monitor identification.

**Assessment of level and type of need**
Accurate and informed early identification followed by appropriate interventions will enhance optimal functioning for parents and children. For example, the NSW SAFE START universal antenatal psychosocial assessment is an opportunity to identify vulnerable families and set in place supportive community and professional networks.

Adult mental health staff working in a range of settings (e.g. community mental health services, inpatient units) should receive targeted training about COPMI and will consequently be more likely to identify that there are children living with their adult clients. They will utilise (MH-OAT) assessment tools to assist in conducting a comprehensive assessment and care plan. They will be better placed to assess the level and type of need and input required for the children, parents and families.

Further development and tailoring of training or resources will assist other government and non-government partners to work better with this vulnerable group.

**Support and intervention and recovery**
Interventions will be multi-faceted, targeting the children, the parent experiencing mental health problems, and the family:

- Support for children can promote resilience, coping skills and problem-solving skills, which will be reflected in improved outcomes such as achieving developmental milestones, school readiness and attendance.
- Early detection and intervention measures would be expected to reduce the number of children and young carers with emotional and behavioural problems who require specialist services.
- Ongoing support and intervention for the parent with a mental illness promotes recovery and will encourage positive parenting skills and healthy attachment which in turn is likely to increase parental confidence and self-esteem and decrease the likelihood of relapse.
- Improved parental mental health and parenting capacity will reduce the proportion of parents who are unable to meet their children’s needs and will ensure their safety.
- The support of family and significant others, especially when the parent is unwell, can enhance the social network and assist with preservation of the family unit.

The following section outlines actions for each of the strategic directions. A summary of some COPMI initiatives and activities currently undertaken in NSW is provided in Section 3 of the COPMI Framework Support Document. The Support Document (Section 4) also provides some supplementary examples of programs relevant to Strategic Directions One and Two.
3.1 STRATEGIC DIRECTION ONE: 
Promote the wellbeing and reduce the risks associated with mental illness for infants, children, adolescents and their parents/carers and families.

Prevention should occur through early identification of needs and timely support. It is important to be able to identify the population group in order to anticipate and respond to their specific needs and reduce the likelihood of risk.

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| Promote awareness and information for people with a mental illness who plan to become a parent or who are pregnant. | ■ Ensure mental health service participation in development of AHS SAFE START plans to localise the SAFE START Strategic Policy (a component of the NSW Health/Families NSW Supporting Families Early (SFE) Package).  
■ Establish and promote linkages with women’s health, early childhood services, family planning services, Drug and Alcohol services and General Practitioners and build on the planning and partnerships strategy in SAFE START Strategic Policy for young children (0–2yrs) of parents with a mental illness.  
■ Provide educational materials for consumers contemplating becoming parents, e.g. The Best for Me and My Baby [see www.copmi.net.au], Having a Baby (http://www.health.nsw.gov.au/pubs/2006/having_a_baby.html) |
| Improve parental knowledge about parenting and appropriate forms of child management (especially for those in contact with services.  
Support the implementation of a broad range of programs to promote the wellbeing and resilience of children of parents with a mental illness and their parents.  
Identify appropriate strategies to increase parents’ resilience. | ■ Support the provision of and/or provide parenting programs and programs for children (e.g. Triple P, Incredible Years, supported play groups).  
■ Work in collaboration with government and non-government organisations to support the provision of services for children and to improve the referral pathways to psycho-education, respite programs (including camps) and leisure activities for children.  
■ Facilitate and support access to resources (e.g. psycho-educational materials such as those available at www.copmi.net.au; raisingchildren.net.au). |
| Identify and reduce risk factors (adult, parent, child, illness, partner, environmental) in families where a parent has a mental illness in order to contribute to children’s health and wellbeing. | ■ Provide information to children, parents and their families about mental illness and available services including carers services, e.g. psycho-education programs and initiatives, promotion of relevant websites [e.g. http://www.sane.org], Family-based Approach to the Prevention of Depressive Symptoms in Children at Risk, (Beardslee, 2003).  
■ Work in collaboration with NGOs to provide peer support groups for children and for parents (e.g. VicChamps Project, Victoria, Australia). |
| Consumer and family participation in addressing parenting needs. | ■ Participation of consumers, families and carers in care planning (e.g. part of Family and Carer Mental Health Program), and whenever possible, in the development of education and training programs (e.g. Crossing Bridges NSW [CBNSW] training program). |
3.2  STRATEGIC DIRECTION TWO: Identify and provide responsive services for families where a parent has a mental illness.

Improving the capacity of mental health services to better identify and respond to families and their children at risk of mental health problems highlights the need for a collective shared responsibility. It also highlights the need to collaborate with other relevant groups and agencies (e.g. Child & Adolescent Mental Health Services [CAMHS], Adult Mental Health Services [AMHS], non-government and government departments) to improve children's wellbeing and safety. These actions are aligned with the obligations identified in the NSW Keep Them Safe Action Plan such that NSW Health will give immediate priority to ensuring that its policies and procedures assist services to identify adult clients who have children and promote timely access to appropriate services for these clients and their families. Working alongside other NSW Health initiatives, such as the NSW Family and Carer Mental Health Program and the NSW SAFE START Program, consideration should be given to improving referral pathways and early intervention in order to:

- Support parents with mental health problems in their parenting role;
- Address the developmental needs of infants, children and adolescents; and,
- Support the needs of partners, siblings, grandparents and others in their caring role.

A responsive and supportive approach may be achieved through early identification, assessment, provision of information and needs-based intervention.

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<td>Identify and record parents with a mental illness at initial contact and at assessment. Identify any issues such as risks for the children (e.g. are they being cared for by a responsible adult whilst their parent is in hospital?). Identify health, developmental and support needs of children and adolescents so that strategies are put in place to address their needs.</td>
<td>Systematic use of standardised procedures and modules, e.g. MHOAT, Family Focussed Assessment (FFA). Develop pathways to care linking mental health services and paediatric and family/community health services to supplement basic good practice. Ensure regular reviews for parents experiencing mental health problems and disorders. Develop and document care plans that are inclusive of parenting responsibilities and children’s needs including the needs of young carers and relapse prevention activities.</td>
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<td>Develop and implement systems to ensure that service delivery is responsive to the needs of parents with mental health problems and disorders and their families through active consultation and collaboration between mental health services. Ensure access to and utilisation of resources developed through the Working with Families initiative and the Family Friendly Mental Health Services program (e.g. Connecting With Carers is Everybody's Business).</td>
<td>Promote the use of MHOAT FFA as part of the assessment of all clients of MHS who identify as adults with dependent children and develop care plans that include the needs of their children when accessing mental health services (e.g. CAMHS, Youth Mental Health, Early Psychosis Programs and AMHS). Develop formalised links and establish procedures and protocols with coordinators of relevant programs (e.g. COPMI, NSW Family &amp; Carer Mental Health Program, SAFE START, Youth Mental Health, Early Psychosis Programs, School Link, Parenting and Drug &amp; Alcohol services). Establish family friendly visiting and treatment areas in hospital and community settings. Refer to appropriate carer support networks such as Carers NSW, ARAFMI NSW, Uniting Care Mental Health and Carer Assist. Ensure printed resources (e.g. pamphlets, posters on carer services including young carers) are available in waiting areas.</td>
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<td>Ensure that women who have at any time had a diagnosis of mental illness have access to timely mental health assessments and early interventions to reduce risk of relapse during the perinatal period.</td>
<td>Refer to SAFE START policy regarding intake and assessment protocols. Include identification of ‘perinatal’ clients in Child &amp; Adolescent and Adult Mental Health client registration and data collection. Identify roles and functions of AMHS and CAMHS in collaborative care coordination and liaison for parent and infant mental health clients.</td>
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<td>Establish formal links between SAFE START, NSW Family &amp; Carer Mental Health Program and the NSW COPMI strategic framework to enable consistent service planning and delivery of appropriate coordinated modes of intervention and care.</td>
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<tr>
<td>Develop integrated mental health services to give immediate priority and provide timely access to mental health assessments and early interventions for children of parents with a mental illness.</td>
<td>Possible options: Rotate AMHS staff into CAMHS and Child and Youth Mental Health Services (on a fulltime basis) and CAMHS staff into AMHS Create or develop consultation-liaison roles between CAMHS and AMH. This could be included in the role of AHS COPMI coordinator or part of a rotational process. Support CAMHS workers to provide clinical service in AMHS teams working jointly (family work) and separately (with children) Physically locate family based CAMH and AMH services in close proximity. Develop clearly articulated service partnerships and agreements between CAMHS and AMH. Identify strategies and protocols that promote and support active partnerships and collaborative practice between AMHS, CAMHS, Infant, Child, Youth and Family Mental Health services and Drug and Alcohol services. Whole Family Teams provide comprehensive assessment and address parenting, family and individual needs. Provide incentives to assist rotation and recruitment of workers in rural areas.</td>
</tr>
<tr>
<td>Identify, adopt and build on national and international early intervention programs for COPMI that are consistent with best practice.</td>
<td>Support CAMHS and AMHS staff to implement specific early intervention programs (see Resource Document that lists AHS examples and <a href="http://www.copmi.net.au">www.copmi.net.au</a>).</td>
</tr>
<tr>
<td>Develop and monitor effective processes to promote care and protection of children and adolescents.</td>
<td>Ensure compliance with all legislation and relevant protocols relating to the care and protection of young people (e.g. PD2006-003 Risk of Harm Assessment Checklist, Interagency Guidelines for the Care and Protection of Children and Young People – currently being revised as part of the Keep Them Safe actions). Ensure that all activities relating to care and protection are documented in the file and that Community Services (CS) and other report forms are included in client files. Develop case management procedures for ‘high-risk’ families.</td>
</tr>
</tbody>
</table>
3.3 STRATEGIC DIRECTION THREE:
Increase and strengthen the capacity of interagency partners to recognise and respond to the needs of children of parents with mental health problems.

