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Abstract

A multi-perspective account of the issues and subsequent interventions for families affected by parental mental illness is reviewed in this article, including those involving the children, the parent with the mental illness, other family members, agencies and society in general. An overview of various issues and interventions for families affected by parental mental illness is seen as potentially useful for practitioners and program developers as well as providing a resource bank for systematic evaluation, research and policy.

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Families affected by parental mental illness are among the most vulnerable in our community. Such families are more likely to experience social isolation, financial hardship and marital discord, with increased risks for children, genetically, psychologically and environmentally (Beardslee, Versage & Gladstone, 1998). Mental illness often refers to is a wide range of psychiatric symptoms that persist over time and are functionally disabling in living skills, social interactions, family relationships, jobs and/or education (Johnson, 1997), and in this article, encompasses conditions such as schizophrenia, major depression and anxiety, and bipolar disorder.

Over the last decade, an increased awareness of the needs of families affected by parental mental illness has resulted in the development of various interventions and programs (Cowling, 2004). Such strategies are most often directed to meeting the unmet needs of the child (e.g. averting risk, developing resilience) or the parent with the mental illness (e.g. their mental health concerns, parenting responsibilities) rather than incorporate the needs of the family as a whole. Additionally, to the best of our knowledge, no standards or guidelines for the types of programs best suited to such families has been presented.

One, partial step towards evidence based practice is to identify the range of issues and subsequent possible interventions for such families, currently available in the literature. Towards this end, a review of the literature for each of the stakeholders is presented. While various interventions are highlighted, we make no claims for best practice. Instead the aim of this paper is, first, to highlight the issues generally associated with families affected by parental mental illness and second, to present examples of interventions currently offered. The model which informs this overview is based on a clinician's perspective, as it focuses primarily on the issues for parents and children. At the same time however, the importance of the broader social context in which parenting takes place is also acknowledged in the final part of this paper.

An overview of the issues and subsequent interventions for families affected by parental mental illness may provide a start to developing a resource bank from which evidence based practices might be systematically drawn and evaluated. In addition, a summary that encapsulates all members of the family as well as emphasizing an integrated, organisational approach underscores the need for holistic practices when

working with such families, rather than focusing on only the child/ren or the mentally ill parent. Consequently, the issues and interventions for the various key stakeholders is presented including; the children, the parent with the mental illness, the remaining family (e.g. other parent, siblings, extended family), the family as a whole, the various agencies that work with such families as well as society as a whole. Table 1 briefly summarises these issues and interventions, as outlined in detail below.

The child

While all children require nurturance and physical care, the child of a parent with a mental illness will experience a home environment different from many other children. Falkov (2004, p.55) summarises this environment when he writes that ‘children whose parents are mentally ill live with the symptoms, behaviours and expressions of mental illness. They see it and feel it...’. The environment of children with a mentally ill parent might at times, be chaotic and threatening, particularly if the child is included in the parental delusional behaviour (Jacobsen & Miller, 1998), though depressed parents might be physically but not emotionally available to their children (Oyserman, Mowbray, Allen-Meares & Firminger, 2000). It has been estimated that there are between 21 to 23 percent of children living in households where at least one parent has a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2005).

Parental mental health places children at a significantly greater risk of having lower social, psychological and physical health than children in families not affected by mental illness. Current research consistently shows a higher rate of behavioural, developmental and emotional problems in such children compared with those in the general community (Beardslee, Versage & Gladstone, 1998; Brotman Band & Weisz, 1988; Cicchetti, Rogosch & Toth, 1998; Klimes-Dougan et al., 1999; Oyserman, et al., 2000), with long term effects including social and occupational dysfunction (Shiner & Marmorstein, 1998). In addition, several studies report increased rates of psychiatric disorders in children from homes with affectively ill parents, compared to children with non ill parents, on both genetic and environmental grounds (Beardslee, Keller, & Seifer, 1996; Hammen, 1991; Weissman et al., 1997).

