

**Adult Mental Health Nurses' Beliefs and  
Practices when Nursing Clients who are  
Parents of Children Under 18**

**Full Project Report**

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Project report: Adult Mental Health Nurses' Beliefs and Practices when Nursing  
Clients who are Parents of Children Under 18

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## **Executive summary**

### **Introduction**

This collaborative study between Flinders University's School of Nursing and Midwifery and the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) used both quantitative and qualitative research methods to gather information from registered psychiatric/mental health nurses working in in-patient and community adult mental health settings about their *beliefs and practices* in relation to assisting their clients, who had enduring mental illness, to address parenting roles and family issues. It also sought to determine the nurses' level of *factual knowledge* and *practices related to that knowledge* with regard to their statutory obligations pertaining to their clients' children.

### **Background to the study**

The 'Mental Health Promotion and Prevention National Action Plan', under the 'Second National Mental Health Care Plan, 1998-2003' was released in January 1999. It identified several areas requiring attention with regard to children with parents affected by mental illness (AICAFMHA 2001 p.vii).

While the reported prevalence of emotional and behavioural difficulties among such children varies, it is reportedly much higher than for the general population (Farrell et al. 1999). Parents with a mental illness can find it difficult at times to provide for their children's needs (Pope 1998; Kowalenko et al. 1999) and there is a greater risk of children being removed from their care (Isaac, Minty et al. 1986). However, many families in which a parent is affected by mental illness are, or can be supported to parent their children effectively.

### **Overview**

This study needs to be seen as an initial, information-seeking activity, intended to provide timely and relevant information about mental health workforce beliefs and practices in relation to clients who are also parents of dependent children. It was developed to explore several hypotheses in addition to beliefs and practices in relation to assisting clients to address parenting roles and family issues. These were that:

- most psychiatric/mental health nurses working in adult mental health settings are aware that some of their clients are parents of children under 18;
- these nurses are aware it is possible that when their client is unwell, their children may be 'at risk' in some way; and
- despite knowing this, these nurses may be reluctant to engage in their statutory 'duty to protect' these children in the manner specified by the Children's Protection Act 1993, for a range of reasons.

Data collection took place in 2003. In March/April, a questionnaire was sent to every psychiatric/mental health nurse on the register of the South Australian Nurses Board (NBSA). A series of follow-up focus groups and telephone interviews in June/July 2003 further explored the complexity of these issues.

## **Summary of key findings**

The data analysis made it clear that the vast majority of nurses felt it was part of their role to discuss parenting with their clients but over a quarter of them reported barriers to doing so. Most respondents also believed that part of their role includes speaking with children of their clients if requested, but some were unaware of resource materials to assist them or felt ill-prepared to do so.

The majority of nurses reported referring clients to community agencies for support with parenting or family issues. However, the most commonly listed agency recommended to families was child and adolescent mental health services which may indicate an over-reliance on that type of agency for support that could be provided by generalist child and family health and welfare agencies. The majority of nurses also reported that they worked with other agencies to support clients and their families but over 50% had experienced barriers to doing so. More than a quarter indicated that there were not systems in place to help them work with other agencies to address family or parenting issues with clients.

Of note is that although 96% were aware of their Mandated Child Protection Notifier status, more than a third of those who had reason to believe that a client's children were at risk of neglect or abuse had made no formal notification in this regard. The most common reasons given for not formally reporting their concerns related to a lack of confidence in the child protection response by the Department of Family and Youth Services (FAYS)<sup>1</sup> or a belief that their role in child protection notification was solely to report their concerns to a senior colleague or other mental health team member.

## **Recommendations**

It is important that nurses in adult mental health services are provided with information and skills training to assist them to support clients' parenting roles and to protect children with a parent with a mental illness who may be at risk of harm. Multi-disciplinary training in association with professionals from a range of service settings (e.g. child protection and child and family health and welfare) may be valuable in assisting nurses to enhance their client referral processes and collaborative work practice in this area. This may also assist nurses and their colleagues to explore some of the ethical issues associated with the care of parents with mental health problems (e.g. the ethics relating to confidentiality and of child welfare decisions).

Systems, processes and policies identified as barriers to effective collaboration with community agencies and clients also need to be addressed if nurses are to be

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<sup>1</sup> Family and Youth Services (FAYS), a section of the then Department of Human Services was the name of the State Government body responsible for child protection in South Australia at the time of the study.

It has since been renamed Child, Youth and Family Services within the Department for Families and Communities

supported in their role. The valuable recommendations pertaining to service delivery at the individual worker, team, mental health service and broader systems level that have been collated during this study could form the basis of further consultations and service improvement planning with adult mental health services staff, child protection services and relevant community agencies.

## **1. Introduction**

While many people who have a mental illness are also capable parents, mental health problems can affect parent-child interactions in a variety of ways. For example, parents with depression, when ill, are less able to be affectionate and responsive (Kowalenko et al.1999), and parents who have schizophrenia may have unusual or inappropriate affective responses to their child (Pope 1998). In addition, when a parent is affected by a mental illness, the family is at greater risk of experiencing relationship discord, discontinuity of care, poor general parenting skills, social isolation, and poverty and its sequelae, such as poor housing and lack of transport (Kowalenko et al. 1999). These findings were one of the catalysts for this research project.

### **1.1 The research purpose and intended outcomes**

#### ***1.1.1 Purpose***

This multi-method project had four aims:

To gather broad-based information from registered psychiatric/mental health nurses (working in inpatient and community adult mental health settings in South Australia) about their *beliefs and practices* in relation to assisting their adult clients, who had ongoing mental illness, to address parenting roles and family issues.

To elicit the level of *factual knowledge* and *practices related to that knowledge* held by these nurses about their statutory obligations pertaining to the welfare of their clients' children.

To utilise this data to *determine the specific requirements for this group of health care professionals*, to enable them to better meet the needs of their clients who are parents and their children.

To *utilise this information to suggest recommendations* to aid the nurses in dealing with these complex areas of their practice.

For the purposes of this study, children did not have to be living with their biological parent.

#### ***1.1.2 The specific questions this study sought to answer***

This study sought to answer the following specific questions:

- Do nurses working in adult mental health services believe that addressing the expressed or perceived needs of these families as a whole is part of their role as an adult mental health nurse? What circumstances informed their decision?
- Do nurses working in adult mental health services raise issues relating to the client's parenting role? What circumstances informed their decision?
- Do nurses working in adult mental health services speak with the child/children about their parent's mental illness if requested? What circumstances informed their decision?

- Where do these nurses access information about these practice issues for their professional development?
- Do nurses working in adult mental health services understand their responsibilities under the South Australian Children's Protection Act, Section 11? Have they ever had to act according to these responsibilities?
- Have these nurses received any formal training as to their responsibilities under the South Australian Children's Protection Act 1993, Section 11?

The hypothesis for these last two questions was that even though psychiatric/mental health nurses working in adult mental health settings might be aware that some of their adult clients were parents and that their children might possibly be 'at risk' in some way, these nurses were reluctant to engage in their 'duty to protect' these children in the manner specified by the South Australian Children's Protection Act 1993. This may be due to several factors, for example, the nurses may be:

- unaware of their legal obligation in this area;
- unable to recognise manifestations of risk, abuse and/or neglect;
- frightened of possible litigation;
- fearful that raising such a concern could result in a serious threat to their therapeutic relationship with the parent/caregiver;
- wary of suggesting, or being seen to infer that they were concerned about a child simply because that child's parent had a mental illness.