Parents with mental health problems often do not seek support and are sometimes reluctant to initiate contact. However, parents may be in contact with a range of services that may be able to identify their needs and those of their children and family. Improved partnerships between adult and child and adolescent mental health, community health and other government and non-government agencies is needed for a collaborative approach to support children, parents and their families. This approach builds on existing successful interagency partnerships such as Brighter Futures which targets vulnerable families, Families NSW, Housing and Accommodation and Support Initiative (HASI) and the NSW School-Link Initiative.

<table>
<thead>
<tr>
<th>Action</th>
<th>How</th>
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</table>
| Area Mental Health Services to work collaboratively with interagency partners to assist in identifying and intervening with families at risk of mental health problems. | In relation to COPMI, implementation of state plans and policies including:  
- NSW Interagency Action Plan for Better Mental Health  
- NSW Aboriginal Mental Health and Wellbeing Policy 2006-2010  
- Multicultural Mental Health Plan 2008-2012  
- Supporting Families Early Package.  
- COPMI and other relevant AHS staff to involve interagency partners in education and training workshops at a local level.  
- COPMI staff to assist in the development of local protocols and cross service development to assist in the identification and care planning for vulnerable families. |
| Develop effective pathways to care between AMHS and CAMHS, Youth Mental Health, Early Psychosis Services, Child & Family and maternity services and other agencies, including NGOs and consumer and carer services. | Develop intra-agency partnerships to improve referrals and early response for COPMI.  
Identify target groups, types of services to be provided, roles and responsibilities of the agencies involved, barriers and inclusion of monitoring and evaluation. |
| Support interagency, government and NGO collaboration to improve health and mental outcomes of children and their parents with a mental illness. | Ensure that existing inter-departmental committees provide input and ongoing support for COPMI services. |
| Develop effective partnerships with drug and alcohol services to enhance the wellbeing of parents with co-morbidity. | Develop pathways of care supported by relevant policies and protocols for families with mental health and drug and alcohol problems who have young children.  
Liaise with drug and alcohol services and promote joint care plans of all MHS clients with co-morbidity issues and who identify as adults with dependent children. |
| Develop effective partnerships with criminal justice agencies to identify and address the needs of their children. | Liaise with relevant criminal justice agencies and develop joint protocols and procedures and pathways to care. |
| Develop effective partnerships with Aboriginal, Torres Strait Islander and Multicultural services to ensure the needs of these priority populations are met. | Develop pathways of care supported by relevant policies and protocols for Aboriginal, Torres Strait Islander and CALD families with mental health problems who have children.  
Liaise with Aboriginal, Torres Strait Islander and Multicultural services and promote culturally appropriate joint care plans for all MHS clients who identify as being Aboriginal or from CALD background and who have dependent children. |
3.4 STRATEGIC DIRECTION FOUR: Support the ability of the workforce to provide appropriate family focused interventions and care to parents with mental illness, their children and families.

Well-trained, competent and supported staff will be able to provide high quality services for children of parents with a mental illness and their families.

This strategic direction is based on the following AICAFMHA recommendations for workforce:

- promote wellbeing and reduce risk for children of parents with a mental illness and their families
- support families and children
- address grief and loss issues
- facilitate and support access to information, education and decision-making
- ensure care and protection of children.

<table>
<thead>
<tr>
<th>Action</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support the promotion and implementation of the COPMI Framework at a workforce policy and planning level.</td>
<td>Identify the needs of the COPMI coordinators and include in MH workforce development planning at AHS and departmental levels.</td>
</tr>
<tr>
<td>Provide statewide coordination to assist in the development, implementation and evaluation of local protocols.</td>
<td>AHS COPMI representation and participation in statewide working party.</td>
</tr>
<tr>
<td>Where appropriate, include consumers and carers in education for clinical staff, managers and policy makers.</td>
<td>Engage NGOs, consumers and carer groups such as ARAFMI NSW, and the NSW Community Advisory Group–Mental Health Inc. to determine level of support needed for consumers, families and carers and involvement in education.</td>
</tr>
<tr>
<td>Include in AHS orientation package for new AHS MH clinicians information on COPMI initiatives.</td>
<td>Inclusion of COPMI Service description and the contact details of COPMI coordinators.</td>
</tr>
<tr>
<td>Raise awareness of the importance and availability of COPMI training within the AHS and with interagency partners.</td>
<td>Promote COPMI training such as CBNSW, new programs (e.g. AICAFMHA’s COPMI e-learning program), AHS training calendars, workforce and development training schedules, newsletters and at associated CAMHS specific training events.</td>
</tr>
<tr>
<td>Ensure all mental health staff attend training programs relevant to the needs of COPMI (e.g. CBNSW).</td>
<td>AHS executive to support AMHS and CAMHS staff to attend COPMI training (CBNSW) and have access to regular supervision.</td>
</tr>
<tr>
<td>Modify CBNSW and/or develop training programs for other human service agencies (e.g. Drug &amp; Alcohol, CS, ADHC).</td>
<td>Relevant working groups (including government, NGO and consumer/carer representatives) to inform competency-based workforce development relevant to COPMI.</td>
</tr>
<tr>
<td>Training materials to be developed or sourced to reflect the needs of the broad range of agencies involved in supporting COPMI.</td>
<td></td>
</tr>
<tr>
<td>Encourage all mental health professionals working with families to access relevant COPMI literature and resource materials including websites to support their work.</td>
<td>Disseminate relevant COPMI resources and information at points of contact such as Consultation-Liaison visits, through newsletters/ AHS websites and at COPMI in-services and related CAMHS specific training and events.</td>
</tr>
<tr>
<td>Work with the Family and Carer Mental Health Program to target COPMI needs in mainstream training and development of mental health service staff.</td>
<td>Use materials developed through the Working with Families initiative and the Family friendly Mental health services program to support the training and development of mental health service staff.</td>
</tr>
</tbody>
</table>
SECTION 4

Evaluation – Monitoring Outcomes and Responding to Change

With the assistance of the COPMI Working Party (of the Child & Adolescent Mental Health Subcommittee of the Mental Health Program Council), an evaluation strategy will be developed. It will be based on National, state and other monitoring processes, focusing on key areas, utilising existing tools and options and making recommendations which will assist measurement of benchmark achievement.

Progress on the NSW Mental Health Service Framework for COPMI will be monitored using the Australian Public Mental Health Services KPIs (i.e., effective, appropriate, efficient, accessible, continuous, responsive, capable, safe, sustainable), along with any further relevant and valid performance indicators for COPMI that are developed under the National Mental Health Plan or for the purposes of evaluating The COPMI Framework. Of particular relevance to this Framework is the identification of adult clients of mental health services who are parents and their children, and assessment of need for the children, parents and their families. This will be achieved and monitored through AHS reporting of client clinical outcomes through MHOAT, as well as completion and compliance rates.

Annual financial and program reporting, and reporting and evaluation of key funded projects and initiatives will assist in efficient and effective service delivery. Monitoring and reporting on the development and implementation of local processes and protocols and the involvement of and outcomes for consumers and carers will assist in the overall evaluation.

It will be necessary to evaluate efficacy and effectiveness of intervention programs in order to build the evidence base for this population and to assist in the recommendation of appropriate services, programs and interventions. An evaluation template will be developed to assist in reporting outcomes for this Framework.
Introduction

The NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010–2015 consists of two parts.

Part One: NSW COPMI Framework

This document sets out the strategic directions for the continuing development of Area Mental Health Services for children of parents with a mental illness and their families. The COPMI Framework also aims to assist Area Mental Health Services in the ongoing development of collaborative approaches with other human service agencies working with the children and their families.

Part Two: NSW COPMI Framework – Support Document

This document provides information and resources to support the framework and to facilitate the implementation of the framework process. It consists of the following sections:

- **Section 1: Prevalence and Significance of COPMI**
  This section provides data on prevalence and the impacts and outcomes for children of parents with a mental illness and their parents, including risk and protective factors for children and young people.

- **Section 2: Policy and Planning Context**
  This section provides more detailed information on National and NSW State policies and planning documents relevant to the NSW COPMI Framework.
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1.1 Prevalence

It is estimated that in Australia there are 577,507 families in which a parent has a mental illness with 1,082,402 children living in such households, i.e. nearly a quarter of children living in Australian households have at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2005). Several overseas studies report on prevalence. For example, a national comorbidity survey conducted in the U.S. established that 68% of women meeting criteria for psychiatric disorder were mothers, and 55% of the men meeting criteria were fathers (Nicholson, Biebel, Williams, & Katz-Leavy, 2004). In the UK, Oates (1997) found that 25% of all new female referrals to psychiatric services had a child under the age of five. Oates also cites two community studies, with one finding that among adults with schizophrenia, 26% lived in households with children under 16 years, and the other finding that 60% of women with serious chronic mental illness had children under the age of 16, and 25% had children under the age of 25.