An important issue often discussed in association with parental mental illness is of the attachment bond between parent and child. Attachment theory is based on the premise that an infant's first attachment experience (usually his or her mother) profoundly shapes the child's cognitive and emotional development (Bowlby, 1969; 1988) as well as present and future relationships (Karen, 1998). A parent, who responds sensitively and consistently to a child's needs, sends messages that build a sense of security and self identity (Howes, 1999). Sometimes, however, because of a parent's mental illness (or for other reasons, such as addiction), instead of sensitive, responsive nurturing, an infant may face inconsistency and/or neglect. Such parental cues often lead to various attachment problems in adult relationships (Karen, 1998; Mickelson, Kessler & Shaver, 1997).

Closely related to the concept of attachment is the broader term, 'connectedness', which according to Lee, Draper and Lee (2001) encompasses an individual's various caring and supportive relationships. Masten and colleagues (1988) found that social and emotional connections with others were a significant moderator on the effects of a variety of disadvantages, including parental mental illness. For instance, Rutter (1979) showed that a positive relationship with at least one parent, especially during infancy and early childhood, is a protective factor for children's psychological health. Howes (1999) argues that children have the potential to form many different kinds of relationships, while Harrison (2003) emphasizes the role of child care workers and teachers in a child's social network. As well, siblings within families which experience disadvantage also have the potential to provide support to each other (Widmer & Weiss, 2000). In a series of interviews with young people, Fudge and Mason (2004) found that positive peer relations and having someone to talk to on a regular basis was an important coping mechanism. Overall, such research indicates that if or when the primary adult is not able to appropriately support the child, meaningful social and emotional connections, from within and outside of the family, might be effectively made elsewhere.

In addition to social and emotional support, practical assistance is also important. The most difficult time for children appears to be when the parent is hospitalised or

experiencing an acute phase of their illness (Fudge & Mason, 2004). Maybery, Ling and Szakacs (2002) found that during a parent's hospitalization, the level of risk for children is heightened where there is no other parent or relative to look after the children, particularly in single parent families (where the mentally ill parent is the sole parent). In such times, young people report problems accessing transport to go to visit a parent in hospital, limited finances, the separation from their siblings (e.g. whilst in foster care) and the often-unfriendly nature of the hospital environment (Maybery, Ling & Szakacs, 2002).

Assuming the domestic and emotional responsibilities for their mentally ill parent and/or younger siblings is another issue for young people, particularly in single parent families (Aldridge & Becker, 2003). Care-giving has been associated with limiting young people's recreation, friendships, educational achievement and personal growth (Atkin, 1992). More recently, there is a growing recognition that some degree of caring in childhood is normal and encouraged as a part of 'healthy' child development, that the experience of caring can be positive (for instance in developing closer family ties and encouraging independence) and that the division between caring and being cared for is not always clear, given the reciprocity of support and guidance that occurs between many children and their ill parent (Aldridge & Becker, 1999; Morris, 1993). Nonetheless, because respite care has generally been underdeveloped for people with mental health issues (Atkin, 1992) care-giving can become onerous. Additionally, while young carers may take on substantial care responsibilities within their families, they are rarely consulted by professionals about their parent's needs and their own needs as children and carers (Aldridge & Becker, 2003).

Other problems identified in children whose parents have a mental illness are maladaptive coping strategies. Maybery and colleagues (2002) found that many children adapted problematic coping styles when their parent was ill, such as withdrawing, avoiding and distancing. Folkman (et al., 1991) found that the long term overuse of emotion focused activities (such as those illustrated above) can be problematic and consequently highlighted the need to develop problem focused activities that aim to change the environment or oneself in relation to it.

Delvin and O'Brien (1999) found that children tend to form misconceptions about their parent's mental illness, and recommended ongoing, age appropriate information. Falkov (2004) suggests that younger children might simply need to learn what a mental illness is and what to do when mummy is unwell while Hay (2004) points out that it might be important to present to adolescents the prodromal signs and degree of 'inheritability' of the mental illness. Falkov (2004) suggests that it is important for children to express themselves and their fears about parental mental illness as part of an ongoing process, rather than a one off event. Many children reported wanting to hear this information from their parents themselves (Fudge & Mason, 2004), though Falkov (2004) points out that it is everyone's responsibility including mental health practitioners to talk about a parent's mental illness.