The survey consisted of questions requiring a likert scale response, using the range of possibilities 'never/occasionally/sometimes/always', and open-ended questions.

## **1.2 Significance**

### ***1.2.1 The National context for the study***

Many adult mental health services in Australia do not ask, or have only recently begun to ask and record whether their adult clients have children and whether the children live with them. Further, adults with a mental illness may not wish to volunteer this information because they fear losing care of their children. A significant body of Australian evidence shows that many clients in adult mental health settings have, and are principally responsible for children:

...anywhere between 29% and 35% of mental health service clients are female parents of dependent children under the age of 18 (Cowling 1999; Farrell et al. 1999; Hearle et al. 1999). These mothers are likely to be in their mid-thirties and have very young children – that is, less than six years old – 70% of whom are living with them (Farrell et al. 1999). In addition, around 30% of these clients also have a history of drug or alcohol abuse. Cowling (1999) also estimated, given current census data and accepted incidence rates of mental illness, that at least 27,000 Australian children are affected by maternal psychotic illness alone (AICAFMHA 2001 p.2).

This information, coupled with other studies that postulate that having a parent

with a mental illness places these children 'at risk' of a wide variety of psychosocial and psychopathological sequelae has caused concern at a national level (O'Donovan 1994; Cuff & Mildred 1998; Einfeld & McLaughlin 1998; Pope 1998; Cowling 1999; Farrell et al. 1999; Kalucy & Thomas 1999; Kowalenko et al. 1999).

The 'Mental Health Promotion and Prevention National Action Plan' established in January 1999, under the 'Second National Mental Health Care Plan 1998-2003' identified several areas requiring attention with regard to children who have parents affected by mental illness. These include:

...evaluating the effectiveness and sustainability of prevention initiatives, researching effective community-based interventions and developing positive outcomes for these children, including better knowledge and understanding of parental illness and improved support, mental health and parenting (AICAFMHA 2001 p.vii).

In September 2001, AICAFMHA was successful in tendering for an Australian Government-funded national initiative that aimed to improve outcomes for children of parents with a mental illness through the development of guidelines and principles for workers/services and resource materials for workers, parents and young people. The Children of Parents with a Mental Illness (COPMI) project Phase One began in January 2002 and ended in May 2004 with the release and distribution of a range of resources, including the document 'Principles and Actions for Services and People Working with Children of Parents with a Mental Illness' (AICAFMHA 2004).

### *1.2.2 The South Australian context*

In keeping with the Primary Health Care focus of the South Australian Generational Health Review, this project was located within early intervention/health promotion ideology, both for children in relation to the detection and alleviation of possible distress, and for the parent in terms of optimising their parenting abilities via contact with informed mental health nurses.

The particular significance of this study was that it gathered information about beliefs and work practices from psychiatric/mental health nurses working in **adult mental health settings** where the predominant focus of therapeutic intervention is on the adult client, and not necessarily their families, children or significant others. This division in the locus of care is enacted structurally in South Australia by providing two services – Child Adolescent Mental Health Services for children under the age of 18, and Adult Mental Health Services for persons between the ages of 18 and 65.

Under Sections 11(1) and (2) of the South Australian Children's Protection Act 1993, nurses are obliged by law to notify Family and Youth Services (FAYS) if they suspect, on reasonable grounds, that a child/young person is being, or has been neglected or abused, and the suspicion is formed in the course of the nurses' work.

In South Australia, The Mandated Notification Program conducted by FAYS-accredited trainers stresses a ‘partnership’ approach between government and non-government agencies, and children/young people and families in relation to taking responsibility for child abuse and neglect. In this context, partnership is a continuum of relationships between agencies and families, which range from the voluntary to the statutory – it cannot be equated with voluntariness and equality (Morrison 1996).

### **1.3 The broad overview of the study**

It is asserted that families where a parent has a mental illness can be supported to parent their children effectively. Keeping families together also has important, positive outcomes for the child and for the parent who has the mental illness. They can attain improved mental health through assistance in managing the stresses of parenting and avoiding the trauma that may result from the loss of access to beloved children and a valued parenting role (AICAFMHA 2001).

This project provides information to help workers and services meet the needs of these children and families.

## **2. Literature review**

Whilst not all children of parents with a mental illness will experience difficulties as a result of their parent's health status, a relationship between parental mental illness and child psychiatric problems and other adverse outcomes for offspring has been well documented (Zahn-Waxler et al. 1984; Quinton & Rutter 1985; Rutter & Quinton 1987; Coyne et al. 1992; Beardslee et al. 1998; Field 1998; Wickramaratne & Weissman 1998; Beck 1999; Johnson et al. 2001; Raju et al. 2001; Wals et al. 2001).

### **2.1 Nature of the risk to children of parents with a mental illness**

Falkov (1998) noted that living with a mentally ill parent could affect any aspect of a child's development, including cognition, emotional and physical health, and behavioural and social development. His child fatality study in the United Kingdom highlighted a small but significant group of children who died as a result of their parent's mental illness (Falkov 1996). A report for the New South Wales Child Death Review Team (Lawrence et al. 2002) noted that the effects of parental mental illness precipitated death in 11 of 60 (18%) fatal child assault cases in the three and a half years preceding July 1999.

The interrelationships between parental mental illness and childhood risk are complex, multifaceted and changeable over time, with outcomes depending upon child characteristics (including age), alterations in family functions, and stressors and protective factors other than parenting, such as socio-economic resources, housing, major life events and community supports (Falkov 1998; Feldman et al. 1987). In respect to child safety, the main adult psychiatric disorders implicated in substantial physical abuse and neglect of children appear to be depression, substance dependence and personality disorder, occurring either individually or in various combinations (Falkov 1998).

Despite their increased risk of developing a psychiatric disorder during childhood, it is far from inevitable that all children of mentally ill parents will suffer such disorders. Research evidence has also shown that intervention for such children and their families can be successful in increasing their resistance to developing mental health problems later (Beardslee et al. 1998). This has led the Australian Government (Commonwealth Department of Health and Aged Care 2000) to recognise children of parents with a mental illness as a potential key target group for mental health promotion, prevention and early intervention.

#### **2.1.1 Incidence**

In Australia, only broad estimates can be made of the number of children affected by parental mental illness. There is currently no Australia-wide collection of data regarding people with parenting responsibilities who attend mental health services (AICAFMHA 2004). Even if this were in place, it would not capture data relating to parents with mental health problems who do not attend recognised mental health services and/or who do not disclose their parenting status due to concerns that their child/children may be removed from their care.

The AICAFMHA Scoping Project Report (2001) cites Australian studies that

indicate anywhere between 29% and 35% of mental health services clients are female parents of dependent children under the age of 18. These mothers are likely to be in their mid-thirties and have children less than six years of age, 70% of whom are living with them (Farrell et al. 1999).