Other small-scale studies provide further data demonstrating the prevalence of clients of mental health settings who are parents. An Australian study conducted with clients in tertiary mental health settings found that 36% of the participants had children, with 75% of the children aged under 16 years (Hearle, Plant, Jenner, Barkla, & McGrath, 1999). In Victoria, a study of mental health, help-seeking and service use among clients of an area health service inpatient unit and community teams found that 16% of adult clients were parents of dependent children (101 children) (Cowling, Luk, Mileshkin, & Birleson, 2004).

1.2 Impacts and Outcomes for Children and Parents

The current lack of comparative data for NSW poses a significant problem in terms of identification of need and determination of service provision. However the significance of the above figures lies in the reported outcomes for children and young people where a parent has a mental illness. Mental illness impacts on parenting behaviour and capacity in various ways (Maybery et al., 2005).

In Australia it has been estimated that between 25-50% of children and young people with parents with a mental illness experience psychological disorder (Barnett, Schaafsm, Guzman, & Parker, 1991) and 10–14% have a greater chance of psychotic illness compared with the general population (Hearle et al., 1999). Aggregated data indicate that these children have a 70% chance of developing at least minor adjustment problems by adolescence. When both parents have a mental illness, there is at least a 30–50% chance of children developing mental health problems (Rubovits, 1996). Cowling et al. (2004) found that children of parents with a mental illness were 2.5 times more likely to have mental health problems than the general population (based on parental report).

Meltzer, Gatward, Goodman and Ford (2000) found that children with parents who screened positive on the General Health Questionnaire-12 (GHQ-12) were three times more likely to have a mental disorder than those whose parents had sub-threshold scores. The proportion of children with mental disorders increased steadily with increases in parental GHQ scores. The follow-up survey (Meltzer, Gatward, Corbin, Goodman, & Ford, 2003) showed that among children with emotional disorders at Time 1 whose mothers continued to have poor mental health, 37% still had an emotional disorder at Time 2. For those children with mothers who consistently scored low on the GHQ-12, only 14% persisted with emotional disorders.

Regarding specificity, a child with a parent who has an affective illness has a 40% chance of developing affective disorder by age 20, compared to a 20–25% risk in the general population (Beardslee, Bemporad, Keller, & Klerman, 1983). Children of parents with bipolar disorder have been found to be 2.7 times more likely than other children to develop a mental disorder (Lapalme et al., 1997); children of mothers with schizophrenia may have more anxious attachment patterns than children of mothers without schizophrenia (Naeslund, Persson-Blennow, McNeil, Kaj, & Malmquist-Larsson, 1984); and, offspring of women with psychoses have been found to be at a twofold higher risk of foetal death or still birth due to a combination of genetic, antenatal and obstetric factors (Webb, Abel, Pickles, & Appleby, 2005). Where mothers have an eating disorder, children are at increased risk compared with controls of disturbances in their development.
of developing disturbed eating habits and attitudes as well as being at risk of developing eating disorder psychopathology (Stein, Woolley, Cooper, Winterbottom, Fairburn, & Cortina-Borja, 2006).

Additional impacts include:

- poor school attendance in young people identified as ‘primary carers’ (for their parent)
- problems associated with stigma associated with mental illness (Hinshaw, 2005). For example, direct effects may be bullying at school where peers know that a child’s parent has a mental illness. A child may be excluded from social occasions. The effects on parents of negative community attitudes may be relayed to the children through the parent’s concealment of their illness or personality/behavioural changes.

### 1.3 Young Carers

One in eight people in Australia identify themselves as carers, which represents around 750,000 people in NSW. The Australian Bureau of Statistics (ABS) estimates the actual number of mental health carers in NSW may be up to 110,000.

Young carers often encounter particular difficulty completing their secondary education, maintaining social networks and getting into paid employment. These restraints come on top of the issues often encountered by other carers, such as isolation and feelings of helplessness. Young people who live with or care for an adult with mental illness sometimes miss out on education, joining in sports and having a social life (Falkov, 1998).

The Report from focus groups with service providers and policymakers held in NSW as part of the ARC Project (SPRC, 2008) indicated an understanding about the issues young carers face. Some of the most common issues or problems experienced by young carers included:

- The problem of identifying young people as carers.
- Young carers at risk of poor mental health
- Disconnection from education

As for many adult carers, children caring for parents with a mental illness often undertake domestic, emotional and household management responsibilities. Parents rely on their children for immediate, flexible and continuous care and assistance not available from professionals yet children are rarely recognised or consulted by professionals (Aldridge & Becker, 2003).

### 1.4 Mental Illness and Substance Abuse

People living with a mental illness are at increased risk of developing problems with drug or alcohol use. A national household survey in 1998 found that 18% of Australian adults had suffered from a mental illness during the past 12 months. Of these, almost 8% had experienced a substance use disorder during that time (McKey, 1998).

The most recent Australian National Council on Drugs (ANCD, 2007) report has provided up to date information on drug use in the family and its impacts and implications for children. There are two critical points relating to the impact and service requirements associated with parental mental illness and substance abuse and children. ‘Among the relevant key findings, parental substance misuse might be seen as a possible marker of co-morbid parental psychopathology, which may in itself contribute to greater impairments to child outcomes than substance use alone. To improve child outcomes in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role. In practice, this might translate into both improved training opportunities for alcohol and other drug (AOD) workers to help better address mental health issues, and improved liaison with mental health services. It appears likely that employing experienced mental health workers in AOD services will increase the use of such treatment options within substance using families.’ (ANCD, 2007, pp.viii-1x).

The Victorian Child Death Review Committee also found a pattern of multiple problems including drug use and mental illness, drug use and domestic violence, or drug use and transience in 12 (85%) out of the 14 child deaths reviewed (Victorian Child Death Review Committee, 2005).

The NSW Ombudsman’s report of reviewable child deaths in 2006 states that of 123 reviewable deaths, there was a history of parental substance abuse in 63 of the families. Eighteen children were identified as having been born to a mother who used illicit substances or hazardous levels of alcohol during pregnancy (NSW Ombudsman, 2007). As a result of previous reviews, several agency responses have been developed to help address these issues (e.g. new clinical guidelines for methadone and buprenorphine treatment that includes guidance on the identification and reporting of risk of harm to children of patients receiving treatment; trial of new Parental Drug Testing Policy).
1.5 Mental Illness and Child Protection Issues

The Annual Statistical Report for child protection and out-of-home care for 2004/05 published by the NSW Department of Community Services (2006) states that the primary reported issue in 8.9% (19,230) of reports of child abuse and neglect for that period was drug and alcohol use by the carer. The report for 2005/06 (NSW Department of Community Services, 2007) shows an increase in these reports, with the primary reported issue being drug and alcohol use by the carer in 9.3% (22,487) of reports. Mental health issues (which include the emotional state of the carer, the psychiatric disability of the carer and suicide risk or attempt of the carer) accounted for 7.8% of primary report issues (NSW Department of Community Services, 2006).

A USA study found that mothers with serious mental illness were almost three times as likely to have had involvement in the child welfare system or to have children who had an out-of-home care placement than mothers without a psychiatric diagnosis (Park, Solomon & Mandell, 2006). Research in the UK found that whereas parental mental illness was implicated in 13% of reports to child protection authorities (Bell, Conroy, & Gibbons, 1995), mental illness was implicated in 20% of all cases at initial investigation (Cleaver & Freeman, 1995), 25% of all cases at the protection planning meeting phase (Farmer & Owen, 1995), and in 42% of all cases that proceeded to Children’s Court care proceedings (Cleaver, Unell & Aldgate, 1999). Cleaver and Freeman (1995) showed that more than 40% of child protection cases in their survey involved multi-problem families characterised by a combination of parental mental illness, drug and alcohol abuse and domestic violence.

An important association exists between parental mental illness and child fatalities. Whilst small in number, these tragedies highlight the importance of knowing which clients are parents and the systematic consideration of the parenting needs of clients and the needs of their children.

The NSW Commission for Children and Young People (2002) and NSW Child Death Review Team (2003) are two reports concerning fatal assaults of children and young people. It was reported that, over a six-and-a-half year period, 17 out of the 100 children (all aged 10 years old or younger) who died as a result of fatal assault were killed by parents affected by mental illness. Nine of the fatalities occurred during an episode of parental depression, and eight occurred while the parent was experiencing acute psychotic symptoms. The second of these reports concluded that the NSW interagency guidelines for working with children and young people and their families were not adhered to and recommended research into factors that promote or hinder adherence to interagency policy and practice.

The Report of Reviewable Deaths in 2006 by the NSW Ombudsman reported on 123 reviewable child deaths, of which 40 were determined to be due to abuse or neglect. Nine of the children who died in these circumstances had not been reported to CS.

1.6 Aboriginal Children and Young People

Aboriginal peoples comprise just under 2% (119,865) of the total population of NSW (ABS, 2006). The number of Aboriginal children and young people referred to Community Services (CS) for assessment is disproportionate to the population. In the period 2004–2005, 12% of children and young people referred (9,600) were Indigenous children and young people (Community Services, 2006).