Based on the issues raised above, there appears to be a number of important intervention strategies when working with children whose parent has a mental illness. In the first instance, children whose parents have a mental illness need, like all children, appropriate physical and emotional care. More specifically, as attachment bonds might be problematic with the mentally ill parent, children require the opportunity to develop and enhance meaningful social and emotional connections, from within and outside of the family. Practical support is important, particularly in times of high need (such as a parent being hospitalised), and include allowing the children to have regular access to the parent in hospital and having a family member (i.e. other parent, aunty) or trusted friend living in the family home for the duration of hospitalization. Some children also need to learn and practice effective, problem focused coping strategies. Respite from onerous care-giving is also required. Children whose parents have a mental illness need to be provided with age appropriate information and education about their genetic disposition to mental illness, mental illness generally and their parent's mental illness in particular (Falkov, 2004).

The parent with a mental illness

Nicholson and colleagues (2001) point out that the needs of parents affected by mental illness are generic to all parents, as well as specific to their illness. The main

issues for mentally ill parents centre on their capacity and motivation for managing their mental illness and at the same time assuming parenting responsibilities. Risley-Curtiss et al. (2004) found that with appropriate diagnosis, support, treatment and medication, most people with a serious mental illness experience widespread improvement in many areas including parenting behaviours. However, they also found that many people have difficulty adhering to treatment, the most common reasons being the sometimes 'trial and error' approach of many drug treatments and the often debilitating effect of many psychotic drugs (such as lethargy and blunting).

Parents with a mental illness require support and sometimes guidance in their parenting behaviours. While it is important to note that the effects of the mental illness are compounded by others factors such as poverty and social isolation, Oyserman (et al., 2000) found that mothers with a serious mental illness have significantly less adequate parenting skills than mothers who do not have a mental illness. For instance, depressed mothers are less likely to be emotionally available and affectionate (Hammen, 1991) and parents with schizophrenia may have unusual or inappropriate affective responses to their child/ren (Jacobsen, Miller & Kirkwood, 1997). However, Rogosch, Mowbray and Bogat (1992) found that not all parents with mental illness evidence the same degree of parenting difficulty, as those with more severe and chronic disturbance were associated with less sensitive and competence parenting behaviours than parents with less debilitating disturbances. Similarly, Mowbray and colleagues (2002) established that a specific mental illness diagnosis is neither an independent nor useful predictor for parenting problems or strengths. Instead, Mowbray (et al., 2002) showed that current symptomatology and community networking was more indicative of parenting capacity and consequently stressed the need for quality treatment for clients with a mental illness and the enhancement of existing community supports.

While there are many parenting programs in the community, Ackerson (2003a) argues that these typically fail to address the specific needs of parents with a mental illness. Thomas and Kalucy (2002; 2003) showed that problems with motivation and stigma may impede parents' attendance or, if attendance occurs, the program often does not address a parent's specific needs. Underscoring the importance of providing specific

parenting training, Ackerson (2003a) found that most mothers saw themselves as lax or permissive, rather than harsh or punitive. Similarly, Nicholson, Sweeney and Geller (1998a) showed that many parents worry about the impact of their illness on their children and often prioritise their child's needs ahead of their own. Even though some clients might exhibit problematic parenting behaviours, many are open to interventions that enhance their parenting capacity and sense of maternal self competence (Oyserman et al., 2000). Generally, mothers are more likely to be effective when given the opportunity to take on responsibilities (Goepfer, et al., 1996) and many consider parenting to be just as important as employment (Mowbray, Oyserman & Ross, 1995) and a valued role in their lives (Nicholson et al., 1998a).