## **2.2 Parenting and mental illness**

Most of the literature relating to parenting and mental illness is specifically about mothering. Nicholson et al. (1998) note that many of the issues raised by mothers with mental illness are generic to all parents, while others are specific to the situation of living with mental illness. Issues that mothers with a mental illness have identified as specific to their situation include dealing with the stigma of mental illness (which limits their ability to freely discuss areas of concern), managing day-to-day parenting whilst managing mental illness, and custody of, and contact with their children (Apfel & Handel 1993; White et al. 1995; Nicholson et al. 1998; Kowalenko et al. 2000; Noack 2002). Two studies also noted that some parents with a mental illness may not be aware of, or may minimise the effect of their illness on their children (Singer et al. 2000; Thomas & Kalucy 2002).

Mustard (2002), Keating and Hertzman (1999), the National Research Council of Medicine in the U.S.A. (NRCIOM 2001), and Shonkoff and Phillips (2000) have all drawn attention to the significance of the early years (conception to five years) on the individual's social, emotional and physical development. Their work and that of others in the field has raised awareness of the major impact parents and other caregivers have on very young children. Perinatal mental health problems experienced by women and their families may result in serious disturbance to healthy parenting but the perinatal period offers a 'window of opportunity' to implement a range of mental health early intervention strategies (Kowalenko et al. 2000).

## **2.3 Mentally ill parents' effects on partners**

Ostman and Hansson's (2001) study involving 115 spouses of severely mentally ill people showed that healthy spouses were more likely to give up their own occupation if there were dependent children in the family than if there were no children. Spouses in households containing children were also more likely to experience greater needs for their own care and support from psychiatric services compared to spouses without minor children. In the majority of cases, partners also reported that the children needed support due to their parent's illness but that these needs were met in only half the cases.

Other studies (Quinton & Rutter 1985) highlight the high level of marital discord and marriage breakdown in families where a partner experiences severe mental illness.

Faddern et al's (1987) review of the literature found the burden of care of a patient with a mental illness in the home was considerable in areas such as reduction of social and leisure activities, and financial problems. They noted that 'Despite their burden, relatives do not complain much, although they receive little

support, advice or information from the professionals engaged in treating the patient' (Faddern et al. 1987, p. 285).

#### **2.4 Conflict of interest?**

In Weir and Douglas' (1999) 'Child Protection and Adult Mental Health; Conflict of Interest?', contributing authors explore a range of issues relating to the vexing issue of the apparent conflict of interest between the needs and rights of the parent with a mental illness and those of their child/children. In some situations, neglect of a child's emotional needs may be unintentional, with the parent doing their best to provide care for their child whilst also struggling with the impact of their illness. In response, some adult workers may feel the need to defend their client, as they perceive the client is victimised unfairly if their capacity to care for their child is questioned.

#### **2.5 Adult Mental Health workforce development**

Byrne et al.'s (2000) Australian study of 77 people who provided services to parents with a mental illness found that lack of liaison between service agencies, lack of appropriate community resources, and high workloads and lack of time were perceived as the most significant barriers to working with parents and their families. (The majority of people in this study worked in government mental health services). Forty-five percent of service providers also indicated that professional development programs would be useful in assisting them in their work with parents with a mental illness and their families.

Whilst acknowledging that mental health workers often perceive they do not have time to commit to extra work and training regarding family inclusive approaches, Maitra and Jolley (2000) noted reluctance within adult mental health services in the U.K. to fully acknowledge child-related issues and the need for investment in preventative work. They believed this 'cultural bias' was deep-rooted and possibly not amenable to later training. Therefore, they have advocated for consideration of the interface between child and adult services at the level of basic professional qualifications of the mental health workforce.

In a recent Australian consultation (AICAFMHA 2003), adult mental health workers identified that they required skill development and maintenance, and their employing organisations' support in order to identify the needs of their adult clients' children and other family members. Australian National Practice Standards for the Mental Health Workforce (Commonwealth Department of Health and Ageing 2002) were released concurrently with the consultation process. The document includes a guiding principle and associated standards that recognise and support the rights of children with a parent with a mental health problem or mental disorder to appropriate information, care and protection.

### **3. Methodology and method**

#### **3.1 Methodology**

This was a study involving both quantitative and qualitative methods – a questionnaire and focus groups were used to collect data. Data from the questionnaire was entered into Excel 97 and analysed using Access 97.

The researchers identified the distribution of a questionnaire and follow-up focus groups as the most cost-effective and time-efficient strategy for collecting information. The questionnaire aimed to identify South Australian registered psychiatric nurses' 1) *beliefs and practices* regarding assisting their adult clients who are parents to address parenting and family issues, and 2) their *knowledge and practices* related to that knowledge, with regard to their statutory obligations regarding children under the age of 18.

The questionnaire (Appendix 1) was mailed to all psychiatric/mental health nurses registered by the Nurses Board of South Australia at the time of the survey (n=1,627), together with a covering letter.

Focus group questions were developed from analysis of the open-ended survey responses, and three focus groups were conducted in metropolitan South Australia. The number of nurses who expressed an interest in participating in a focus group who lived in regional areas in South Australia (Riverland, Iron Triangle, Mount Gambier) was too small (n=8) to warrant separate focus groups. These nurses were asked for their ideas by individual telephone conversations conducted with the principal investigators.

#### **3.2 Ethical issues and rigor**

Rigor and ethically responsible research concerns were addressed in the first instance by seeking ethics approval for this project from the Flinders University Social and Behavioural Ethics Committee (Appendix 2).

As part of this process, an initial introductory letter was developed (Appendix 3). This described the project aims in general, invited participation in the study via the questionnaire, and gave an approximate time it would take to complete the questionnaire plus contact details of both the chief researcher and the Flinders University Social and Behavioural Ethics Committee secretary. It also contained a disclaimer stating that the Nurses Board of South Australia had no vested interest in the project (given that some questions related to statutory obligations and professional practice) and that the researcher had not had access to the registration roll from which the mailing list was derived. Finally, the letter stated that participants were free to withdraw from the study at any time with no disadvantage, repercussions or consequences to themselves.

As part of this particular process, a separate information letter was devised for the focus groups (Appendix 4). Two specific consent forms were developed, one seeking participation from members of the sample group who completed the questionnaire (Appendix 5) and the second seeking participation in a focus group at a later date (Appendix 6). This second consent contained information about the

proposed amount of time these focus groups would take and the details of the proposed remuneration for the participant's travel and time. These consent forms also stated that the participant was free to withdraw from the study at any time with no disadvantage, repercussions or consequences to themselves. Participants received the focus group consent form (Appendix 5) at the same time as the survey, to be returned in a separate envelope at the same time the nurses returned the questionnaire.

A follow-up reminder letter to participants to return the questionnaire was also developed. This clearly explained that participants did not have to complete and/or send back the questionnaire if they did not wish to (Appendix 7).

Specific ethical concerns were considered. These included issues concerning participants' age, their ability to give informed consent, the sample group's understanding of the English language, the impact of this research upon Indigenous Australians, specific cultural/religious groups, permission needed from other people and the involvement of other people, for example in the case of observational studies. The researchers deemed these not applicable to this study, but they appreciated that some of these issues were likely to be more relevant to information discussed in the focus groups as opposed to information sought via the survey instrument. In light of this, these issues were addressed as follows.