A survey conducted in Western Australia provides an indication of the outcomes for children of parents treated in mental health services. The Social and Emotional Wellbeing of Aboriginal Children and Young People report states that 24% of Aboriginal children aged from 4 to 17 years are at high risk of clinically significant emotional or behavioural difficulties. Further, ‘children in the primary care of a person who had used mental health services in Western Australia were one and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children in the primary care of a person who had not accessed these services.’ (Telethon Institute, 2005, p. 14).

In summary, the proportion of reports to CS due to ‘mental issues’, and the overrepresentation of Aboriginal children and young people in CS referrals, aligned with the findings of the WA Telethon study indicate that these young members of the NSW community and their families are extremely vulnerable. However, little specific data are currently available to inform planning and interventions.

1.7 Children from Culturally and Linguistically Diverse (CALD) Backgrounds who have a Parent with a Mental Illness

Over one million people in NSW were born in countries where English is not the primary language, and 18.9% speak a language other than English at home. More than 1.4 million people living in NSW (23.3%) are identified as coming from a CALD background (Community Relations Commission, 2003).
The degree of direct association between parental mental illness and emotional and behavioural problems for children in families from CALD backgrounds is yet to be extensively researched, although some findings have been published which relate to specific cultural groups and adult mental health problems. The greater the exposure to traumatic events by adult refugees the more likely they are to experience mental health problems, with depressive symptoms persisting over time (Beiser, 1988; Hinton, Tiet, Tran, & Chesney, 1997). Parental depression is a known risk factor for adolescent depression (NH&MRC, 1997), indicating the vulnerability of children to depression. Torture and trauma experienced by parents may vicariously affect children through their indirect exposure to this and other pre-migration experiences (Sozomenou et al., 2000) and children themselves may have been subjected to torture. Children from refugee families have been found to experience emotional problems, including social withdrawal, chronic fears, depression, overly dependent behaviour, sleep disturbance, problems at school and difficulties relating to peers (Canadian Task Force, 1988; Jayasuriya, Sang, & Fielding, 1992).

### 1.8 Children in Custody

A survey conducted by the NSW Department of Juvenile Justice (2003) found that of 242 young people in custody, aged 14 to 22 years, 19% had been living with a person who had a physical or mental health problem affecting their daily life. Eighty-eight percent of the young people in custody reported mild, moderate or severe symptoms consistent with a clinical mental disorder, with 21% reporting symptoms consistent with a diagnosis of schizophrenia and 14% reporting symptoms consistent with major depression. Ten percent of young people in the total sample were the parent of one or more children.

#### Table A.1 Examples of Relationship between Parental Mental Ill Health and Outcomes for Children and Young People

<table>
<thead>
<tr>
<th>Age and population groups</th>
<th>Factors</th>
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</thead>
<tbody>
<tr>
<td>Infants</td>
<td>Mothers (155) with a history of psychotic disorder had a higher proportion of stillbirths and neonatal deaths, were less likely than controls to attend for infant immunisations. The physical health of babies who lived with mothers with psychotic disorders was not significantly different from that of matched baby controls. (Howard et al., 2003). Infants of mothers with eating disorders were found to be smaller, in terms of weight for length and weight for age, than either comparison group infants or infants of mothers with post-natal depression (Stein et al., 1996).</td>
</tr>
<tr>
<td>Children</td>
<td>Children (43) of parents (21) with OCD were significantly more likely than control offspring to have lifetime overanxious disorder, separation anxiety disorder, OCD, or ‘any anxiety’ disorder (Black et al., 2003).</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Depression in adolescents aged 15 is twice as likely as in adolescents of never depressed mothers. Severity of maternal depression contributed more to risk than did chronicity (Hammen &amp; Brennan, 2003). 166 adolescents of mothers with schizophrenia, depression, bipolar disorder were assigned to one of five clusters: socially and emotionally competent, anxious and depressed, average adult oriented, delinquent peer oriented, isolated/non-conformist. Predictors for these clusters: boys 4 times more likely to be in delinquent/peer cluster; older children more likely to be depressed; youth whose mothers had problematic substance abuse history were more likely to be in the delinquent/peer oriented cluster; adolescents whose mothers reported more available social support were significantly less likely to be in the isolated/non-conformist cluster (Mowbray et al., 2004).</td>
</tr>
<tr>
<td>Young carers</td>
<td>Young caregivers: higher responsibilities, perceived maturity, worry, activity restrictions, isolation. Feel compelled to care for parent, guilt if engage in outside activities, tendency to protect other family members from distress. Also – enhanced self-efficacy through new skills and knowledge (Pakenham et al., 2006).</td>
</tr>
</tbody>
</table>

### 1.9 Children of Parents in Prison

The New South Wales Corrections Health Service (1999) found that on any given day, 11,000 children in NSW had a parent who was imprisoned. Most of these children were found to be under 10 years of age; a South Australian study found that 19% of children of parents in prison were less than five years of age. A high proportion of female prisoners are mothers of dependent children and studies in both South Australia and Queensland have found that 85% of female inmates had children (Woodward, 2003). Children of prisoners can experience a range of distressing emotions including loss and grief, anxiety, confusion, depression, and feeling suicidal (Woodward, 2003). Parents imprisoned report a range of significant personal difficulties prior to imprisonment. A study conducted in South Australia found that of 106 parents interviewed, 32% had mental health problems prior to imprisonment, 58% reported problems with drugs, 26% with domestic violence, and 22% with alcohol problems (Justice Strategy Division, 2005).
The Social and Emotional Wellbeing of Aboriginal Children and Young People report states that 24% of Aboriginal children aged between 4 to 17 years are at high risk of clinically significant emotional or behavioural difficulties. Further, ‘children in the primary care of a person who had used mental health services in Western Australia were one and a half times more likely to be at high risk of clinically significant emotional or behavioural difficulties than children in the primary care of a person who had not accessed these services.’ (Telethon Institute for Child Health Research, 2005, p. 14).

Common post-migration stresses in Australia for children and adolescents include: 1) identity (even into second, and sometimes the third generation); 2) conflict between different cultures; 3) racism; and, 4) intergenerational conflict.

### Table A.2 Impacts and Protective Factors of Parental Mental Illness and Problem Alcohol and Drug Use and Domestic Violence for Children in Six Age Groups (adapted from Cleaver, Unell & Aldgate, 1999)

<table>
<thead>
<tr>
<th>Age group</th>
<th>Risk Factors/Impacts</th>
<th>Protective Factors</th>
</tr>
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<tbody>
<tr>
<td>Unborn child</td>
<td>Genetic transmission of some forms of mental illness</td>
<td>Good regular antenatal care</td>
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<tr>
<td></td>
<td>Foetal damage brought about by substance misuse or physical violence</td>
<td>Adequate nutrition, income support and housing</td>
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<td></td>
<td>Spontaneous abortion, premature birth, low birthweight, still birth</td>
<td>Avoidance of viruses, smoking, unnecessary medication, stress</td>
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<td></td>
<td>Support for the expectant mother of a caring adult</td>
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<tr>
<td></td>
<td></td>
<td>Alternative safe and supportive residence for expectant mothers subject to violence</td>
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<tr>
<td>0–2 years</td>
<td>Possible neurological and physical damage to baby arising from drug and alcohol use and domestic violence during pregnancy</td>
<td>The presence of an alternative or supplementary caring adult who can respond to the developmental needs of baby</td>
</tr>
<tr>
<td></td>
<td>Physical and emotional neglect of babies detrimental to health</td>
<td>Sufficient income support and good physical standards in home</td>
</tr>
<tr>
<td></td>
<td>Existing health problems of infant exacerbated by living in an impoverished physical environment</td>
<td>Regular supportive help from primary health care team and social services, including day care</td>
</tr>
<tr>
<td></td>
<td>Cognitive development of infant may be delayed through parent’s inconsistent, under-stimulating and neglecting behaviour</td>
<td>An alternative residence for families subjected to violence</td>
</tr>
<tr>
<td></td>
<td>Children may fail to develop a positive identity because they are rejected and uncertain of their developing ‘self’</td>
<td></td>
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<tr>
<td></td>
<td>Babies suffering withdrawal symptoms from foetal addition may be difficult to manage</td>
<td></td>
</tr>
<tr>
<td>3–4 years</td>
<td>Children are placed in physical danger by parents whose capacity to care is limited by mental illness, substance misuse or DV</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical needs of children may be neglected, such as being unfed, unwashed</td>
<td>The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child</td>
</tr>
<tr>
<td></td>
<td>Children may be subjected to physical violence by parents</td>
<td>Sufficient income support and good physical standards in home</td>
</tr>
<tr>
<td></td>
<td>Lack of stimulation, isolation may contribute to delay in cognitive development</td>
<td>Regular supportive help to the family from primary health and social services</td>
</tr>
<tr>
<td></td>
<td>Inconsistent parenting may lead to disruptions in attachment behaviour</td>
<td>Regular attendance at pre-school</td>
</tr>
<tr>
<td></td>
<td>Children may learn inappropriate behaviours through witnessing DV</td>
<td>An alternative residence for families subjected to violence</td>
</tr>
<tr>
<td></td>
<td>Unpredictable and frightening behaviour of parents may result in children displaying PTSD-like symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children may take on responsibilities beyond their years because of parental incapacity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children may be at risk because they are unable to tell anybody about their stress</td>
<td></td>
</tr>
<tr>
<td>Age group</td>
<td>Risk Factors/Impacts</td>
<td>Protective Factors</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5–9 years</td>
<td>- Academic attainment is negatively affected</td>
<td>- Children have the cognitive ability to rationalise drug and alcohol problems in terms of illness</td>
</tr>
<tr>
<td></td>
<td>- Children may develop poor self-esteem and may blame themselves for their parent's problems</td>
<td>- The presence of an alternative, consistent caring adult who can respond to the cognitive and emotional needs of the child</td>
</tr>
<tr>
<td></td>
<td>- Inconsistent parental behaviour may cause anxiety and faulty attachments</td>
<td>- Sufficient income support and good physical standards in the home</td>
</tr>
<tr>
<td></td>
<td>- Unplanned separation can cause distress and disrupt education and friendships</td>
<td>- Regular attendance at school</td>
</tr>
<tr>
<td></td>
<td>- Children may feel embarrassed about their parent's behaviour, and curtail friendships and social interactions</td>
<td>- Sympathetic, empathic and alert teachers</td>
</tr>
<tr>
<td></td>
<td>- Children may take on too much responsibility for themselves, siblings and parents</td>
<td>- An alternative residence for mothers subjected to violence</td>
</tr>
<tr>
<td>10–14 years</td>
<td>- Children may have to cope with puberty without support</td>
<td>- A supportive older sibling</td>
</tr>
<tr>
<td></td>
<td>- Children are at increased risk of psychological problems</td>
<td>- A friend available for mutual support</td>
</tr>
<tr>
<td></td>
<td>- Children's education suffers as they find it difficult to concentrate</td>
<td>- Social networks outside the family</td>
</tr>
<tr>
<td></td>
<td>- School attainment may be below ability</td>
<td>- Belonging to out-of-school activities</td>
</tr>
<tr>
<td></td>
<td>- Children may reject their families and have low self-esteem, are cautious of exposing family to outside scrutiny</td>
<td>- Being taught different ways of coping, and being confident to know what to do if parent incapacitated</td>
</tr>
<tr>
<td></td>
<td>- Children feel isolated, no-one to turn to</td>
<td>- Ability to separate physically, psychologically from stressful situation</td>
</tr>
<tr>
<td></td>
<td>- Children are at risk of emotional disturbance and conduct disorders</td>
<td>- An alternative residence for families subjected to violence</td>
</tr>
<tr>
<td></td>
<td>- Children may be in denial of own needs and feelings</td>
<td></td>
</tr>
</tbody>
</table>

