At-risk families with mental illness: Partnerships in practice

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Abstract
Parents with a mental illness have faced many difficulties in fulfilling their occupational role of parenting. A lack of targeted interventions and collaboration between mental health and welfare services has had negative consequences for these parents and their children. Occupational therapists have a role in selective prevention with high-risk groups. There is a need to focus on determinants, risk and protective factors affecting mental health and to apply this knowledge in developing prevention strategies. Preventative interventions have the potential to improve the mental health of the mother and the child. This article discusses an Australian programme for parents with a mental illness with a focus on partnerships to support the family unit.

Key words
Occupational therapy, at-risk families, partnerships

Introduction
Recently in Australia promotion, prevention and early intervention in mental health have gained increasing attention. Accumulating evidence shows the widespread and long-term benefits that this will have on the social and emotional wellbeing of individuals and populations. This focus also has the potential to reduce the prevalence and burden of mental health problems (Commonwealth Department of Health and Aged Care, 2000b). The National Action Plan for Promotion, Prevention and Early Intervention for Mental Health in Australia identified children as being a priority group (Commonwealth Department of Health and Aged Care, 2000a). It has been recognised that risk factors in childhood are associated with mental health problems in adolescence and an increased risk of mental disorders in adulthood (Commonwealth Department of Health and Aged Care, 2000a). Although a number of groups of children with particular needs have been identified as warranting attention (Raphael, 2000), this article will focus on children of parents with mental illness. Mental health for children means a capacity to enjoy and benefit from a satisfying family life, educational opportunities and freedom from problems that put the development of the child at risk (Raphael).

The current environment of health care in Australia has led to increased opportunities for occupational therapists to develop strategies to work with parents who have a mental illness and their children. In this instance, that involves working from a prevention framework and building inter-agency networks for practice partnerships. This article discusses parenting; the risk and protective factors for the child of a parent who has mental illness; issues faced by parents with a mental illness; before offering suggestions for ways in which welfare and mental health services can work in collaboration to bring about the best outcomes for these families.

Parenting
Parenting is perhaps best defined in behavioural terms that is to say: what a parent does. Parenting includes providing safety, anticipating and protecting from danger and solving problems on behalf of the child (Hill, 1996). Winnicott (1972) asserted that parenting meets the child’s basic needs while allowing for a full range of experience without allowing the child to be overwhelmed by need, emotion or stimulation. This influences the parent-child relationship, which builds the foundation for the child’s future relationships. The child forms internal working models of expectation regarding relationships, the role of others and him or herself within the relationship (Black, 2000). That is why the parent-child relationship is such an important relationship.

Therefore, the role of parenting is essential if the child is to achieve a satisfying and fulfilling life with relationships that are supportive and of good quality. The parent-child relationship is
defined usually in terms of attachment. Attachment is the bond that forms between the child and the parent. Secure attachment is characterized by warmth, proximity seeking, physical contact and sensitive, responsive parenting (Sanders, 1995). Maternal sensitivity particularly was found to be an important antecedent for a secure attachment (DeWolf & van Ijzendoorn, 1997). This sensitivity involves the mother being appropriately and consistently responsive to the baby's cues and signals (Erikson & Egeland, 1999).

In addition, secure attachment has shown to have an affect on the development of the child. Belsky (1997) found that secure attachment led to emotional security, behavioural independence, social competence and intellectual achievement. Erikson and Kurz-Rieimer (1999) stated that parental sensitivity and responsiveness is one of the most important requirements for promoting good development. Gunnar (1998) noted that there is a growing body of evidence that suggests the quality of life experiences in the early years of life actually affect the development of the brain.

**Parental mental illness**

Parenting has been found to be a role that is viewed positively by women with serious mental illness (Mowbray, Oyserman, Bybee, MacFarlane, & Rueda-Riedle, 2001). Sands (1995) in her study, found that women with serious mental illness actually saw parenting as a way to acknowledge themselves as ‘normal’ people. Parenting was a way of being connected with the community. These mothers also acknowledged that the parenting role helped to give them focus and purpose in their lives. Nicholson, Sweeney and Geller (1998a) found mothers prefer to define themselves in light of the parenting role rather than in light of their patienthood. In addition, it has been reported that these parents identify a number of benefits that come from the parenting role. Some of these benefits include receiving love from their children; having a purpose to life; and having the support of the children as they grow into adulthood (Chernomas, Clarke, & Chisholm, 2000).