While the cyclical nature of mental illness might mean a temporary inability to care for their children, parenting behaviours need not necessarily be the focus of intervention. Ackerson (2003a; 2003b) observed that the literature on mentally ill parents focuses on a parent's pathology and not on the strengths parents bring to manage their illness and to care for children, nor their potential parenting capability if their mental illness was properly managed. While a serious mental illness can adversely affect an individual's ability to parent, with adequate resources many individuals with a serious mental illness are able to successfully care for their children. Mullick, Miller and Jacobsen (2001, p.489) suggest, 'Parents within any given diagnostic category can have parenting skills ranging from excellent to maltreating'. Rather than dysfunctional parenting behaviours, Ackerson (2003a) found that many parents with a mental illness regarded the bond between themselves and their children as especially strong and close. While cautioning issues regarding enmeshment, Ackerson (2003a) asserts that many parents with a mental illness had close, mutually interdependent relationships with their children.

Rather than considering parenting as a hindrance, Ackerson's (2003b) found that mentally ill parents are more highly motivated to continue rehabilitation programs compared to clients who are not parents. White et al. (1995) suggest that the demands and rewards of the caretaking role enhance a mother's motivation to remain in treatment. Similarly, Caton, Cournos and Dominguetz (1999) found that mothers with schizophrenia were more likely to have had better premorbid social adjustment

than schizophrenic women who were not mothers. In addition, Wang and Goldschmidt (1996) found that psychiatric patients wanted family focused interventions rather than focusing solely on themselves as the identified patient. Thus, rather than being a hindrance, assuming parenting responsibilities might significantly assist in the rehabilitation and treatment for the parent with the mental illness, highlighting the importance in incorporating a parent's caretaker responsibilities into his or her treatment plan.

Emotional and social supports are particularly important for parents with a mental illness. Cochran and Brasard (1979, as cited in Rogosch, Mowbray & Bogat, 1992) described how social support networks provide various types of assistance for all parents, such as role modelling, providing emotional support, companionship and practical assistance. Accordingly, Rogosch and colleagues (1992) demonstrated that the presence and strength of mentally ill mothers' current supportive relationships predicted adaptive parenting attitudes. Ackerson (2003a) found that those parents with a strong social support network, such as family, friends or church, coped better with crises than those who were socially isolated. Such support was especially critical when alternative care was needed, such as when the parent was hospitalized or very unwell (Ackerson, 2003a). In comparison, parents who did not have such support were more likely to have lost custody of their children (Ackerson, 2003a). However, as parents with a mental illness are more likely to be living without partners (White, Nicholson, Fisher, & Geller, 1995) and marital discord is more common among families in which a parent has a mental illness (Downey & Coyne, 1990), the need for parents to find support from his or her extended family and the wider community is further emphasized.

The family

As well as the mentally ill parent and his or her children, other family members also need to be acknowledged. Nicholson, Sweeney and Geller (1998b) found that caregiver responsibilities often fall on mentally ill parents' spouses or partners (if present) and/or extended family members, particularly children's grandparents and older children. However, they also found that while the partner and other relatives

might be useful to the mentally ill parent (for example, by assisting in household tasks and child care) they may also become a source of stress, by taking over a parent's responsibilities without consulting the parent (Nicholson, Sweeney & Geller, 1998b). Additionally, Merikanages, Prusoff and Weissman (1988) showed depression in one parent is frequently associated with depression and other psychopathology in the other parent. Such literature mirrors other caretaker research (e.g. Nankervis, Bloch, Murphy, & Herrman, 1997) that highlights the stress of family care giving, the psychological and physical needs of carers and the subsequent importance of respite and caregiver education in how to best support themselves and the mentally ill parent.