15 years and over

<table>
<thead>
<tr>
<th>Risk Factors/Impacts</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Inappropriate role models</td>
<td>- Factual information about sex and contraception</td>
</tr>
<tr>
<td>- Adolescents may have problems related to sexual relationships</td>
<td>- Regular attendance at school/further education</td>
</tr>
<tr>
<td>- Poorer life chances due to exclusion and poor school attainment</td>
<td>- Employment</td>
</tr>
<tr>
<td>- Low self-esteem as a consequence of inconsistent parenting</td>
<td>- Sufficient income support and good physical standards in the home</td>
</tr>
<tr>
<td>- Increased isolation from friends and adults outside the family</td>
<td>- Practical and domestic help</td>
</tr>
<tr>
<td>- Emotional problems may result from self-blame and guilt</td>
<td>- Regular medical and dental checks</td>
</tr>
<tr>
<td>- Acknowledgement of their role in the family by professionals, rather than judgements that it is inappropriate</td>
<td>- Sympathetic, empathic and alert teachers</td>
</tr>
<tr>
<td>- An alternative residence for families subjected to violence</td>
<td>- Belonging to organised our of school activities</td>
</tr>
</tbody>
</table>
Age group | Risk Factors/Impacts | Protective Factors
--- | --- | ---
15 years and over (continued) | ■ Adolescent needs may be compromised, or given over to meet needs of parents | ■ A mentor or trusted adult with whom the young person is able to discuss worries, and sensitive issues
 ■ A friend available for mutual support
 ■ Being taught different ways of coping, and being confident to know what to do if parent incapacitated
 ■ Ability to separate physically, psychologically from stressful situation
 ■ Information on how to contact professionals if parent is in crisis
 ■ Acknowledgement of their role in the family by professionals, rather than judgements that their role is inappropriate
 ■ An alternative residence for families subjected to violence

Table A.3 Personal Stories from ARAFMI NSW

A boy’s story

‘We never spoke about mum getting sad when I was younger. That’s what we called it. Dad was always supportive of us at school and sport so I guess it appeared as though nothing was wrong. When mum was sad he tried to shield us, he just wanted to protect us from seeing her like that. Protecting us however also meant keeping us in the dark; he never used to like talking about it and when mum got better it was like nothing had ever happened. The house was quiet for a few weeks then back to normal as though nothing had happened.

It was only later when someone came to our school and told us about depression and mental illness that I realised that was what mum had and dad had been hiding from us. Having heard this person talk to our class and explain that it was ok to tell people I decided to tell some of my friends. ‘Mum has depression’ I said. The first response I got was ‘I thought there was something wrong with her’ and that was from my best friend. I never brought it up again.

It wasn’t until I met a friend in a similar position to me, with a mother living with depression, that I realised that there were services available to support people like me. Because I felt I couldn’t tell anyone and dad had always kept it quiet I just didn’t know what support was out there. I am grateful that I met that person otherwise who knows how things could have turned out.’

Loren’s story

‘Growing up with a mentally ill mum definitely has had an impact on my life and who I am. Strangely now I look back and can see how it has made me a stronger and more independent person.

For my mum, I think that having infants kept her going in the early days. We were her reason to get out of bed in the morning. She had to cook for us, play with us. Mum was wonderful and didn’t want my brother or me missing out on any opportunities. She would wait for me at dancing, drop us off for play dates. I remember finding her crying a couple of times, but these memories are minor in the grand scheme.

It wasn’t until my brother and I became teenagers, less reliant on mum that I noticed a remarkable difference. There was no longer a need for her to get out of bed in the morning, and if we didn’t push her; she wouldn’t. She started to turn to alcohol to deal with her demise; as you can imagine this only increased the strain on our close family unit. I suppose my natural instinct was for me to distance myself from this. My relationship became closer with my dad.

It was at this stage that I felt like the tables turned, and at times I felt like the mother. I would beg her to get out of bed in the morning, take her shopping and encourage her to cook the family meal. I can’t imagine the increased pressure this put on my dad. My relationship with my brother also strengthened.

I live out of home now – so the mental illness is much less a part of my life. I’m removed from most of the desperation that it can cause. Looking to the future, I can see that slowly but surely mum is figuring out what makes her happy - and learning to live for those things.’

Adult child of parent with a mental illness – J’s story

‘Let me tell you about some of the difficulties I faced growing up in a family affected by serious mental illness. School and friendships were particularly difficult. When I was still at primary school I had very poor self-esteem and adopted a ‘victim’ role. I became fearful and isolated. At high school my situation worsened. Dad was really unwell at this time and once or twice brought derelicts home. I wondered what all this meant and though perhaps this was just another aspect of Dad being generous and well meaning. Neighbours became aware of his strange behaviours and whereas we were once invited to social occasions such as Christmas drinks and outdoor picnics, doors were shut and we were shunned. I was swimming in a sea of emotions that I couldn’t acknowledge, understand or deal with: fear, shame, and embarrassment. Confusion and guilt. I was desperate for a safe shore but none came in sight. If someone had explained Dad’s illness to me at this time and if I had been supported through my journey of self-discovery, this would have resulted in a lot less emotional pain and isolation.’
SECTION 2
Policy and Planning Context

This section lists the National and State strategic policy and planning documents that directly align with or are relevant to the NSW Mental Health Service Framework for Children of Parents with Mental Illness.

2.1 National Context

The National Mental Health Plan 2003–2008 priority themes include the promotion of mental health and prevention of mental health problems, increased service responsiveness, measured high-quality outcomes and fostering of research, innovation and sustainability.


The National Practice Standards for the Mental Health Workforce (2002) makes specific reference to children of parents with a mental illness, stating as a guiding principle that mental health professionals recognise and support the rights of the children to appropriate information, care and protection.

The Principles and Actions for Services and People Working with Children of Parents with a Mental Illness (PASP) (AICAFMHA, 2004) was developed from broad ranging consultations across Australia. It is seen as complementary to the implementation of the National Practice Standards for the Mental Health Workforce (2002) in relation to the provision of care, protection and information for children of parents with mental illness and their families. The following Action Areas were identified for service providers to enhance protective factors and reduce risk factors in parents with a mental illness and their children:

- Promotion of wellbeing and risk reduction
- Support for families and children
- Addressing grief and loss issues
- Access to information
- Education and decision making
- Care and protection of children
- Partnerships and cross-agency processes
- Workforce development
- Research and evaluation

The Position Paper – Improving the Mental Health of Infants, Children and Adolescents in Australia (AICAFMHA, 2005) identifies children of parents with a mental illness as having a greater risk of developing mental health problems than their peers but presenting a special challenge for services because many of these children may not access or necessarily require mental health services. These ‘invisible’ children however often need support, respite, information and protection.

