Editorial Perspective: Prato Research Collaborative for change in parent and child mental health – principles and recommendations for working with children and parents living with parental mental illness

Andrea Reupert,[1] Penny Bee,[2] Clemens Hosman,[3,4] Karin van Doesum,[3,5] Louisa M. Drost,[6] Adrian Falkov,[7] Kim Foster,[8,9] Lina Gatsou,[10,11] Brenda Gladstone,[12] Melinda Goodyear,[13,14] Anne Grant,[15] Christine Grove,[1] Sophie Isobel,[16] Nick Kowalenko,[14,17] Camilla Lauritzen,[18] Darryl Maybery,[13] Elaine Mordoch,[19] Joanne Nicholson,[20] Charlotte Reedtz,[18] Tytti Solantaus,[21] Kristin Stavnes,[22,23] Bente M. Weimand,[15,24,25] Scott Yates,[26] and Torleif Ruud[22,25]

[1]School of Educational Psychology and Counselling, Faculty of Education, Monash University, Clayton, Vic., Australia; [2]Division of Nursing, Midwifery & Social Work, University of Manchester, Manchester, UK; [3]Department Clinical Psychology, Radboud University, Nijmegen, The Netherlands; [4]Department of Health Promotion, Maastricht University, Maastricht, The Netherlands; [5]UiT The Artic University of Norway, Tromso, Norway; [6]Rob Giel Research Center, University Medical Center Groningen, Groningen, The Netherlands; [7]Child & Youth MH Service, Royal North Shore Hospital, Sydney, NSW, Australia; [8]School of Nursing, Midwifery & Paramedicine, Australian Catholic University, Melbourne, Vic., Australia; [9]NorthWestern Mental Health, Melbourne Health, Melbourne, Vic., Australia; [10]Child and Adolescent Mental Health Services, Leicestershire Partnership NHS Trust, Leicester, UK; [11]The Faculty of Health and Life Sciences, De Montford University, Leicester, UK; [12]Social & Behavioural Health Sciences Division, Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada; [13]School of Rural Health, Monash University, Warragul, Vic., Australia; [14]Emerging Minds, Hilton, SA, Australia; [15]School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK; [16]Faculty of Medicine and Health, University of Sydney, Camperdown, NSW, Australia; [17]Sydney Children's Hospital Dr Network, Department of Psychological Medicine Children's Hospital, University of Sydney, Westmead, NSW, Australia; [18]Regional Center for Child and Youth Mental Health and Welfare, Faculty of Health Sciences, UiT – Arctic University of Norway, Tromso, Norway; [19]College of Nursing, Rady Faculty of Health Sciences, University of Manitoba, Winnipeg, MB, Canada; [20]Heller School for Social Policy and Management, Institute for Behavioral Health, Schneider Institutes for Health Policy, Brandeis University, Waltham, MA, USA; [21]Mental Health Unit, Finnish Institute for Health and Welfare, Helsinki, Finland; [22]Institute of Clinical Medicine, University of Oslo, Oslo, Norway; [23]Nordland Hospital Trust, Bodø, Norway; [24]Department of Health, Social and Welfare Studies, University of South-Eastern Norway, Drammen, Norway; [25]Mental Health Services, Akershus University Hospital, Lørenskog, Norway; [26]School of Applied Social Sciences, De Montfort University, Leicester, UK

The problem

Twenty three percent of children have at least one parent who has experienced mental illness (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). Additionally, 36% of children attending child mental health services have a parent with a mental illness (Campbell et al., 2020) with another study finding that 36% of clients attending adult services have children under 18 (Ruud et al., 2019). Compared to other children, those whose parents have a mental illness are between two to 13 times more likely to develop a mental illness themselves (Dean et al., 2010), to be less school ready, to present with higher rates of physical injury, more likely to be taken into care, and to develop health conditions such as asthma (Reupert, Maybery,

Nicholson, Gopfert, & Seeman, 2015). Although children's outcomes vary, evidence of this risk has been found across the illness spectrum, including schizophrenia, affective, eating and other psychotic disorders (Reupert et al., 2015). While genetics play an important role in the transmission of mental disorders from parents to children, environmental and socio-economic factors are also critical, including parenting competence, the severity and chronicity of the parents' illness, the quality and quantity of support available to the family and other stressors that are more prevalent in these families (e.g. poverty, housing insecurity) (Reupert et al., 2015).

The need for a child and family focussed approach

When a person experiences mental ill-health, everyone in the family is affected. In turn, family members play a vital role in a person's illness experience. Family focussed practice can "...*improve outcomes for the parent with mental illness, reduce the*

subjective and objective burden of care for families, and provide a preventive and supportive function for children (Foster et al., 2016 p. 7). Targeting relationships, particularly the parent-child relationship, provides an important opportunity to improve outcomes for children and the mental health of parents. Family focussed practice exists on a continuum; the most basic practice involves recognising parental status and ensuring children are safe, through to psycho-education and the delivery of various child/parent/family interventions (Foster et al., 2016).