Participants in this study were over the age of 18 and as South Australian-registered, practicing nurses were deemed able to give informed consent to a document in English. The researchers did not believe this study would impact directly on the health and welfare of Indigenous Australians any more or less than on any other group of Australians. Participants were not asked to identify their cultural background in the survey instrument, or in the focus groups. Finally, this type of study did not require permission from people other than the participants, who chose to take part. Participant observation was not part of this project.

### **3.3 General survey**

A questionnaire was developed seeking information from all psychiatric/mental health nurses registered on the roll held by the Nurses Board of South Australia. This involved liaising with the Nurses Board of South Australia to use their mailing list of nurses who had psychiatric nursing registration. Whilst registration as a psychiatric nurse was the determining factor for inclusion in the survey, working in adult mental health services was also a factor. Many of the nurses identified through the roll were not practising in adult mental health services (or any mental health service for that matter). This was addressed in an early 'inclusion/exclusion' question to ensure only valid responses were received.

### **3.4 Focus groups**

Given the limited ability of questionnaires to grapple with multi-faceted situations, a series of focus groups was conducted in metropolitan and country South Australia. A letter was developed specifically for country participants and sent to all those identified as fitting this category (Appendix 8).

Focus group questions were developed from an analysis of the open-ended survey responses that highlighted a range of complexities in relation to practice/professional issues, including worksite-based cultures, time and client safety (Appendix 9).

These focus groups encouraged participants to discuss these complexities in a more detailed way than was possible via a questionnaire. This enabled the researcher to gather a 'bigger picture' of the practice/professional issues pertaining to multi-faceted situations in their practice.

Participants comprised nurses who identified their willingness to take part in these groups via a question in the survey questionnaire. These nurses identified themselves by completing a tear off slip attached to the questionnaire. They could choose to contribute to this study by participating only in the focus groups (i.e. without completing the questionnaire) or by completing the questionnaire as well.

It was envisioned that one specific face-to-face focus group would be held in the Riverland (regional centre Renmark) and another in the 'Iron Triangle' (regional centre Port Augusta). However, these focus groups did not take place due to insufficient numbers of participants. All non-metropolitan respondents who indicated an interest in being involved in focus groups were invited to either attend a metropolitan group or be interviewed via telephone. Five of this group accepted the offer to participate via telephone interviews.

The focus groups were not audiotaped but the researchers took extensive notes.

## **4. Results**

This section presents a summary of the raw data from the survey. A total of 307 surveys were returned from 1,627 mailed out, giving a return rate of 19%. Information arising from the focus groups and telephone interviews are also included in this section. Twenty-eight nurses participated in the focus groups and 5 nurses participated in telephone interviews.

### **4.1 Results for each section of the survey**

#### ***4.1.1 Section 1: Respondent profile: current or past workplace setting***

A total of 298 (97%) respondents provided information about their current workplace, with 179 (60%) listing this as the Adult Mental Health service sector. Of those respondents working in Adult Mental Health, 108 (60%) were currently working within Metropolitan Inpatient Mental Health Services, 47 (26%) were working within Community Adult Mental Health Services, 6 (3%) reported working in Country Inpatient Adult Mental Health Services and 18 (10%) listed Country Community Adult Mental Health Services as their workplace.

Of those not currently working in the Adult Mental Health sector, 112 reported that they had worked in the past in a mental health setting with adults who were parents or caregivers of children. This was within the last 12 months for 22 (20%) of them, 27 (24%) reported doing so between 1 and 5 years prior to the survey, and 63 (56%) reported working in this area more than 5 years ago.

Respondents who reported never having worked with parents of children under 18 or who had done so more than 5 years prior to the survey period were directed to the survey sections relating to mandatory notification, child abuse and neglect only (Sections 6 and 7). A total of 222 respondents at least partially completed the remainder of the survey. As some nurses did not indicate a response to every question, percentages of the total responses provided are recorded. The total number of individuals responding to each question in Sections 2 to 5 ranged between 212 and 222.

A total of 300 nurses responded to Sections 6 and 7 of the survey tool.

#### ***4.1.2 Section 2: Beliefs about discussing parenting issues with clients***

This section consisted of a number of statements. Respondents were asked whether the statements accurately reflected their personal beliefs, or, where indicated, the beliefs of their workplace.

A total of 96% (of 220) believed that it was their role to discuss their client's family situation and felt confident to do so, while 11% (of 218) reported that they believed it was their role to discuss the family situation with the client but felt ill-equipped to do so. This apparent discrepancy may indicate that some respondents generally felt confident about this role but sometimes felt ill-equipped to undertake it.

A total of 91% (of 217) believed that their workplace supported their role in discussing parenting/family issues with clients, 74% (of 220) believed that they had time to focus on parenting or family issues with their clients, and 72% (of

222) believed that the severity of the client's illness influenced whether they discussed parenting or family issues with them. A total of 85% (of 214) were not deterred from discussing their client's children with them in cases where the children had been removed from the client's care.

A total of 91% (of 212) of nurses reported that they were not deterred from discussing their client's children with them if they were concerned that the client's children may be removed from their care.

In the open-ended responses, 30 participants made comments supporting their strong belief in discussing family/parenting issues with clients. Six commented that they would use sensitivity or caution if raising the issue with a client and seven indicated that they would wait for the client to initiate discussion re this topic.

One respondent reported speaking to other family members if the client was too unwell to discuss parenting/children and one raised the question of confidentiality impacting upon this area.

Six respondents identified barriers to discussing parenting/family issues with clients. Barriers included time and resource constraints, lack of support in the system and the workplace, workplace policies that focus on the individual and lack of training.

#### ***4.1.3 Section 3: Talking with the clients' child/children about their parents' mental illness.***

A total of 60% (of 222) reported that a client or their partner had asked them to talk to their child about mental illness. Of these respondents (n = 132), 83% had spoken with the child/children and felt confident to do so, 9% had spoken with the child/children but felt ill-equipped to do so and a further 8% had informed the client that they didn't believe it was their role to talk with the children about their parents' mental illness. Of this latter group (n = 13), 8 referred the family to another service, 4 referred the family to another worker within their team and 1 provided resource materials to help the client explain the illness to the children. Nurses reported referring clients to other services, including Child and Adolescent Mental Health Services, FAYS, Anglicare<sup>2</sup>, CAFHS<sup>3</sup>, a School Counsellor, Social Workers, OARS<sup>4</sup>, the Schizophrenia Fellowship<sup>5</sup>, the treating psychiatrist, the GP and the VVCS<sup>6</sup> for assistance in explaining the mental illness. Two reported working jointly with others in their team or with other service providers to talk with their clients' children.

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<sup>2</sup> Anglicare is a non-government family and community service of the Anglican Church in Australia

<sup>3</sup> CAFHS is a child and family health service of the South Australian Department of Health

<sup>4</sup> OARS is a non-government service which provides aid to offenders and their families

<sup>5</sup> The Schizophrenia Fellowship was a non-government organisation

<sup>6</sup> VVCS is a service for Vietnam War veterans and their families funded by the Australian Government

Sixty-nine nurses provided the names of resources they had recommended for clients or their significant others to enable them to discuss their mental illness with their child/children. Some were titles of books and pamphlets, while others were names of services which provided or recommended books, videos and pamphlets for purchase, loan or downloading from websites (COPE, COMIC, SANE<sup>7</sup>, Department of Health and Ageing, Mental Health Resource Centre, Vietnam Veterans Counselling Service, Drug and Alcohol Services Council).