Mowbray et al., (2000) found that women who have a serious mental illness, and who are parents are confronted with the challenge of managing illness and parenting responsibilities. The majority of these women experience difficulties of being a single parent with few family supports and even fewer social supports (Bassett, Lampe, & Lloyd, 1999; Diaz-Caneja & Johnston, 2004). Contextual risk factors such as relationship or marital discord, single parenthood, poverty, social isolation and substandard accommodation can impact negatively on the parent’s mental health. This heightens the vulnerability of children in that parent’s care (Hamilton, Hammen, Minasian, & Jones, 1993; Nicholson, Sweeney, & Geller, 1998a; Oyserman, Mowbray, & Zemencuk, 1994; Tiet et al., 1998; White, Nicholson, Fisher, & Geller, 1995). These studies found that parents with a serious mental illness are at increased risk of experiencing these factors. Other symptoms of mental illness that influence the parent-child relationship include passivity, withdrawn interactions with the environment, delusions and incongruent affect (Goodman & Brumley, 1990).

**Risk factors**

Research has identified risk factors for children who have a parent with a mental illness. These include environmental, psychological and social factors which are discussed below.

**Environment**

An environment where the care-giving is indifferent, uninvolved and neglectful affects the child. The child is more likely to develop a poor self-esteem, poor self-control and have a greater propensity for aggression (Patterson, 1982). Inadequate parenting skills, particularly those involving insensitive and inconsistent care provisions are a risk factor for the child developing behavioural difficulties (Hay, 2003).

**Psychological well-being and maternal role**

How rewarding the care-giver finds her role will have consequences not only for her but for her child. A parent’s rating of the quality of the parenting role is important, impacting both on parenting well-being and in turn, on parenting style and child behaviour (Barling, MacEwen, & Nolte, 1993). Many mothers find the maternal role stressful and feel incompetent as they struggle to come to terms with unrealistically high expectations of parenting competence placed on mothers in our society through the mass media (Esdaile, 1996).

**Lack of social supports**

Lack of social support is another difficulty faced by some parents (Diaz-Caneja & Hohnstorf, 2004). Social support has an indirect effect on parenting styles through its mediating effect on parental depression. Increasing social supports for parents leads to a decrease in their perceived level of depression (Meyers, 1999).

**Inconsistent parenting**

Inconsistency appears in two forms. One form of inconsistency is a low probability of responding (either detecting or disciplining) to a child’s misbehaviour. The other form of inconsistency is when a parent responds both negatively and positively to the same misbehaviour at different times (Acker & O'Leary, 1996).

**Social disadvantage**

Social disadvantage is frequently associated with low socioeconomic status (SES). Living in poverty has been linked with poor outcomes in every area of development and functioning (Bradley & Corwyn, 2002). The sequelae of poverty such as crime, violence, substandard schooling, substandard accommodation and neighbourhood decay reduce the life chances of children who live with these conditions (Walsh, 1998).

**Lower parental educational level**

A compelling fact of low SES among parents is that they tend to have a lower educational level. This impacts upon parenting skills and results in the use of more discipline and lower levels of nurturing behaviour (Fox, Platz, & Bentley, 1995). It has been reported that children of these parents have a high incidence
of identified problem behaviours (McMunn, Nazoo, Marmot, Boreham, & Goodman, 2001).

**Single parent families**

McMunn et al. (2001) identified that lone parenting worsens poverty, which affects the child’s development. It is the added stress that the single parent bears as he or she seeks to raise children with minimal support and with minimal time away from the parenting role, which causes added burden on the parent-child relationship. This in turn impacts adversely upon the child’s behaviour (Fox et al., 1995; McMunn et al., 2001).

**Intergenerational transmission of behaviours**

Lutenbacher (2002) commented on the fact that parenting practices and tolerated levels of violence tend to be transmitted from one generation to the next.

**Ineffective parental monitoring**

It has been reported in the literature that it is not only the presence of negative parenting that impacts negatively upon a child’s development, but also the absence of positive parenting (Bolger, Patterson, Thompson, & Kupersmidt, 1995; Brody et al., 1999; McCoy et al., 1999). Keenan and Shaw (1994) found that lack of supervision, lack of parent-child involvement and child neglect were predictive of behaviour disorders.

**Abuse**

Abuse occurs when a caretaker, who is responsible for the child’s welfare, commits an act that harms the child or allows an event to occur that endangers or harms the child (Peterson, Kohrt, Shadoin, & Authier, 1995). A number of studies have found that children of psychologically distant, neglectful, physically abusive and verbally rejecting parents function more poorly than control infants and that their functioning deteriorates over time (Egeland & Sroufe, 1981; Erikson, Egeland, & Pianta, 1989).