A child focussed approach is different from a family focussed approach. A child focussed approach means acknowledging each child's unique experiences and providing children with opportunities to participate in decisions that directly impact them. Though some consider a family focussed approach to be inclusive of children, (Foster et al., 2016), we differentiate a family from a child focussed approach, to ensure that children's rights are guaranteed, as per the UN Convention of the Rights of the Child (1989). Family and child focussed approaches can be complementary and synergic, as each addresses individual and shared aspects of family life (Fauber & Kendall, 1992).

Available child, parent and family supports

There are various manualised interventions which target the child, the parent, and/or family. The format (e.g. individual, group-based, face-to-face or online) and content (e.g. psychoeducational, behavioural or psychotherapeutic) of these varies and is determined by the family's needs, children's ages, practitioners' skills, service orientation and intervention availability.

Peer support and psychoeducation programs have been developed for children, including online interventions, though the evidence base for these is still emerging (Bee et al., 2014). Most interventions focus on the parent with a mental health issue, and aim to promote parents' capacity to support their children within the context of their illness. Such interventions have proven to be effective, with a meta-analysis showing reduction to the risk of a child developing the same mental illness as their parent by up to 40% (Siegenthaler, Munder, & Egger, 2012). A limited number of interventions target both parents and children. Data suggest that family centred, strength-based approaches, which aim to promote family discussions about the parent's illness, hold promise for improving parent-child relationships, though more rigorous evaluation is required (Bee et al., 2014). Another approach is for practitioners to initiate informal conversations with a client about their parenting and children (Foster, Goodyear, Grant, Weimand, & Nicholson, 2019) to highlight children's needs and prompt referrals.

Adult mental health services primarily focus on treating the parent's illness and often do not consider children's needs unless children present with their own health difficulties, or where abuse or neglect is identified. Barriers to family focussed practice include a lack of intra- and interagency collaboration, reimbursement schedules that are limited to the presenting client, no/little time for working with clients' children (or the parent/carer's mental health), and deficits in practitioners' training, confidence and skill (Grant, Reupert, Maybery, & Goodyear, 2019). Nonetheless, child and adolescent as well as adult service settings offer a prime opportunity to prevent intergenerational mental illness and provide early intervention with children and their families.

Principles for working with children and parents

The following principles serve to guide the implementation of policy development, organisational change and practice in child and adolescent, adult and other services:

- There is a bi-directional relationship between parent's and children's mental health. Both need to be addressed.
- Children's mental, emotional and social needs require support as early as possible to prevent future negative outcomes.
- Parents play a critical role in children's development and need to be supported in this role.
- A collaborative, strengths-based response to the unique and cultural needs of all family configurations is required.
- Children and other significant family members need to be considered in ongoing conversations and decision-making opportunities with services, to identify and address their needs.
- All health services (e.g. perinatal, child and adolescent, adult mental health, primary health), community-based agencies (including schools, sporting organisations) and other services (e.g. family support, housing, child protection) have a role in addressing the needs of these children and parents.

Such principles can be operationalised into recommendations for practice, and workforce and systems change.

Recommendations for practice

1. In child and adolescent orientated services:

- sensitively inquire whether parents of clients have mental health concerns.
- ascertain the impact of the parent's illness on the child.

- engage with parents to identify, and respond to, their needs and/or initiate and coordinate agency referrals for them.

2. In adult orientated services:

    - at intake, identify parenting status including pregnancy.
    - engage with clients in their parenting role and responsibilities.
    - engage with clients' children to identify, and respond to, their needs and/or initiate and coordinate agency referrals for children.

3. Across child and adolescent and adult oriented services:

    - assess family strengths and needs, including the quality and quantity of family supports, parenting strengths and vulnerabilities.
    - provide age appropriate information about the parent's mental illness to children, parents and other family members.
    - consult with children and other family members on plans for parent's possible hospitalisation. (e.g. where children might stay, and how children might keep in touch with their parent).
    - follow up and monitor child and other family member needs, especially at developmental milestones e.g., the perinatal period or school transitions.

Recommendations for workforce/service change

1. *Intake procedures* in child services need a sensitive way of identifying the mental health of the parent/s. Likewise, in adult services, intake needs to include parenting status (including pregnancy) and the number, age and residence of dependent children.
2. *Education and training programs* are provided on child and family focussed practice to practitioners across health, welfare, child safety and other organisations.
3. *Clear procedures including referral processes* are developed for working with clients on their parenting and for their children. Practitioners need to consider what information is released, with whose permission, to whom and how services might work together.
4. *Facilities are family friendly* including waiting areas and psychiatric units (e.g. a child friendly visiting room). Psychiatric units should have processes that allow parents and children to maintain contact.
5. *Leadership and management teams* are supportive of a child and family focussed approach and provide the necessary time and resources for practitioners to work in this way.