The First and Final Reports of the Senate Select Committee on Mental Health, A National Approach to Mental Health – From Crisis to Community (2006) contain several recommendations directly relevant to this COPMI Framework including:

- ensuring that the objectives in the next National Mental Health Strategic Plan increase emphasis on delivery of community care, prevention and early intervention, providing a more appropriate balance between these services and emergency care
- allocating funding to develop and expand services specifically designed for supporting children who have a parent or parents with mental illness
- creating better links between child and maternal health services and mental health services, and providing funding for programs to assist families identified through maternal and child health services as having, or at risk of, mental illness.

2.2 NSW State Context

The NSW State Plan, Investing in a Better Future (2010) is a long term plan to deliver the best possible services to the people of NSW. It sets out the main areas where the community expects improvements, and shows how those improvements will occur. About 75 percent of the priorities and targets have been retained from the State Plan launched in 2006, but changes have been made to strengthen targets and drive local delivery. Relevant
change areas and priorities for COPMI include:

a. Healthy Communities: priority is improved outcomes in mental health

b. Stronger Communities: priority is improved child wellbeing, health and Safety.

Within each of the two priorities listed above, the targets relevant for children of parents with a mental illness include reducing re-admissions within 28 days to any facility, increasing the employment of public mental health services clients, increasing the proportion of children who have a safe and healthy start to life, increasing the proportion of NSW children and young people with age appropriate life and learning skills and children and young people in NSW, along with their families, have access to appropriate and responsive services when needed.

*NSW: A New Direction for Mental Health Services (2006)* sets out a five year plan for the enhancement of mental health services. There are four areas of focus that have some linkage with positive outcomes for children of parents with mental illness:

1. promotion, prevention and early intervention;
2. integration of the care system;
3. increasing participation in employment and community; and,
4. enhancing workforce capacity.

The *NSW Interagency Action Plan for Better Mental Health (Everyone’s Responsibility) (2005)* acknowledges that improvement of mental health requires a whole-of-government approach which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice, with mental health services. The Plan sets out three Strategic Directions:

1. prevention and early intervention;
2. community support services; and,
3 coordination of emergency responses.

One action identified in the Plan and which has already been achieved was the development and dissemination of a resource kit to support professionals working with the children of parents with a mental illness.

The *NSW Mental Health Sentinel Events Review Committee, Tracking Tragedy 2007 Report* noted that, during the review period, 2 of the 9 identified cases of homicide by clients of adult mental health services involved children. The review highlighted the risk that family members are exposed to when another member of the family experiences a serious mental illness. Over 50% of victims of violence perpetrated by those experiencing a serious mental illness are family members. Children are a very vulnerable group. The Report in 2005 (for the period 2002–2004) recommended that NSW Health develop a clinical guideline for the management of risk to children of a parent with a major psychiatric disorder (Recommendation 6) and this is noted in the most recent report. The NSW Mental Health Service Framework for Children of Parents with Mental Illness is part of a response to the *Tracking Tragedy* Reports. The current document lays the strategic service framework for COPMI, with next steps involving the development of relevant clinical guidelines and protocols for working with this population.

*Keep Them Safe: A shared approach to child wellbeing 2009–2014* sets out the NSW Government’s five year Plan to improve the safety and wellbeing of children and young people. The Plan responds to the *Report of the Special Commission of Inquiry into Child Protection Services in NSW* (November 2008). A key objective of the new approach is to create an integrated system that supports vulnerable children, young people and their families.

There are seven elements to the Action Plan:

- The universal service system
- Strengthening early intervention and community-based services
- Better protection for children at risk
- Changing practice and systems
- Supporting Aboriginal children and families
- Strengthening partnership across the community services sector
- Delivering the Plan and measuring success.

NSW Health will continue to promote awareness of child protection responsibilities throughout the drug and alcohol/mental health workforce and will also give immediate priority to ensuring that its policies and procedures can assist these services to identify adult clients who have children and promote timely access to appropriate services for these clients and their families.

The *NSW Aboriginal Mental Health and Wellbeing Policy 2006–2010* includes the Aboriginal Definition of Health: ‘not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.’ The Strategic Directions set out in the Policy state that all policies, strategies, programs, services and research projects of the NSW Department of Health and Area...
Health Services must reflect a respect for the Aboriginal person as an individual, within a family, community, nation and society. Aboriginal people, Aboriginal communities and Aboriginal community-controlled organisations are to be consulted in the identifications of needs, development, implementation and evaluation of health programs and services which are the responsibility of the NSW Department of Health and Area Health Services. The policy specifies that programs be developed for children of Aboriginal families affected by mental illness.

Getting in Early: A Framework for Early Intervention and Prevention in Mental Health for Young People in New South Wales (2001) contains four strategies including ‘developing and implementing prevention programs’. A group identified in this strategy is young people with a personal or parental history of depression.

The NSW Health/Families NSW Supporting Families Early (SFE) package brings together initiatives from NSW Health’s Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office, in order to promote an integrated approach to the care of women, their infants and families in the perinatal period. Three companion documents form the SFE package. The first part of the package, the Supporting Families Early Maternal and Child Health Primary Health Care Policy, identifies a model for the provision of universal assessment, coordinated care, and home visiting, by NSW Health’s maternity and community health services, for all parents expecting or caring for a new baby.

The SAFE START Strategic Policy provides direction for the provision of coordinated and planned mental health responses to primary health workers involved in the identification of families at risk of, or with, mental health problems, during the critical perinatal period. It outlines the core structure and components required by NSW Mental Health services to develop and implement the SAFE START model. The SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants, outlines the rationale for psychosocial assessment, risk prevention and early intervention. It proposes a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment in the perinatal period. It also examines the broader specialist role of Mental Health Services in addressing the needs of parents with, or at risk of, developing mental health problems.

The NSW Community Mental Health Strategy 2007–2012 This Strategy describes the model for community mental health services to be developed and delivered by 2012. This model covers the spectrum of mental health care and provides a framework for improving responses to the needs of people with mental illness or disorder, their families and carers across NSW, across the age range, and across diverse communities. The purpose of this Strategy is to guide mental health services (public sector and specialist mental health NGO services) in the implementation of this model over the next five years to 2012. The Strategy is intended to inform consumers, their families and carers and other stakeholders about directions in community mental health and about what they can expect from community mental health services. It provides a common framework for collaboration and partnerships with a range of key agencies and services in the provision of community mental health care.

The NSW Multicultural Mental Health Plan 2008–2012 focuses on improving service delivery and workforce practices to meet the mental health needs of people from CALD communities. This requires strong partnerships between NSW mental health service providers, CALD consumers of mental health services and consumers’ families and carers, in order to:

- Promote broad awareness of consumer rights;
- Gain equitable access to appropriate services and information; and
- Provide the opportunity to participate at all levels of care.

The five strategic priorities for multicultural mental health are:

- Integrated policies that guide informed and data driven planning processes.
- Renewing a focus on education, prevention and early intervention.
- Delivering culturally inclusive and responsive mental health services.
- Enhancing cultural competencies in mental health service delivery.
- Promoting culturally inclusive research, evaluation and innovation.

Critical to these five priorities is the continued integration of multicultural mental health issues into the mainstream mental health agenda.

2.3 Other Planning Contexts

from abuse and neglect are contained in the *NSW Children and Young Persons (Care and Protection) Act 1998*. This legislation, by its nature, determines the responsibilities parents have to care for their children. The personal and human rights of parents are contained in United Nations documents such as the *Universal Declaration of Human Rights*, and the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*.

The Royal Australian and New Zealand College of Psychiatrists have two relevant Position Statements: #56 *Children of Parents with a Mental Illness* and #57 *Mothers, Babies and Psychiatric Inpatient Treatment*. Position Statement #56 recommends that all assessments of adults with a mental illness must include:

- identification of all dependent children
- their current circumstances and safety
- the parent’s capacity to provide physical and emotional care
- the direct effect of the parent’s mental illness on each child
- the availability of alternative care and support for each child
- in the case of acute parental illness, as soon as is possible, discussion with the parent about their concerns about their children.

It is also recommended that there is consultation with child and adolescent services as appropriate, and consideration of child protection issues. Child and adolescent psychiatrists should prioritise secondary consultations with adult mental health services and service providers. Interagency collaboration should be promoted, particularly with adult mental health services, and training and ongoing education of psychiatrists must include these issues.