**Neglect**

Neglect occurs when the caretaker responsible for the care of the child, either deliberately or by inattentiveness, permits the child to experience avoidable present suffering and/or fails to provide the basics of life that the child requires developing in all areas (Peterson et al., 1995). Neglectful parents tend to have a predominance of negative rather than positive contacts with the neglected child (Wiehe, 1996).

**Protective factors**

For children who have a parent with a mental illness, there are a number of protective factors potentially influencing the development of mental health problems and mental disorders in children. These may include individual and family factors, school context, life events, and community and cultural factors (Commonwealth Department of Health and Aged Care, 2000b).

Children with high intelligence seem to find it easier to distinguish between their mother and the symptoms of her mental illness. They are better able to separate themselves from the illness and understand that they are not responsible for the illness (Wasow, 1995). Those children that are involved in hobbies or have interests which help them to form other social networks that are supportive seem to have derived solace, satisfaction and healthy escape from the chaotic home environment (Wasow). A secure and stable family and supportive relationship with another adult mitigates distress and fosters competence in the child to relate to others (Commonwealth Department of Health and Aged Care, 2000b). Other factors that contribute to positive mental health include personal resiliency and social advantage (Raphael, 2000), a sense of connectedness and strong cultural identity (Commonwealth Department of Health and Aged Care, 2000b). Achievements in mental health can be gained by improving the environments that affect the development of resilience in children, for example parenting skills programmes for parents of at-risk children (Commonwealth Department of Health and Aged Care, 2000b).

**Mental health services and child welfare agencies: Issues**

**Fear of loss of custody as a barrier to seeking help**

Studies have shown that, just as with the general population there is variability in parenting skills, there is a similar variability among women who have a mental illness (Brunette & Dean, 2002; Nicholson et al., 1998a). Unfortunately though, it has been found that parents with a mental illness have to prove that they are able to parent. This is opposed to the general population whom it is assumed can parent until they prove otherwise (Nicholson et al., 1998b). It is likely that agencies assess parenting of people with serious mental illness focus excessively on deficits and fail to acknowledge parenting skills when it comes to decisions about child placement (Oyserman et al., 1994). Oyserman et al. found that reports by welfare agencies and mental health services often failed to describe the parent’s competencies in the parenting role. Further they suggested that adequate though imperfect parenting should not be assumed to place a child at risk. Optimal parenting abilities may not be required to obtain “good enough” parenting. In other words, mental illness does not make a parent incapable. All factors need to be considered before making the decision to remove a child from a parent. Included in this decision-making process is the need for assessment of parenting skills that is objective and accurate.

Mothers with schizophrenia are at particularly high risk of having their baby supervised by social services (Howard, Shah, Salmon, & Appleby, 2003). Fear of loss of the child to welfare services is a major issue for parents who have a serious mental illness (Bassett et al., 1999). This fear would often result in them not seeking help or support for fear of being seen as “not coping” or being labeled a “failure” by authorities (Cowling, 1999). In one recent Australian study, 52% of the parents expressed fears that they would lose custody of their children if they sought help with parenting (Plant et al., 2002). A central theme throughout women’s accounts of their involvement with mental health services and welfare services related to the welfare of children was a pervasive fear of losing custody (Diaz-Caneja
& Johnston, 2004). Unfortunately, these fears are well founded. A number of studies have shown that these parents lose custody of their children at a disproportionate rate to the general population (Coverdale, Aruffo, & Grunebaum, 1992; Howard et al., 2003; Kumar et al., 1995; Miller & Finnerty, 1996). Difficulty in regaining custody of the child has been reported in the literature (Sands, 1995). Chernomas et al. (2000) found that the repercussions resulting from losing custody of a child, continues for the parent. They often experience a deep sense of loss, grief and anger for many years, struggling to come to terms with being judged unfit to parent.

Welfare agencies

For the child welfare agencies, careful assessment of the parent’s capacity to manage, the quality of the attachment between parent and child, and the impact of the parent’s illness on the child’s development and well-being are critical issues when considering whether or not a child is returned to the parent’s care (Evans, 1999). However these capacities are rarely acknowledged. Budd (2001) reviewed 190 expert reports that had been tendered in court. He found a number of problems with the assessments including a failure to describe the parent’s care-giving abilities and the quality of the child’s relationship with the parent.