6. *Position descriptions* include an expectation that practitioners (at least some in each setting) work in a family focussed manner. Likewise, there are practitioners who ensure children's perceptions are considered.
7. *Confidentiality arrangements* are clear and communicated to all practitioners, clients and family members about what can and cannot be discussed. Sensitive discussions are held with clients, when well, about what information is released to which family members.
8. *Practice standards, processes, guidelines and time* are provided for practitioners to engage in cross-agency and cross-sector communication and collaboration.

Recommendations for systems change

1. *Specific policies* are developed in regard to working with children and parents (including cross sector/agency collaboration) alongside *legislature* that clearly outlines identification and response procedures for children and parents living with parental mental illness.
2. *Collaborative models* are established and supported between services, including information sharing and referral pathways.
3. *Education and training* programs are offered, which incorporate child and family practices and/or interventions across nursing, psychology, medicine, social work, psychiatry and occupational therapy programs in the workforce and at university.
4. *Accessible services and interventions* that offer psychoeducation and appropriate support are provided for children and families.
5. *Benchmarking and auditing* are routinely conducted across child and youth, and adult mental health sectors, to ensure that parenting status is identified, and that children and parents are provided with appropriate support to improve outcomes.

Conclusion

Given the evidence to date, it is critical that appropriate prevention and early intervention initiatives are provided to children and parents living with parental mental illness. Current practice paradigms are based on individualistic models of practice, particularly in mental health services. This must change. This article provides clear direction as to the changes that are needed.

Acknowledgements

Correspondence

Andrea Reupert, School of Educational Psychology and Counselling, Faculty of Education, Monash University, Clayton, Vic., Australia; Email: andrea.reupert@monash.edu

---

Key points

- Due to a range of factors, children whose parent/s have a mental illness are at risk for their own mental health problems.
- Although there are evidence-based interventions available for these children and families, these have largely not been picked up by services.
- In addition to supporting individual clients, services need to consider the whole family.

References

Bee, P., Bower, P., Byford, S., Churchill, R., Calam, R., Stallard, S., … & Abel, K. (2014). The clinical-effectiveness, cost-effectiveness and acceptability of community-based interventions aimed at improving or maintaining quality of life in children of parents with severe mental illness: A systematic review. *Health Technology Assessment*, *18*, 1–250.

Campbell, T., Reupert, A., Sutton, K., Basud, S., Davidson, G., Middeldorp, C., … & Maybery, D. (2020). Prevalence of mental illness among parents of children receiving treatment within child and adolescent mental health services (CAMHS): A scoping review. *European Child & Adolescent Psychiatry*, *30*, 997–1012.

Dean, K., Stevens, H., Mortensen, B., Murray, R.M., Walsh, E., & Pedersen, C.B. (2010). Full spectrum of psychiatric outcomes among offspring with parental history of mental disorder. *Archives of General Psychiatry*, *67*, 822–829.

Fauber, R.L., & Kendall, P.C. (1992). Children and families: Integrating the focus of interventions. *Journal of Psychotherapy Integration*, *2*, 107–123.

Foster, K., Goodyear, M., Grant, A., Weimand, B., & Nicholson, J. (2019). Family-focused practice with EASE: A practice framework for strengthening recovery when mental health consumers are parents. *International Journal of Mental Health Nursing*, *28*, 351–360.

Foster, K., Maybery, D., Reupert, A., Gladstone, B., Grant, A., Ruud, T., … & Kowalenko, N. (2016). Family-focused practice in mental health care: an integrative review. *Child & Youth Services*, *37*, 129–155.

Grant, A., Reupert, A., Maybery, D., & Goodyear, M. (2019). Predictors and enablers of mental health nurses' family-focused practice. *International Journal of Mental Health Nursing*, *28*, 140–151.

Maybery, D., Reupert, A., Patrick, K., Goodyear, M., & Crase, L. (2009). Prevalence of children whose parents have a mental illness. *Psychiatric Bulletin*, *33*, 22–26.

Reupert, A., Maybery, D., Nicholson, J., Gopfert, M., & Seeman, M. (Eds.) (2015). *Parental psychiatric disorder: Distressed parents and their families*. Cambridge: Cambridge University Press.

Ruud, T., Maybery, D., Reupert, A., Weimand, B., Foster, K., Grant, A., … & Ose, S. (2019). Adult mental health outpatients who have minor children: Prevalence of parents, referrals of their children and patient characteristics. *Frontiers in Psychiatry*, *10*, 163.

Siegenthaler, E., Munder, T., & Egger, M. (2012). Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systemic review and meta-analysis. *Journey of the American Academy of Child & Adolescent Psychiatry*, *51*, 8–17.