A total of 83% (of 117) felt that they would like to see something developed for clients to help them discuss their mental illness with their children, but acknowledged that they did not know what was currently available, while the remaining 17% felt there was nothing they would like to see developed.

Fourteen respondents said they would welcome the development of any resources that were age specific. Three specifically suggested books; 4 suggested pamphlets; 6 suggested videos for children; 1 suggested an Aboriginal publication as they 'are easier to understand'; 1 wanted to see more community self-help/interest groups with access to Mental Health professionals; and 1 requested a guide for clients re how to approach the subject and what language to use.

#### ***4.1.4 Section 4: Referral to other agencies***

A total of 85% (of 224) reported that they had referred a client or their significant other to services to assist them with parenting or family issues. Of these respondents, 50% had referred to CAMHS, 42% to DASC, 41% to CAFHS, 39% to a Non-Government Organisation (e.g. Anglicare, Centacare) and 34% to Aboriginal Health/Support Services. It must be noted that some respondents reported referring clients to more than one agency.

#### ***4.1.5 Section 5: Working with other agencies***

In this section of the survey, nurses were asked to reflect upon their experiences of working with other agencies regarding client's parenting/family issues. A total of 89% (of 221) reported feeling comfortable discussing client's parenting/family issues with other agencies if parental consent had been given for this to occur, while 20% (of 214) reported having reservations about discussing parenting/family issues with other agencies despite having gained their client's permission.

When asked about systems to help them work with other agencies to address family/parenting issues with the client, 72% (of 208) felt that there were systems in place and 29% did not feel there were systems in place. A total of 87% (of 216) were aware of how/where to get the help their clients

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<sup>7</sup> COPE, COMIC and SANE are non-government organisations that advocate for and provide information for families and/or people with a mental illness

needed to support them in their parenting role and 45% (of 209) felt that time pressures prevented them from working with other agencies regarding a client's family/parenting issues.

Major barriers were experienced by 53% (of 220) when working with agencies to address these issues. Barriers reported included:

- time and resource constraints;
- workload pressures on other agencies;
- attitudes and behaviours of others (including the stigma associated with mental illness);
- lack of understanding of mental illness;
- communication breakdown;
- confidentiality barriers to information exchange;
- difficulty of access to services for those in the country;
- restrictive criteria of agencies providing services;
- and practical barriers such as access to childcare and transport for clients.

#### **4.1.6 Section 6: Mandatory Notification**

Under this section, 96%(of 300) of respondents were aware that they were a Mandated Notifier.

Two-hundred-and-eighty respondents could identify where they learnt about being a mandated notifier: 24% indicated that it was during their orientation to a position; 23% had learnt about their role during a formal 'Mandated Notification' training session; 21% had learnt about it as part of their nurse education; 12% believed they had been informed by the Nurses Board; 11% had been informed by a senior staff member or colleague; and the remainder had learnt from the media or elsewhere, or couldn't recall.

#### **4.1.7 Section 7: Child abuse or neglect**

In relation to child abuse or neglect, 71% (of 300) of respondents reported that they had witnessed, or heard from a client who was a parent/caregiver something which made them believe that the client's child/children under 18 were at risk of abuse or neglect. Fifty-nine percent of these respondents had had this experience on average one or two times per year, 21% had had this experience 3-5 times per year and 20% had had this experience more than 5 times per year.

A list of possible responses to this situation was provided. Respondents could select from these and/or also note alternative responses they had made to the situation. Responses indicated that: 63% (of 215) reported the incident to FAYS and 3% had not reported the incident to FAYS because they were unhappy with the way they had dealt with a previous report they or their colleague had made; 1% (of 93 respondents) had not reported because they did not want it to affect their relationship with their client; 2% had not reported because they did not think there was anything FAYS could do about the situation; 22% had not reported but

asked another member of the mental health team to investigate further; 7% had not reported the incident but discussed it with a colleague or senior staff member and were advised not to do anything; and 1 respondent replied that they had not reported it because they did not know what to do.

A total of 69 nurses reported responding in a different way to the responses listed but most stated that they had discussed their concerns with colleagues (leaving any reporting to another team member) or defended their lack of response by identifying their lack of confidence in FAYS' child protection process. Seven nurses reported that they or their Mental Health Team had actively worked to reduce the risk to the child/ren without notifying FAYS, and four reported that they did not make a formal notification of child abuse as they believed that one had already been made.

#### **4.1.8 Section 8: Comments**

Six key themes were identified in the nurses' written comments in this section. These were:

- More awareness/education is required for mental health staff regarding this area (e.g. child development, parenting, resources available, roles and responsibilities of other agencies).
- Resources are often not available within the MH team and the community to meet needs/reduce risks of families and children of parents with a mental illness.
- Roles and responsibilities regarding the care of children are not well defined within the MH team and are open to abuse (e.g. power is exercised by some members over others in determining if a case is one of neglect/abuse).
- Conflict is experienced by some nurses between their responsibility to maintain the therapeutic relationship with the client and their duty of care regarding children.
- Time limitations in the MH workplace affect the response nurses and other health professionals may make to parents/children, especially regarding preventive approaches.
- Legislative barriers (e.g. giving information to families where a client is incapable of giving consent) make it difficult to gain a full picture of what is happening.

## **5. Discussion and conclusions**

The responses by the adult mental health/psychiatric nurses in this study indicate that the vast majority clearly believe that part of their role involves discussing family and parenting concerns with clients and, if requested, talking with their clients' children about mental illness.

A number of barriers have been identified which prevent nurses fulfilling these roles, including lack of time, skills and knowledge, difficulties in collaborating with other agencies, poor knowledge of the resources available for children and families, and practical issues such as access to services for those in rural areas.

The confidentiality of client information was identified as a barrier to collaborating with other agencies regarding clients' parenting and family concerns. However, over 40 nurses had reservations about discussing parenting/family issues with another agency even when they had the client's permission to do so, and this needs to be investigated further.

Most nurses knew of community agencies they could refer clients to for support with family or parenting concerns but surprisingly the Child and Adolescent Mental Health Services (CAMHS) was the most frequently quoted external agency to which nurses referred clients and their partners for parenting and/or family issues. This requires further exploration as it may be that mental health/psychiatric nurses' training or the fragmentation of mental health services in South Australia leads adult mental health nurses to perceive clients' family and parenting issues predominantly within a mental health framework. Alternatively, they may perceive CAMHS as having the skills to relate well to parents with a mental illness. As CAMHS has heavy workloads and long waiting lists in South Australia for non-urgent cases, referrals to this agency may lead to increased frustration for families seeking advice and support that more 'generalist' child and family agencies could provide in a more timely and non-stigmatising manner.

Findings from the study confirmed the hypothesis that most nurses are aware of their statutory 'duty to protect' under the Children's Protection Act 1993, but that some do not make a formal notification when they have formed a belief that a child is at risk of abuse or neglect.