Mental health services

For mental health services, there have been a number of issues, such as compartmentalisation of services, which influence the service’s ability to meet the needs of these families. Adult mental health services do not see that servicing the family is their role. Rather they see their role as dealing with the service user as an individual (Devlin & O’Brien, 1999; Webster, 1992). Parenting has not been considered a mental health issue (Cowling, McGorry & Hay, 1995). Additionally, there is a conflict between the role of advocate for the service user and feelings of responsibility for the welfare of the child (Grunbaum & Gammeltoft, 1993; Schwab, Clark & Drake, 1991). Finally, the lack of psychosocial rehabilitation interventions that focus on parenting skills and supporting parents in their role has been reported (Zemencuk, Rogosch, & Mowbray, 1995).

Collaboration

It is important for mental health services and child welfare agencies to collaborate to support parents with a mental illness and their children. If they work together using their expertise, good outcomes may result. Mental health services need to focus not just on symptom resolution but on recovery, and include valued life roles such as parenting (Brunette & Dean, 2002). Child welfare agencies need to focus not just on child protection but on providing support for parents, and networking with other agencies. This will enhance the provision of services that assist people to parent satisfactorily (Hearle & McGrath, 2000).

Hearle and McGrath (2000) imply that in the past both mental health and child welfare service provision has tended to meet the needs of the organization rather than the needs of the service user. The challenge is to set up a programme and processes within each service and with each other to achieve better outcomes for the service user. Raphael (2000) highlighted the need for individuals, agencies and organizations to work together to maximize opportunity for prevention, early intervention and treatment. She suggested partnerships need to be built on a collaborative and equitable basis, with shared goals and recognition of the expertise that each partner brings.

Occupational therapy

Occupational therapy literature shows little that is specific to infants and young children and their families, within a mental health community context. Such literature that is available tends to emphasize those children with a psychiatric diagnosis (Sholle-Martin & Alessi, 1990) or who have been abused and neglected (Wright, 1994). Scaletti (1999) recommended the use of a community development approach in the field of child and family mental health. According to Schultz-Krohn and Cara (2000), a family-centred approach has been promoted in the practice arena of early intervention and occupational therapy. This approach offers a framework for identifying the strengths and vulnerabilities of parents and their infants and young children, and provides a focus for treatment. Occupational therapy focuses on the occupational roles of clients and for parents with a mental illness, parenthood is their main occupational role. Occupational therapists are able to assess the person’s occupational performance in this area and design specialized intervention programmes based on the parent needs and that of their children. Additional skills that occupational therapists bring to parenting programmes include understanding the meaning and value of occupation, knowledge of developmental issues, use of activities, and activity analysis (Bassett, Lampe, & Lloyd, 2001).

According to Raphael (2000), in order to enhance family functioning, effective interventions need to be offered in collaboration with relevant agencies that may include adult mental health and general health services and other support and welfare services. Occupational therapists working in adult mental health services could consider offering selective prevention programmes to high-risk populations. Selective prevention interventions aim to reduce the risks to a targeted population, for example positive parenting programmes in disadvantaged populations (Commonwealth Department of Health and Aged Care, 2000a). There is the potential to achieve long-term mental health benefits from such programmes. The focus should include enhancing parenting skills; promoting attachment and provision of positive, safe, engaging, learning environments for young children; and improving the mental health of parents (Commonwealth Department of Health and Aged Care, 2000b).

Living with under fives

The Living with Under Fives programme is a selective intervention programme developed by occupational therapists in an Australian adult mental health service. Prior to the development of this programme, there were no services available that addressed the parenting needs of parents with a mental illness. The aim of the Living with Under Fives programme was to:
1. Improve parenting skills in at-risk families; and
2. Improve inter-agency coordination and access to child welfare services.

**Parenting skills in at-risk families**

Living with Under Fives is a rehabilitation group programme for parents with a mental illness and their children under school age (Bassett et al., 2001). The parent must have the child either living with them or have access visits. The aim of the programme is to target parenting behaviours and the parent-child interaction with the goal of improving parenting behaviours, lessening parental stress and improving the quality of the parent-child interaction.