Among families with depression or schizophrenia, Warner, Mufson and Weissman, (1995) showed lower family cohesion and poorer communication as more prevalent than in families without a diagnosable disorder. Similarly, Dickstein (et al., 1998) found that family unit functioning, based on domains such as task accomplishment, communication, roles, affect management, interpersonal involvement and behaviour control, was less healthy in families with maternal mental illness compared with families with no maternal mental illness. Such research suggests that the family unit has specific needs over and above individual parent-child or spousal relationships. When working with at risk families, Marvin and Stewart (1990) argue that rather than focus on the parent-child dyad, the interaction style of the family unit needs to be focus of intervention. Marvin and Stewart (1990, citing Bowlby, 1969) argue that within each family there exists a variety of relationship networks or subgroups (such as the child-mother, child-father, mother-father and mother-child-father, between children, and amongst the extended family) as well as an overarching 'working model', or shared expectations and plans regarding attachment and care-giving behaviour. The idea of an overarching 'working model' means that the family as a whole system needs to be the focus on intervention, for families experiencing problems in attachment. Focusing also on the broader family dynamic, Hammen (1991) found that the parenting patterns established by depressed mothers might be learnt by their children, who in turn, parent in much the same way, thereby maintaining negative interactional patterns across generations.

However, while much attachment theory appears to encourage a holistic approach to intervention, most attachment programs focus on selective subgroups within the family unit. Robinson (2002) argued that most attachment programs tend to focus on the parent's and/or infants interactive behaviours and on their representation of the child-parent relationship rather than the interaction patterns between the various familial networks and the broader, everyday functioning of the family unit. Several studies have shown that while many attachment interventions do enhance maternal sensitivity, they are not always successful at changing the child or infant's attachment organisation or classification (Egeland & Erickson, 1993; van Ijzendoorn, Juffer, & Duyvesteyn, 1995). This means that while most attachment programs are effective in enhancing a parent's ability to interpret children's cues, they tend to be less effective at changing the quality of the child's attachment pattern. This might be due, in part, to Dickstein (et al., 1998) suggestion that families affected by parental illness face increased rigidity within and among family subsystems, in spite of reasonably healthy other sub-systems such as might exist between a parent and a child. Family therapy might be an alternative intervention for this target group (Williams, 2004) while the Circle of Security project (Marvin, et al., 2002) focuses on attachment issues between family members through the generations with promising results.

Another promising intervention has been developed by Beardslee and colleagues, for families and their children aged 8 to 15 years, in which at least one parent had experienced a recent episode of affective disorder (Beardslee, et al., 1997a; Beardslee, et al., 1997b; Beardslee, Gladstone, Wright & Cooper, 2003). Using two different approaches (either lecture or clinician-facilitated intervention) but with similar content, the programs were designed to provide information about mood disorders to parents, to enhance parents' skill in communicating information to their children and to open dialogue within families about the effects of parental depression. At 2 ½ years after enrolment children reported greater understanding of parental affective disorder and better adaptive functioning. Parents report increased marital support and improved knowledge and communication about mental illness, indicating strong overall support for this family based approach.

Another issue for families affected by parental mental illness is that they are more likely to experience crises, such as the hospitalisation of a parent, or acute mental illness episode. The exposure to any critical incident has the potential to generate anxiety, stress and hurt to the individuals involved and while the strain is particularly felt in the time just after the incident occurs, it may endure for a lengthy period (Wilson & Raphael, 1993). As prior planning is the key to optimum management of a critical incident in any setting (Kirkland & Maybery, 2001) it is important for all members of a family to plan for future episodes of hospitalisation or periods of illness. An example of one such approach is the 'Supporting Our Family' Kit developed by COMIC, and available from <http://www.howstat.com/comic/>. This crisis plan invites family members to nominate a contact person if a parent is ill or in hospital, who each child might stay with, who needs to be told if the child is staying somewhere else and so on.

Human service and mental health agencies

Many agencies, which work with families affected by parental mental illness, tend to have a singular and/or negative focus when defining their client base. In addition, many human and health agency workers do not have the training and knowledge to work effectively with such families. In a survey of programs across North America, Nicholson et al., (2001) found that many organisations are often fragmented and uncoordinated, so that they tend to focus only on the client (either the 'child' or 'adult'), and do not consider a client's environment (such as his or her school, or family base) and/or contextual demands (such as parenting responsibilities). Nicholson et al. (2001) points out that program eligibility requirements may limit participation to eligible adults or children but not both, as is generally needed for families affected by parental mental illness.