The most common reasons given for not formally reporting their concerns related to a lack of confidence in the child protection response by FAYS or a belief that child protection notification was the responsibility of a senior colleague or other mental health team member. These findings would appear to suggest that the relationship between the Child Protection and Mental Health systems in South Australia needs to be strengthened, with possible specific education, policy and practice implications regarding the needs of children of parents with a mental illness. Adult psychiatric teams and services would appear to need support to create a culture that takes family members and child protection issues into account. Team members may need to be empowered to exercise their duties of care toward their clients' dependent children.

This study found some evidence that psychiatric/mental health nurses grapple

with conflicts of interest when caring for their clients who have children. Information from both the survey results and focus groups indicates that there is some confusion between nurses' responsibility to act equally for the wellbeing of the client and their child/children, or solely put the client's or child's welfare above all else.

All focus group participants and many survey respondents were able to provide suggestions for service improvement in the area of services to parents and children affected by parental mental illness. It is vital that the voice of practitioners continues to be sought and considered in the development of education strategies, policies, protocols and inter-agency arrangements to improve outcomes for these families.

## Appendix 1 Questionnaire

### **Adult Mental Health Nurse Questionnaire Regarding beliefs and practices when nursing clients who are parents of children under 18**

**January, 2003**

#### PLEASE NOTE:

The researchers wish to acknowledge the sensitivity and complexity of this issue. We in no way wish to suggest or infer, that persons with a mental illness will automatically require assistance with parenting responsibilities.

Your responses to this questionnaire will remain confidential.

Please ensure you do not identify any client or their significant other/s, a colleague or your work site in your responses.

Throughout this survey document the term 'child/ren' refers to persons under 18 years of age and 'parenting' refers to care of this age group by the child's parent or other caregiver.

#### INSTRUCTIONS:

Please answer each question by ticking one box which best describes your situation.

## Section 1. Demographic information

- a. Please indicate your current workplace
- <sup>1</sup> Metropolitan Inpatient Adult Mental Health service
  - <sup>2</sup> Metropolitan Community Adult Mental Health service
  - <sup>3</sup> Country Inpatient Adult Mental Health service
  - <sup>4</sup> Country Community Adult Mental Health service
  - <sup>5</sup> I do not currently work in the adult mental health area

If you ticked one of the first 4 boxes above, please go directly to Section 2. If you ticked the last box, please answer the following question.

- b. Have you ever worked in a mental health setting (community or inpatient) with adults who are parents or caregivers of children?
- <sup>1</sup> No *If No, please complete ONLY Section 6 and 7*
  - <sup>2</sup> Yes

If Yes, how recently have you worked with clients who are parents or caregivers of children?

*Please tick one box*

- <sup>1</sup> Within the last 12 months
- <sup>2</sup> Not within the last 12 months but within the last 5 years
- <sup>3</sup> More than 5 years ago *If you tick this box, please complete ONLY Section 6 and 7*

## Section 2. Discussing parenting issues with clients

As a general rule, do the following statements accurately reflect your personal beliefs or, where indicated, those of your workplace.

1. I believe that it is part of my role as an adult mental health nurse to discuss the family situation of my client and I feel confident to do so  
<sup>1</sup> No  
<sup>2</sup> Yes
2. I believe it is part of my role as an adult mental health nurse to discuss the family situation of my client, but I feel ill equipped to do so  
<sup>1</sup> No  
<sup>2</sup> Yes
3. My workplace supports my role in discussing parenting/family issues with my clients  
<sup>1</sup> No  
<sup>2</sup> Yes
4. I have time to focus on parenting or family issues with my clients  
<sup>1</sup> No  
<sup>2</sup> Yes
5. The severity of the client's illness influences whether I discuss family or parenting issues with them  
<sup>1</sup> No  
<sup>2</sup> Yes
6. I do not discuss the client's children with them when I know their children have been removed from their care  
<sup>1</sup> No  
<sup>2</sup> Yes
7. I do not discuss the client's children if they are concerned that their children may be removed from their care  
<sup>1</sup> No  
<sup>2</sup> Yes
8. Please use this space to add any further comments.

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### Section 3. Talking with the client's child/ren about their parent/s mental illness

1. Has an adult client or their significant other/s ever asked you to talk to their child/ren about their mental illness?

- ☐<sup>1</sup> No *If No, please go directly to Section 4*  
☐<sup>2</sup> Yes *If Yes, what has been your response?*

- ☐<sup>1</sup> I have spoken with the child/ren and have felt confident to do so  
☐<sup>2</sup> I have spoken with the child/ren, but I felt ill equipped to do so  
☐<sup>3</sup> I've informed the client/their significant other/s that I don't believe it's my role to talk with their child/ren about their parent's mental illness, but

- ☐<sup>1</sup> I referred the client or their significant others/s on to another service/s  
*Please name the service/s*

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- ☐<sup>2</sup> I referred the client or their significant others/s on to another worker within the inpatient/community mental health team

- ☐<sup>3</sup> I have recommended or provided material resources (eg pamphlets, videos, books) to help the client (or significant others) explain the illness to the child/ren *Please name the resources that you have been found to be useful*

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2. If you have acted in a different way to the responses described above, please tell us how you have responded

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3. Are there any material resources or resource libraries currently available that you recommend for clients or their significant others to enable them to discuss their mental illness with their children? (eg something suitable for a certain age group or about a particular mental health issue)?

<sup>1</sup> No

<sup>2</sup> Yes (please state)

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4. Are there any material resources that you would like to see developed for clients or their significant others to enable them to discuss their mental illness with their children? (eg something suitable for a certain age group or about a particular mental health issue)?

<sup>1</sup> No

<sup>2</sup> Yes (please state)

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## Section 4. Referral to other agencies

1. Have you ever referred a client or their significant other/s to service/s to assist them with parenting or family issues?

⊗<sup>1</sup> No     *If No, please go directly to Section 5*

⊗<sup>2</sup> Yes     *If Yes, please indicate any service/s you have referred the client or significant other/s to*

*Please tick as many boxes as necessary*

⊗<sup>1</sup> Mental Health Resource Centre

⊗<sup>2</sup> Child Adolescent Mental Health Services (CAMHS)

⊗<sup>3</sup> Community Health Centre

⊗<sup>4</sup> Women's Health Centre

⊗<sup>5</sup> Migrant Health/Support Services

⊗<sup>6</sup> Aboriginal Health/Support Services

⊗<sup>7</sup> Non-Government Community services (eg Anglicare, Centacare)

⊗<sup>8</sup> Women's Shelter

⊗<sup>9</sup> Drug and Alcohol Service/s

⊗<sup>10</sup> Child, Adolescent, Family Health Services (CAFHS)

⊗<sup>11</sup> Other/s     *(please state)*

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## Section 5. Working with other agencies

As a general rule, do the following statements reflect your experience?