The programme conducted by occupational therapists is located in a community setting and is held once per week for two hours each school term. This group is based on a playgroup model and parents are encouraged to interact with their children in age appropriate activities. During the group sessions, group leaders model appropriate interactional behaviours. There is also an educational section for parents, which addresses such pertinent issues as discipline, nutrition, community access, and strategies for when a parent is becoming unwell. Parents provide regular feedback about the programme and how they perceive themselves to be, in terms of developing parental coping strategies and parenting skills. This feedback is incorporated into subsequent group sessions. A full description of this programme has been previously reported (Bassett et al., 2001).

**Interagency coordination and access**

In developing the programme, the occupational therapists considered it essential that a working relationship was established with child welfare services, as many of the parents were involved with that service. There was little communication between the mental health service and child welfare services concerning the child and any parenting or custody and access issues. The occupational therapist took an active role in establishing mechanisms of communication between the two services. This involved meeting staff from the local area office to: 1) inform them about the programme; 2) establish a referral system so that at-risk families could attend the programme; and 3) establish a feedback system to report on parents’ group participation and parenting skill development.

Parents, who receive treatment from the mental health service and are involved with welfare services or the Department of Family Services, are encouraged to become involved in the group programme. In addition, the Department of Family Services identifies parents with a mental illness who are not receiving treatment from the mental health services and refers them to the programme. The Department utilizes the group programme to monitor parenting skills in at-risk families and for access visits where parents are wishing to regain custody of their children.

Strong working partnerships have developed between group leaders, caseworkers and parents. There is open communication between both agencies with parents involved in those communications. The Department of Family Services is provided with feedback on the parent’s involvement in the group at the end of the ten-week group programme. They also request feedback when orders are being reviewed.

Group leaders provide parenting assessments to the Department of Family Services when child custody issues are raised. These assessments are based on a parent-child observation tool and observations within the group. The assessment focuses on specific interactions and quality of interactions over time. The Department of Family Services values the parenting assessments they receive, which consider aspects of parental mental health and its impact on parenting skills. Risk and protective factors are now more clearly identified and plans developed to bring about better outcomes for these families.

Parents are shown any written reports and are aware of any verbal reports given to the Department of Family Services. When the Department of Family Services needs to change orders or they perceive any issues of concern they liaise with the occupational therapist from the group programme. This enables the group leaders and parents to discuss these concerns and develop education sessions around identified areas of concern and to model desired behaviours within the group.

Parents report having greater input into the decision-making process and feel that they are being given an opportunity to develop skills and be supported in the parenting role. Group leaders feel less frustrated with the Department of Family Services and have a better understanding of how this department operates and the whole issue of child protection. The Department of Family Services believe that this collaboration has assisted them in being able to make more informed decisions about child protection and child custody issues than previously. They also feel they have a better link now with the Integrated Mental Health Service, which has improved working relationships and access to services. This has been described by one mother as:

*It is good knowing Family Services are talking with Mental Health so they all know what is happening. I feel I have a voice in it all and that one-sided decisions are not being made. I, at last, have hope – I’m no longer seen as a bad mother but rather as a mother who needs support.*

**Future directions**

While anecdotally, this programme is thought to meet identified needs of the target population, formal evaluation is recognised as essential. The first author decided it was necessary to develop a parent-child observation instrument for use in conjunction with self-report tools. This instrument could be used to measure whether or not the parenting programme was effective in improving parent-child relationships and parenting skills. The utility, reliability and validity of the instrument have recently been reported (Bassett, 2004).

**Conclusion**

The experience of mental illness in a parent can affect the quality of parenting, and impact on child development and wellbeing. There are a number of issues common to all parents including broad social factors and parent child attachment. However so-
cial disadvantage, which is often associated with mental illness and characteristics inherent in mental illness, have the potential to negatively impact on the quality of parenting. An understanding of risk and protective factors is important in effective prevention. Occupational therapists could consider developing selective prevention methods and partnership approaches when working with parents who have a mental illness. Partnerships need to include the family unit and relevant agencies involved with the parents and their children. Communication between the stakeholders is vital in ensuring an effective collaborative relationship. When mental health services, child welfare services, and families work together, the outcomes for both parent and child may be optimized. Future directions include conducting an assessment of parenting skills that is objective and standardized, to more accurately inform decision making about the capacity of people with a mental illness to be parents.

**Key points**

- The role of parenting is essential to stimulate the physical, cognitive, social and emotional development of young children.
- Risk may influence a child’s vulnerability to a range of mental disorders and mental health problems.
- Interventions need to focus on risk and protective factors and the tasks of parenting for parents with a mental illness.
- Occupational therapists have focused on selective prevention and collaborative partnerships with families and welfare agencies.

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**References**