Position Statement #57 notes that even brief separations from the mother can produce negative consequences for the infant, and that joint admission to a psychiatric inpatient unit constitutes an investment in the baby’s future health. The College position is that it is best clinical practice that mother and baby be admitted to hospital together, preferably in a mother-and-baby psychiatric unit. Exceptions to such admissions are cases where the baby’s or mother’s emotional or physical wellbeing may be jeopardised.
SECTION 3

NSW Activities and Initiatives

3.1 NSW Initiatives and Programs for Children of Parents with Mental Illness and their Families

NSW Health is committed to improving access to early intervention for COPMI. This commitment has been demonstrated in the allocation of $2.24m for COPMI since 1997 and $660,000 provided as recurrent annual funding since 1996–1997. Several areas of service development have been targeted including:

- Training and education of mental health and related staff to enhance the awareness of needs of dependent children of parents with a mental illness.
- Designated COPMI worker positions to support enhancement of clinical practice and organisational change.
- Statewide coordination involving development and implementation of professional education and training, inter-agency partnerships, promotion of school-based initiatives that increase understanding of mental illness, clinical leadership and advocacy for participation of consumers and carers.
- Direct services for families where a parent has a mental health problem and their children and young people.
- Interagency partnerships including Community Services and Non-Government organisations, e.g. Charmian Clift Cottages Inc. is a community-based non-government residential program for women with a mental illness and their dependent children, currently funded by the NSW Department of Health and Community Services supported Accommodation Assistance Program (SAAP).
- An information and resource kit is available for mental health staff. The kit provides a consistent, quality package of information and resources to assist in improving support for workers and for families with mental health problems and disorders.
- Distribution by the Community Services of a Dual Diagnosis Kit to better equip families, carers and service providers to support children of parents affected by both mental illness and substance misuse.

3.2 Other Relevant NSW Initiatives and Programs

Families NSW

Families NSW is the NSW Government’s prevention and early intervention strategy to help parents give their children a good start in life. Families NSW helps to improve children’s health and wellbeing by:

- Helping parents to build their skills and confidence in parenting
- Supporting parents so they can respond to problems early
- Building communities that support families
- Improving the way agencies work together to make sure families get the services they need.

Families NSW is delivered jointly by five Government agencies (NSW Health and Areas Health Services, Community Services, Education and Training, Housing and Ageing, Disability and Home Care). It relies on Government and NGO services working differently together and with communities to plan and develop more response and coordinated services. Among the programs are: Schools as Community Centres, Supported Playgroups, Universal Health Home Visiting, and Universal Parenting Program and SAFE START.

SAFE START

The SAFE START model aims to provide psychosocial assessment and depression screening for all women expecting or caring for an infant in NSW. Integral to the model is implementation of integrated care pathways for vulnerable families identified through the universal assessment and depression screening process. The benefits of good perinatal and infant mental health extend beyond early family life and the school years. Evidence shows that the development of health, social, and emotional skills in the first two years of life equips children to become adults who can form intimate relationships, effectively care for their own children and hold a job. The SAFE START model embraces early detection of vulnerable families and provision of integrated support and intervention packages to optimise parent-infant relationships in the first two years of parenting.
**Family and Carer Mental Health Program**

The NSW Family and Carer Mental Health Program is a statewide partnership between the Area Health Services and four NGOs to provide support to families and carers of people with a mental illness. Key initiatives under this program include:

- **Family-friendly mental health services**
  The Program supports the development of mental health services so that families and carers are recognised, supported and included in treatment planning and service provision.

- **Mental health family and carer support**
  The four NGOs supplying the Mental Health Family and Carer Support Service provide not only education and training to build coping skills and resilience but also support services including direct provision of individual support, information, advocacy and peer support.

- **Generic family and carer supports**
  The Program will support awareness of, and access to, mainstream support services such as counselling, respite and financial support.

The outcomes of the family and carer program are:

- Improved family/carer wellbeing
- Improved outcomes for consumers
- Increased family and carer knowledge and ability to manage caring role effectively
- Families and carers are supported to have continuous involvement
- Referral of families and carers to support/training by the mental health service
- Open communication between services about family/carer issues
- Consistency of services and support across NSW.

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<thead>
<tr>
<th>Area Health Service</th>
<th>Program/Position</th>
<th>Details</th>
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<tbody>
<tr>
<td>South Eastern Sydney Illawarra</td>
<td>COPMI Program, Central and Southern Network</td>
<td>Position provides range of services: psychoeducation, family work, case management, referrals to specialist services, consultation with AMHS, camps and fun days, education and liaison, development of clinical pathways.</td>
</tr>
<tr>
<td>Sydney South West</td>
<td>Program for Families where a Parent has a Mental Illness (North East cluster)</td>
<td>Program includes:</td>
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<tr>
<td></td>
<td></td>
<td>■ School holiday program for children and young people 6–15 years</td>
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<td></td>
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<td>■ Small group program for mothers</td>
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<td></td>
<td></td>
<td>■ Playgroup for parents with mental illness/children</td>
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<tr>
<td></td>
<td></td>
<td>■ Antenatal and postnatal support for women</td>
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<td></td>
<td></td>
<td>■ Assessment and referral service</td>
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<td></td>
<td></td>
<td>■ Consultation and liaison service for mental health services and other government and non-government agencies</td>
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<td></td>
<td></td>
<td>■ Provision of information and resources to staff and families.</td>
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<tr>
<td>Sydney South West</td>
<td>Gaining Ground</td>
<td>Gaining Ground coordinates Getaway Camps for 9–16 year olds; Advent Program</td>
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<tr>
<td>Sydney West</td>
<td>Sydney West Area Health Service COPMI</td>
<td>COPMI activities:</td>
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<tr>
<td></td>
<td></td>
<td>■ Parenting Together Playgroup (South Windsor, in partnership with Hawkesbury Community Health Service, Family Co-op and Hawkesbury Community Services).</td>
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<td>■ Groups for children, young people and parents.</td>
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<td></td>
<td></td>
<td>■ Building COPMI capacity of Mental Health, Community Health, DET, CS (Community Services, previously known as Department of Community Services), NGOs and other professionals through in-services, clinical consultation, conferences.</td>
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<tr>
<td></td>
<td></td>
<td>■ Brief clinical interventions (for children, parents and families) with primary workers on COPMI related issues including mental health education and assessment.</td>
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<td></td>
<td></td>
<td>Evaluation depends on the individual activity or project being undertaken.</td>
</tr>
<tr>
<td>Sydney West</td>
<td>Western Sydney Family Program</td>
<td>Family workers providing direct clinical provision to families affected by parental mental ill health, referrals to specialist services and enhancing parenting strategies. Mostly a home-based service.</td>
</tr>
</tbody>
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### Area Health Service

<table>
<thead>
<tr>
<th>Program/Position</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td><strong>Northern Sydney Central Coast</strong></td>
<td>Prevention – Parenting and COPMI</td>
</tr>
<tr>
<td><strong>Northern Sydney Central Coast</strong></td>
<td>Parent Link</td>
</tr>
<tr>
<td><strong>Greater Southern</strong></td>
<td>GSAHS Family and Carer Assist partnership</td>
</tr>
<tr>
<td><strong>Greater Western</strong></td>
<td>Promotion Prevention</td>
</tr>
</tbody>
</table>

COPMI position coordinates a range of capacity building strategies:
- Education, training and consultation for MH service and key partners
- Convenes Central Coast COPMI Network and associated working parties (clinical pathways in health, supporting COPMI in schools, services development for children and young people)
- Partnership with ARAFMI to provide the Young People Connecting program
- Collaboration with the children and young people’s mental health team to develop and pilot an inpatient parenting initiative
- Triple P with mental health service clients
- Policy development

**Table B.2 Examples of NSW COPMI Activities-NGOs and Other Agencies (see www.copmi.net.au)**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Program</th>
<th>Details</th>
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<tbody>
<tr>
<td>Schizophrenia Fellowship</td>
<td><strong>ON FIRE!</strong></td>
<td>Community funded, staffed by volunteers. Provides: peer support groups; fun day outings; creative expression groups; Skills 4 Life Groups; Mental Health Learning Groups. Standardised measures used to evaluate camps.</td>
</tr>
<tr>
<td>Benevolent Society</td>
<td>Early Intervention Program</td>
<td>NGO established to work with vulnerable families in the community. The program focuses on families where parents have a mental illness, antenatally up to age 5. Outreach home visiting service. Evaluated as part of the service.</td>
</tr>
<tr>
<td>Benevolent Society</td>
<td>Central Sydney Scarba Service</td>
<td>For children aged 0–12 years who have been abused/neglected. Offers home visiting to ensure children are safe, families are supported, and children are supported. Referrals from CS.</td>
</tr>
<tr>
<td>Barnardos South Coast</td>
<td>Barnardos South Coast ‘POPPY’ Playgroup</td>
<td>A free playgroup for families of young children (0–5) where a parent has a mental illness, funded through Families NSW. It is facilitated by a Family Worker and an Early Childhood Teacher and involves other health professionals to assist parents with parenting, health, child development and other issues.</td>
</tr>
<tr>
<td>Carers NSW</td>
<td>Young Carers Project</td>
<td>Support for young carers through: camps; newsletters; phone group counselling and support; interactive website. Evaluation reports on 3 camps cited on website. Funding: ADHC and FaHCSIA</td>
</tr>
<tr>
<td>SDN Children’s Services</td>
<td>Partnerships with Parents, Redfern</td>
<td>Works with vulnerable families to support them in their parenting of under 5s in inner Sydney including young parents, Aboriginal families, families who have mental health issues, drug and alcohol involvement, or CS involvement. Provides a baby group at Redfern Bay Health Centre; assist with a group at the Aboriginal Children’s Centre, and 1:1 family work.</td>
</tr>
<tr>
<td>North Coast NSW – Ontrack</td>
<td>Northern Kids Care Program</td>
<td>Consists of a medium term home visiting family support program for 0–18 years, workshops for 6–12 year olds based on Kids Time format, After school workshops for 8–12 based on Vic Champs model. After-schools workshops for 13–18 – PATS model. Primary school support and education SKIPS, Volunteer mentoring program for 13–18 year olds.</td>
</tr>
<tr>
<td>Family Inclusion Network</td>
<td>Central Coast Outreach</td>
<td>Supports families and parents that have children in out-of-home care (OOHC) or are at risk of losing their children through the child protection system. It provides information, support, advocacy and education to families and professionals alike.</td>
</tr>
</tbody>
</table>
## Table B.3 Examples of NSW Young Carer / COPMI Activities Undertaken Through NSW Family and Carer Mental Health Program NGOs