When reviewing adult and child services in Europe, Hetherington and Baistow (2001) stressed the importance of informal communication between agencies, though at the same time highlighted time and geographic difficulties in doing so. Fleck-Henderson (2000) uses the term 'seeing double' to describe how workers are being asked to simultaneously recognise and work with the needs of adult clients and of their

child/ren, though Cousins (2004) points out that this might not be possible for all workers, for both personal and professional reasons, particularly for child protection workers. Mowbray et al., (2000) found that while parents identified their mental health provider as a source of support, only 20% of parents listed their provider as someone who could provide assistance in being a mother, perhaps because of mothers' concerns about losing custody of their children.

Many government departments have consequently recommended that mental health agencies be encouraged to take a leadership role in developing community linkages (for example, in Australia, Commonwealth Department of Health and Aged Care, 2000). Accordingly, collaboration between and within organisations is vital, for example, if child protection workers are called for suspected cases of abuse, they may need to work closely with adult mental health workers in order to best work with the parent. Hetherington and Baistow (2001) suggest that adult mental health services need to, as part of their standard intake practice, record whether patients are parents, the ages of children and who is caring for them. The rationale for this assessment would be for adult mental health services to then offer assistance to parents in their responsibilities as primary caregivers (Hetherington & Baistow, 2001). Falkov's (1998) training resource, 'Crossing Bridges', is designed to encourage inter-agency collaboration across specialist areas, by covering information on adult mental health, parenting, the parent-child relationship and child development.

As well as organisational barriers, many human and health agency workers do not have the skills and knowledge to identify, refer and/or intervene appropriately with different family members. Bibou-Nakou (2004) found that while many teachers in Greece acknowledged that supporting children whose parents had a mental illness were a part of their responsibilities, they did not feel that they had adequate training and knowledge to do this. Similarly, although many of their clients are parents, Maybery and Reupert (2006) found that adult mental health workers lack the knowledge, skills and resources (including time) to work with their clients on parenting issues.

Ackerson (2003b) suggests that many human and health agency workers often take a problem and deficit focus approach when working with clients, and as Nicholson et al., (2001) notes, their services are often only available when parents or children have a diagnosable problem or after abuse or neglect has been identified. A preventative stance is not often assumed. Ackerson (2003a) suggests that rather than focus on parents' deficits, workers need to acknowledge the cyclical nature of mental illness, and an individual's parenting strengths. This might also lessen the stigma often associated with seeking treatment for many parents.

A broader focus

The discriminatory economic and social barriers that prevent the mentally ill from securing an acceptable quality of life also needs to be addressed. Having a mental disorder often leads to a 'snowball effect', as other problems follow, including unemployment, isolation and poverty. In teasing out impacting variables for at risk children, Rutter (1981) found that the direct effects of parental illness was less influential than the social adversity usually associated with mental illness. From this perspective, many of the problems experienced by families affected by parental mental illness are more the result of society and governments' failure to provide effective and enabling services, than the mental illness per se. Accordingly, maladaptive coping might instead be constructed as 'personal, individualised solution to structural social problems' (Lawrence, 1992, p.45). In this way, rather than only focus on the problems within families affected by parental mental illness, we need to also address the failure of governments and society to enable the mentally ill to have independence, freedom from discrimination and full family functioning.

The stigma associated with mental illness is a problem for many families. North Americans rated leprosy and mental illness as two of the worst things that can happen to anyone (National Institute of Mental Health, 1986). Despite the existence of effective treatments for many mental disorders, the fear of stigmatization and possible custody loss often deters individuals from seeking help and/or remaining in treatment (Nicholson, Sweeney & Geller, 1998). The association of mental illness with violence

and child abuse, in the media and the community has increased in recent years (see Fraser, 1994; Nicholson, Sweeney & Geller, 1998).