1. With client's permission, I feel comfortable discussing their parenting/family issues with other agencies

<sup>1</sup> No  
<sup>2</sup> Yes

2. With client's permission, I still have reservations about discussing their parenting/family issues with other agencies

<sup>1</sup> No  
<sup>2</sup> Yes

3. There are systems in place to help me work with other agencies to address family/parenting issues with the client

<sup>1</sup> No  
<sup>2</sup> Yes

4. I am aware of how or where to get the help the client needs to support them in their parenting role

<sup>1</sup> No  
<sup>2</sup> Yes

5. Pressures of time prevent me from working with other agencies regarding a client's family/parenting issues

<sup>1</sup> No  
<sup>2</sup> Yes

6. Have you experienced any major barriers when working with agencies to address these issues?

<sup>1</sup> No  
<sup>2</sup> Yes (please explain)

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## Section 6. Mandatory Notification

**NOTE:** This relates to certain people being obliged by law to notify Family and Youth Services (FAYS) if they suspect on reasonable grounds that a child/young person has been or is being abused or neglected, and the suspicion is formed in the course of the person's work

1. Are you aware that as a Registered Nurse (General, Psychiatric) or Midwife, you are a Mandated Notifier?

<sup>1</sup> ☐ No *If No, please go directly to Section 7*

<sup>2</sup> ☐ Yes

2. Where did you learn about being a Mandated Notifier?

<sup>1</sup> ☐ I was informed during orientation to my current or a previous position

<sup>2</sup> ☐ I was informed during a formal 'Mandated Notification' training session

<sup>3</sup> ☐ A senior staff member informed me

<sup>4</sup> ☐ I learnt about it through the media (eg press or television)

<sup>5</sup> ☐ The Nurses Board informed me

<sup>6</sup> ☐ A colleague informed me

<sup>7</sup> ☐ I learnt about it whilst I was studying to be a nurse

<sup>8</sup> ☐ Other *(please state)*

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## Section 7. Child abuse or neglect

1. Have you ever witnessed or heard from a client who is a parent/caregiver, something, which makes you believe that their child/ren under 18 is at risk of abuse or neglect?

<sup>1</sup> No *If No, please go directly to Section 8*

<sup>2</sup> Yes

If Yes, please indicate how often as a general rule this situation has arisen for you

<sup>1</sup> 1 or 2 times per year

<sup>2</sup> 3-5 times per year

<sup>3</sup> more than 5 times per year

What has been your response? *(Please tick as many boxes as necessary)*

<sup>1</sup> I reported it to Family and Youth Services (FAYS)

<sup>2</sup> I didn't report it because I was unhappy with the way they had dealt with a previous report a colleague or I had made

<sup>3</sup> I didn't report it because I didn't want it to affect my relationship with the client

<sup>4</sup> I didn't report it because I didn't think there was anything FAYS could do about the child's situation

<sup>5</sup> I didn't report it but asked another member of the mental health team to investigate further

<sup>6</sup> I didn't report it but I discussed the situation with a colleague or senior staff member and was advised not to do anything

<sup>7</sup> I didn't report it because I didn't know what to do

<sup>8</sup> I responded in a different way to those listed above *(please describe)*

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## Appendix 2 Information letter and consent form for questionnaire participants



FLINDERS UNIVERSITY  
ADELAIDE • AUSTRALIA

*School of Nursing and Midwifery  
Faculty of Health Sciences*

AICAFMHA



*promoting mental health for  
young Australians*

January 2003

Dear Colleague,

I hold the position of Lecturer in Mental

Health, in the School of Nursing and Midwifery at Flinders University.

I am undertaking research in conjunction with Mr Phil Robinson and Ms Elizabeth Fudge, from the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA).

**Please note:**

**The Nurses Board of South Australia have approved this mail out (on behalf of the researchers) to all Psychiatric / Mental Health Nurses presently registered on the South Australian roll. However the Nurses Board has no vested interest in this project what so ever. To protect your privacy, the researchers have not been privy to the mailing list that was used in this survey. Therefore your anonymity is assured.**

The purpose of this project is twofold:

Firstly, to gather information about your *beliefs and practices* regarding assisting your adult clients who are parents, to address parenting and family issues they may raise with you.

Secondly, a small part of this study will gather information about the *knowledge* you have and your *practices* related to that knowledge, to do with your statutory obligations regarding children under the age of 18.

I would be most grateful if you would volunteer to assist in this project, by completing the attached, anonymous questionnaire. **(Please be sure that you do not in any way, identify yourself, your workplace, a client or their family in any information you provide.)** It is anticipated that this questionnaire will take you approximately 20 minutes to complete.

A separate page asks whether you would also be willing to be a participant in a focus group at a later date, to explore the complexity of this issue in greater depth with other colleagues and the researchers. It is anticipated that these groups will take 1 hour. The project has funding to provide you with some remuneration for costs involved. The metropolitan venues for these are still to be determined. We also hope to conduct a focus group in Renmark and Port Augusta to canvas rural issues. It is anticipated that these groups will last up to 2 hours.

If you are willing to take part in a focus group, would you kindly complete the attached form and send it in the separate envelope. By doing this, we are unable to link your questionnaire with your contact details, therefore your anonymity is preserved.

These focus groups will be taped and the conversations transcribed and used in the preparation of a report of this project and for other publications. Be assured that all information you provide in the questionnaire and/or focus groups will be treated in the strictest confidence and no one will be individually identifiable in the resulting report or other publications. It will however, be necessary to make the recording available to several people for transcription. You may be assured that such persons will be advised of the requirements above and that the confidentiality of the material is respected and maintained.

**Please Note:**

**We have coded your envelope to enable the mailing house to cross check responses and we will send you one courtesy reminder with another questionnaire if we do not receive your reply within 3 weeks. This will just be a method of reminder. If you do not want to complete the questionnaire at all, please ignore this. Further, you are of course, entirely free to discontinue your participation at any time or to decline to answer particular questions.**

Any inquiries you may have concerning this project should be directed to me at the address below, or by telephone on 82013455, fax 82761602 or e-mail [jan.thompson@flinders.edu.au](mailto:jan.thompson@flinders.edu.au)

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 8201-3513, fax 8201-3756, and email [Lesley.Wyndram@flinders.edu.au](mailto:Lesley.Wyndram@flinders.edu.au).

Thank you very much for your contribution to this project.  
Yours sincerely,

*Ms Jan Thompson  
Lecturer in Mental Health  
School of Nursing and Midwifery  
Flinders University  
GPO Box 2100  
Adelaide 5001*

## Appendix 3 Information letter and registration form for focus group participation



FLINDERS UNIVERSITY  
ADELAIDE • AUSTRALIA

*School of Nursing and Midwifery  
Faculty of Health Sciences*

AICAFMHA



*promoting mental health for  
young Australians*

June, 2003

Dear

**Re: The Research Project:**

**Exploring the complex issues involved in nursing adult clients with a mental illness, who are also parents/carers of children under 18**

I have your name as a person interested in exploring the complexities of this issue via a focus group. We have been overwhelmed with the response to our request for focus group participants and at present have 70 people registered. Clearly this is an issue that many people are concerned about.

We have had some delays with the project for a number of reasons but are now able to give you some possible dates for workshops where we can discuss this issue further.

Due to this large number of interested people, it is not possible to run focus groups in the traditional sense of 5-8 participants per group as there will simply be too many to run and transcribing such a large number of 'voices' will be impossible. We have therefore decided to conduct 3 *workshop* sessions in metropolitan Adelaide & 1 in a regional centre (still to be negotiated), to enable broader discussion of the issues that impact upon your practice.

At these sessions, we plan to provide you with an overview of the key issues identified in the data from the questionnaires and then explore in detail, the more complex concerns you have, that were not addressed in the questionnaire format.

We would like to make these sessions informal but also productive, in terms of generating recommendations and strategies from you that can inform our report.