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Program &amp; AHS Program is Run In</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARAFMI NSW</td>
<td>Connect for Kids Northern Sydney Central Coast AHS</td>
<td>A 3-day program that delivers psychosocial education around mental illness. It provides young carers with information, skills and resources to assist them to cope better with their situation. They also have lots of opportunity to interact and connect with other kids who share their experiences. The program highlights some of the issues that young people face, and encourages parents to discuss these areas with their children.</td>
</tr>
<tr>
<td>Carer Assist</td>
<td>Young Carer/ COPMI Carer Advocate Greater Southern AHS</td>
<td>Position is based in Wagga Wagga and coordinates a range of young carer / COPMI activities including a Study Skills Centre and a Young Carer Support Group run in collaboration with Northcott and Interreach. The Carer Advocate provides support and advocacy for kids living in families where someone has a mental illness.</td>
</tr>
<tr>
<td>Carer Assist</td>
<td>Queanbeyan Kids Club Greater Southern AHS</td>
<td>Run in conjunction with the Greater Southern Area Health Service, the Queanbeyan Kids Club provides a range of services for young carers including a support group and an annual camp.</td>
</tr>
<tr>
<td>Carers NSW</td>
<td>SMILES South Eastern Sydney Illawarra AHS North Coast AHS Greater Western AHS</td>
<td>The SMILES program is run for kids 8–16 years of age. It provides age-appropriate education about mental illness and life skills to enhance coping for children who have a family member experiencing a mental health problem.</td>
</tr>
<tr>
<td>Carers NSW</td>
<td>PATS Program North Coast AHS</td>
<td>The Paying Attention To Self (PATS) Program is a peer support program for 13–18 year olds that teaches coping strategies, helps build resilience and educates about mental illnesses. This program is run in conjunction with Northern Kids Care.</td>
</tr>
<tr>
<td>Uniting Care Mental Health</td>
<td>Peer Support Program Sydney West AHS</td>
<td>In conjunction with Sydney West AHS, Uniting Care Mental Health runs a peer support group of children between the ages of 8–12 yrs old with a parent who has been diagnosed with a mental illness. The monthly group provides age appropriate psycho-education about mental illness via the use of different abilities and games and aims to help the children identify and utilise their strengths and abilities, in order to build resilience and coping skills. The group provides children an opportunity to build their social networks via extra-curricular activities, enables them to share information and strategies with each other and holds day outings during school holidays.</td>
</tr>
<tr>
<td>Uniting Care Mental Health</td>
<td>ACE Program Sydney West AHS</td>
<td>The Adolescent Carer Education Program is a 2-day program for young people aged 13–17 who have a parent, family member or friend with a mental illness. The training provides information about mental illness, strategies for managing stress and solving problems and the opportunity for children to identify personal strengths and how they help in coping.</td>
</tr>
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SECTION 4
Supplementary Examples for Strategic Directions

4.1 Strategic Direction One

The Family-based Approach to the Prevention of Depressive Symptoms in Children at Risk (Beardslee et al., 2003), is a preventive intervention designed to provide information about mood disorders to parents, to equip parents with the skills needed to communicate with their children, and to open dialogue with children about the effects of parental depression. Two manual-based intervention programs were trialled with families assigned randomly to either a lecture or clinician-facilitated intervention. Results show significant benefits from both, with the clinician-facilitated program more beneficial. Communication within the family was enhanced; children reported increased understanding of their parent due to the intervention, and decreased internalising symptomatology over time.

In Victoria, the VicChamps Project was implemented in both a metropolitan and rural area between 2003-2006 as a mental health promotion project focusing on families with children aged 5–12 years, where parents had a mental illness (Maybery, Reupert & Goodyear, 2006). The project included peer support groups for 8–12 year olds, and concurrent parent and child groups for 5–7 year olds, as well as workforce development strategies. The wellbeing of children in the 8–12 year group (222) was assessed using the Strengths and Difficulties Questionnaire (SDQ) with wellbeing increasing as a result of their participation (reduced emotional difficulties, hyperactivity, and problems with peer relationships). The majority of children reported feeling more comfortable with asking questions about mental illness, and realised they were not alone in living with a parent with mental illness. Parents were very satisfied with the benefits to their children, reflecting the children’s responses that they had a comfortable environment in which to talk and learn more about mental illness. The workforce development comprised formal training which enhanced the capacity of mental health workers to routinely identify, engage with and refer children. The VicChamps project evaluation found that those who attended the training increased their level of support, education and referrals regarding children of parents with a mental illness, compared with those who did not attend the training.

The Parenting and Mental Illness Program (NSCCAHS) is based on Triple P level 4 group program with two additional sessions included following a pilot program and consultation with parents. Results for 19 parents participating in the six sessions showed the score for ‘intensity’ on the Eyberg Child Behaviour Inventory decreased at the end of the group program (13 responses); as did scores on the Parenting Scale (15 responses). All participants rated the program as ‘good’ to excellent’, with most stating the program met their child’s needs, their own needs, and gave them the type of help they wanted (Phelan et al., 2006).

4.2 Strategic Direction Two

The Psychiatric Inpatient Unit in the Department of Psychological Medicine at Royal Hobart Hospital has a Family Room. The room is furnished comfortably, has a TV, toys, play mat and other items that make it a non-threatening environment where children can visit their parents away from other patients. The family room also contains space to bath a baby, or the privacy required to breastfeed (Personal Communication.)

Family Friendly Mental Health Service initiatives include the establishment of family rooms in some inpatient units in NSW.
SECTION 5

References

5.1 NSW Legislation, Policies and Procedures


NSW Health Department (2001). Getting in Early: A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW.


NSW Health Department (2007). NSW Aboriginal Mental Health and Wellbeing Policy.


NSW Health Department (2009). NSW Health/Families NSW Supporting Families Early Package: Maternal and child health primary health care policy; SAFE START Strategic Policy; SAFE START Guidelines: Improving mental health outcomes for parents and infants.


5.2 Australian Government Policies and Procedures


5.3 General References


Corrections: Staff and Clients Conference convened by the Australian Institute of Criminology in conjunction with the Department for Correctional Services S.A. Adelaide: 31 October – 1 November 2000.


Murray, D., Cooper, P.J., & Hipwell, A. (2003). Mental health of parents caring for infants. Archives of Women’s Health, 6 (Suppl. 2), s71-s77.


## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
</tr>
<tr>
<td>ACE Program</td>
<td>Adolescent Carer Education Program</td>
</tr>
<tr>
<td>ADHC</td>
<td>Ageing, Disability and Home Care (previously known as DADHC)</td>
</tr>
<tr>
<td>AHS</td>
<td>Area Health Service</td>
</tr>
<tr>
<td>AICAFMHA</td>
<td>Australian Infant, Child, Adolescent and Family Mental Health Association</td>
</tr>
<tr>
<td>AMHS</td>
<td>Adult Mental Health Services</td>
</tr>
<tr>
<td>AOD Services</td>
<td>Alcohol and Other Drug Services</td>
</tr>
<tr>
<td>ARAFMI NSW</td>
<td>Association for Relatives and Friends of the Mentally Ill New South Wales</td>
</tr>
<tr>
<td>CALD communities</td>
<td>Culturally and Linguistically Diverse Communities</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
</tr>
<tr>
<td>CBNSW</td>
<td>Crossing Bridges New South Wales</td>
</tr>
<tr>
<td>COPMI</td>
<td>Children of Parents with a Mental Illness</td>
</tr>
<tr>
<td>CS</td>
<td>Community Services (previously known as Department of Community Services)</td>
</tr>
<tr>
<td>DET</td>
<td>Department of Education and Training</td>
</tr>
<tr>
<td>FFA</td>
<td>Family Focussed Assessment</td>
</tr>
<tr>
<td>FSAHS</td>
<td>Family Support Area Health Service</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing, Community Services and Indigenous Affairs</td>
</tr>
<tr>
<td>GSAHS</td>
<td>Greater Southern Area Health Service</td>
</tr>
<tr>
<td>HASI</td>
<td>Housing and Accommodation and Support Initiative</td>
</tr>
<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MH-OAT</td>
<td>Mental Health Outcome and Assessment Tools</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>NSCCAHS</td>
<td>Northern Sydney Central Coast Area Health Service</td>
</tr>
<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
</tr>
<tr>
<td>OOHC</td>
<td>Out of Home Care</td>
</tr>
<tr>
<td>PATS</td>
<td>Paying Attention To Self</td>
</tr>
<tr>
<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
</tr>
<tr>
<td>SFE Package</td>
<td>Supporting Families Early Package</td>
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<tr>
<td>SOG</td>
<td>Senior Officers Group</td>
</tr>
<tr>
<td>Triple P</td>
<td>Positive Parenting Program</td>
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