The way that mental illness is socially constructed needs to be changed, in order to encourage understanding, respect and inclusion for families in this situation. One way of doing this is through the collective political power of the mental health survivor; for example, the Pandora Foundation in the Netherlands involves service users to influence policy and to provide information, advice, support, education and press releases. Another approach comes from Byrne (2000), who presents a practical model of stigma management aimed at various target groups, through consultation and flexible public education programs that take place over time.

Summary and implications

Policy makers need to assume a preventative focus and address the societal and economic barriers that create the distress experienced by many families affected by parental mental illness. At the same time, practitioners and program developers need to consider not only on the child or the parent with the mental illness, but recognise that families affected by parental mental illness require multiple foci and interventions (see Table 1 for a summary of these issues and interventions). A multi-faceted approach is required that acknowledges all stakeholders, including the child, the parent, the family, agencies and society as a whole.

The aim of this article was to present the varied and interrelated issues for families affected by parental mental illness, rather than focusing on one part of family, such as the child or the mentally ill parent. An overview of the range of interventions, as outlined in Table 1, is seen as potentially useful for practitioners and program developers working with such families as well as providing a resource bank for systematic evaluation, research and policy. Additionally, Maybery, Ling, Szakacs and Reupert (2005) found that children whose parent has a mental illness have different opinions to 'what helps', compared to their parents and agency workers. Consequently, research needs to also take a multi perspective approach, and identify all key stakeholders' perspectives on needs, issues and effective interventions.

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Table 1: Issues and interventions for stakeholders affected by parental mental illness.

Target group	Issues	Intervention strategies
Child	Attachment problems leading to relationship issues in child and adulthood.	Provide children with ongoing opportunities to relate closely to consistent, healthy and supportive others, from within the family (i.e. siblings, the partner of the mentally ill parent, extended family members) as well as outside the family (e.g. friends of the family, peers, teachers, coaches).
	Transport, accommodation and domestic issues when parent is unwell or hospitalised.	Family friendly hospital facilities, practical support for transport and various domestic issues, alternative or assisted stay at home accommodation.
	Problematic coping styles.	Provide opportunities to learn and practise adaptive problem solving strategies.
	Misconceptions about parent's mental illness	Provide ongoing opportunities for child to express themselves about illness. Provide age appropriate education about parental mental illness and mental illness generally.
	Young people assuming onerous caring responsibilities for parent and/or siblings	Provide education and adequate respite for care giving.
Parent with mental illness	Managing the parent's mental illness.	Appropriate, sensitive and timely assessment, intervention and rehabilitation. Ensure that rehabilitation acknowledges and includes children and parenting role.
	Assuming parent responsibilities.	Provide appropriate parent role models, education about attachment, connectedness and specific and individualised parenting topics. Ensure that practical support is available, for instance, for looking after children when the parent is very unwell or hospitalised.

	Identifying and accessing emotional and social support.	Ensure that rehabilitation incorporates and develops a client's community and family support system/s.
Other Family	Family stress associated with caring for a mentally ill parent.	Provide psychological and practical support, education and respite for all carers.
	Low family cohesion and poor communication.	Family based intervention and attachment programs.

	Crises including the hospitalisation of a parent and/or parent having an acute episode.	Initiate and develop critical incident plans involving all family members.
Human Service and Mental Health agencies	Fragmented and uncoordinated services	Organisational commitment to share information within and across services. Agencies develop policy responses that consider the family context of clients.
	Inadequate worker skills regarding families affected by parental mental illness. Workers knowledge is often negative, reactive and/or deficit based.	Further training and education regarding the issues of families affected by mental illness.
Society	Social, political, and economic barriers that exclude families from an acceptable quality of life. Stigma and stereotypes towards those with a mental illness and their families.	Government policies and programs that support and encourage supportive communities and the inclusion of those with a mental illness. Ongoing psycho-education and public programs targeting stigma and stereotypes across the community, including the media.