As a result of the large numbers of interested participants, we have decided to use the small amount of money that we had budgeted for remuneration for attendance, to provide all participants with tea, coffee, sandwiches & pastries instead.

**These sessions will be held at Glenside Hospital in  
The Nursing Education & Research Unit**

**The proposed dates are:**

**Thursday, June 26<sup>th</sup>**

**Time: 10-12.00pm with refreshments provided**

**Thursday, July 3<sup>rd</sup>**

**Time: 4 – 6pm with refreshments provided**

**Monday, July 7<sup>th</sup>**

**Time: 10-12pm with refreshments provided**

We believe it would be difficult to run these workshops with more than 25 people, so we are asking you to register your interest **in one of these sessions** by returning the attachment in the pre-paid envelope and **we will register you on a first come first served basis.**

If the workshop you choose has reached 25 participants, we will contact you by telephone or e-mail so you can choose another time if possible.

Thank you for your continuing interest in this project and I look forward to seeing you at one of these sessions.

Regards,

Jan Thompson  
And on behalf of Elizabeth Fudge

## **Appendix 4 Focus group form for questionnaire participants**

### **ARE YOU WILLING TO BE PART OF A FOCUS GROUP?**

**If you are willing to take part in a focus group to discuss the complexity of these issues further, please fill in your contact details below, and *place this completed form in the separate envelope.***

**Enclose this separate envelope, with your completed questionnaire, in the reply paid envelope provided and return them both to:**

Jan Thompson  
School of Nursing & Midwifery  
Flinders University of South Australia  
GPO Box 2100  
ADELAIDE SA 5001

**Yes, I am willing to be a participant in a small focus group to discuss these issues further.**

Name: \_\_\_\_\_

Contact Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Most Suitable Contact Number: \_\_\_\_\_  
\_\_\_\_\_

**Thankyou very much for your assistance.**

Philip Robinson, Chair, Board of  
Directors,  
Elizabeth Fudge, Project Manager,  
AICAFMHA

Jan Thompson,  
Lecturer in Mental Health Nursing, School  
of Nursing & Midwifery Flinders  
University of South Australia

## Appendix 5 Consent form to participate in a focus group

### CONSENT FORM TO TAKE PART IN A FOCUS GROUP INTERVIEW

I .....being over the age of 18 years, hereby consent to participate in a focus group for the research project:

#### **Addressing the needs of Children of Parents with a Mental Illness – an Adult Mental Health Service Approach**

The aims of this focus group are to:

Gather information about my *beliefs and practices* regarding assisting my adult clients who are parents, to address parenting and family issues and to gather information about my knowledge and *practices related to that knowledge*, to do with my statutory obligations regarding children under the age of 18. I understand the focus group will explore the complexities of these issues as they relate to the adult Inpatient and Community Psychiatric setting in South Australia.

**To avoid the potential for illegal acts to be cited, such as not reporting a concern for a child/children, I have been cautioned about making any statement that will identify myself, my workplace, clients and/or their families.**

1. I have read the Information Letter provided.
2. Details of procedures and any risks have been explained to my satisfaction.
3. I agree to my information and participation being recorded on audio tape.
4. I am aware that I should retain a copy of the Information Letter and Consent Form for future reference.
5. I understand that:
  - I may not directly benefit from taking part in this research.
  - I am free to withdraw from the project at any time and am free to decline to answer particular questions.
  - While the information gained in this study will be published as explained, I will not be identified in any way and individual information will remain confidential.

**Participant's signature..... Date.....**

I certify that I have explained the study to the volunteer and consider that she/he understands what is involved and freely consents to participation.

**Researcher's signature..... Date.....**

*NB. Two signed copies should be obtained.*

6. *I, the participant whose signature appears below, have read a transcript of my participation and agree to its use by the researcher as explained.*

**Participant's signature..... Date.....**

## Appendix 6 Reminder letter re questionnaire



FLINDERS UNIVERSITY  
ADELAIDE • AUSTRALIA

*School of Nursing and Midwifery  
Faculty of Health Sciences*

AICAFMHA



*promoting mental health for  
young Australians*

March 2003

Dear Colleague,

In January 2003, we posted a questionnaire to you entitled:

**“Beliefs and practices when nursing clients who are parents of children under 18”**

It would appear by the responses so far, that this is an extremely complex issue which has touched the lives of many registered psychiatric / mental health nurses’ at some time in their career.

As I have not yet received a reply from you, (based on cross checking the coded reply paid envelopes) I am sending you this reminder, in case you would still like to take the opportunity to have your say about this issue. If this is the case, please return this questionnaire by **MONDAY, MARCH 31<sup>st</sup>**.

You are of course under no obligation to take part in this survey at all and this will be the last reminder notice sent. I do apologise if you have already returned your questionnaire, but some were returned in non-coded envelopes and therefore the mailing house was unable to cross-reference them within their coding system.

Please be assured that the researchers have still not been privy to the original mailing list and so I have no way of connecting your personal details to your coded envelope.

Kind Regards,

Jan Thompson  
(On behalf of the researchers)

## **Appendix 7 Letter to country participants re focus groups**

Research Topic: Adult Mental Health Nurses' Beliefs and Practices When Nursing Clients Who Are Parents of Children Under 18

Dear

Thankyou for your expression of interest in being involved in a focus group to explore issues relating to children and others in families affected by parental mental illness. As a follow-up to a questionnaire circulated earlier this year, three focus groups have been held in the Adelaide metropolitan area but we did not receive sufficient expressions of interest from rural based mental health nurses to hold a further session in the country.

We believe, however, that your input would add great value to the study we are conducting. Could you therefore please consider some options for providing further information that are listed on the attached form and indicate if one would suit you (*place a tick in the box which corresponds to your response*). We would appreciate it if you could return the form to Jan Thompson e-mail/mail before the end of July.

**My contact details are [jan.thompson@flinders.edu.au](mailto:jan.thompson@flinders.edu.au)**

**Work telephone: (08) 82013455**

Yours sincerely

Jan Thompson

on behalf of the researchers Jan Thompson (Flinders University of South Australia), Elizabeth Fudge and Phil Robinson (Australian Infant Child Adolescent and Family Mental Health Association).

Research Topic: Adult Mental Health Nurses' Beliefs and Practices When Nursing Clients Who Are Parents of Children Under 18  
Country Based Participants – Follow-up interviews

Name (Please print clearly): .....

E-mail address (if applicable): .....

Postal

address:.....

I would like to be interviewed by one of the researchers by telephone. Please call me on (08) .....(phone number). The best time of day to call me is.....

*[NB: The cost of the phone call will be met by the researchers]*

I would like to receive some further questions and then dictate my comments onto a 'Dictaphone' and

I have a 'Dictaphone' that takes mini-cassettes OR

I will need to borrow a 'Dictaphone' and I will return it by mail within a fortnight of receipt; please send it to me at the following address .....

.....

I do not wish to participate in further research/interviews regarding this topic.

Please return this form in the stamp addressed envelope enclosed **before the end of July 2003.**

*Thankyou again, from Jan Thompson (Flinders University of South Australia),  
Elizabeth Fudge and Phil Robinson (Australian Infant Child Adolescent and  
Family Mental Health Association).*

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