"Family Focus": An evaluation of an e-learning resource for professionals working

with families where a parent has a mental illness.

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One in five Australians will have a mental illness during adulthood and just over 20 percent of children grow up in households where a parent has a mental illness including anxiety and/or depression (Maybery *et al,* 2009). Such children have higher risks of mental health problems compared to children who do not have a parent or parents with a mental illness, on the basis of genetic and environmental factors (Franic *et al,* 2010; Vreeburg *et al,* 2010). This literature review will first examine the general issues for children whose parents have a mental illness, then specifically present studies focusing on parental anxiety and/or depression and its impact on children. It will then examine the resources currently available to families affected by parental mental illness (FAPMI), especially those related to anxiety and depression. The theories of working systemically as well as workforce barriers pertaining to working with FAPMI will be examined, followed by a discussion on the tailored training programs available to mental health professionals working with this client group. Finally, this review will lead into a discussion of the development of a new Australian e-resource "Family Focus", a specialised program in this area.

Parental mental illness and its effect on children

Mental illness affects a large number of Australians, many of whom have children. In 1993, a three-year study revealed that across Australia, 27,000 children were living with a parent who had a serious mental illness such as schizophrenia, psychosis or bipolar disorder (Ladd, 2007). Another study found that 23% of families consisted of a parent with a mental illness and approximately 60, 000 children were living with a parent diagnosed with a severe mental illness (Maybery *et al*., 2009). It is well established that many children living with a parent who has a mental illness are at greater risk of receiving low levels of physical care and

supervision compared to their same age peers, moreover these children may take on greater responsibilities and tasks in caring for their parent/s and/or siblings (Aldridge, 2006; Aldridge & Becker, 2003; Cowling, 1999; Ladd, 2007).

A number of studies have been conducted reporting on the physical and psychological impact of parental mental illness on children. Macfie and Swan (2009) interviewed children who have a mother with bipolar personality disorder and found that compared to other children, these children demonstrate more parent-child role reversal, fear of abandonment, negative expectations of both parents, shameful representations of the self, confusion of boundaries between fantasy and reality, less narrative coherence and more traumatic themes was observed in the children's story telling. Research in this area also suggests that having a parent with a mental illness puts children at increased risk of developing a mental illness themselves, on both genetic and environmental grounds (Harold *et al*., 2011). Young "caregivers" of parents with a mental illness often experience developmental issues, academic problems, social, emotional and psychological problems (Mechling, 2011) and they might assume greater responsibilities in the home than children who do not have a parent with a mental illness such as paying bills, shopping, cooking and taking care of younger siblings (Ladd, 2007).

There is however, research to suggest that children are not *necessarily* at increased risk of physical and/or psychological harm when living with a parent who has a mental illness and that in some cases, children develop personal attributes such as greater resilience and independence. Maunu and Stein (2010) found that nine young adults who have a parent with a mental illness reported positive experiences and positive personal outcomes as a result of having a parent with a mental illness.

Positive outcomes commonly included reports of personal strength, independence and compassion. The young adults also reported feelings of grief around their parent's mental illness and confusion around their faith and spirituality. Grant et al., (2009) as well as Cowling (1999) similarly found that children report both positive and negative impacts as a result of specifically becoming "carers" for their parent/s with a mental illness. Positive impacts included feelings of closeness between the child and parent and feelings of self-worth for the child due to some level of dependency the parent displays for the child. Thus having a parent with a mental illness does not necessarily implicate adverse impacts for children.

Parental depression and anxiety and the experience of and risk factors to children

Although it is not always the case, depression can render parents emotionally and physically unavailable to their children and anxiety can cause parents to be over-involved and over protective (Aldridge, 2006; Cowling, 1999). Both mood disorders in parents might affect children's level of self-efficacy, and adversely impact on their interpersonal relationships and cognitive development. These children sometimes assume onerous caring responsibilities, and tend to negotiate their parents' affect/mood states (Aldridge & Becker, 2003). Kaimal and Beardslee (2010) examined the qualitative changes in adolescents' experiences of their parent's depression from ages seventeen to nineteen years. They observed that over time, emerging adults from low adversity families i.e. families not affected by complex needs such as homelessness, tended to shift their mindset regarding their parent's depression from a self-oriented perspective to an other-oriented perspective. This was a positive finding indicating that as emerging adults became more independent

in their lives i.e. entered university or work-life and spent more time away from the home environment, they began to separate their parent's mood states from their parent as a whole and think about their parent's depression differently. For young children, as opposed to emerging adolescents, their home environment is essentially their whole world, where they spend most of their time in the company of their parents and family members, they have less exposure to other adults and people their own age. Therefore, they are more vulnerable to the cognitive and behavioural patterns of their parents than young adults.

Parental depression and/or anxiety can affect children through genetic heritability as well as environmental exposure. Beardslee *et al,* (2011) discussed multiple factors contributing to depression in children and young adults who have a parent with a mental illness which included but was not limited to a history of parental depression, availability of the other parent who does not have anxiety and/or depression, the temperament of the child, dysfunctional neuroregulatory mechanisms such as brain asymmetry, cortical activity and cortical thinning in the right hemisphere of the brain, less activity in reward/loss processing in the brain, sleep disturbances, birth weight, early menarche, parenting style and cognitive behaviours/patterns, the child's attachment style, and exposure to stressful or traumatic life events. More specifically, heightened "awakening response" of the hypothalamic-pituitary-adrenal (HPA) axis is often associated with depression and anxiety in individuals and this type of response has been shown to exist even in "unaffected" children of individuals with depression and/or anxiety (Vreeburg *et al,* 2010).

There is some evidence to suggest that child temperament can influence the

degree of sensitivity a child has to their parent's depression and/or anxiety i.e. to their cognitive schemas/patterns of thinking, thus rendering children with certain temperaments more or less vulnerable to developing emotional problems (Kiff *et al,* 2011). Accordingly, a combination of genetic risk factors as well as exposure to negative cognitive patterns, with-drawl and emotional instability from one or more parents experiencing depression and/or anxiety, puts children at increased risk of developing emotional problems themselves, when compared to other children in the community who do not have a parent with depression and/or anxiety (Aldridge, 2006).

A "family sensitive approach" for supporting parents and their children

Given the environmental impact of parental depression/anxiety on children, Franic *et al.,* (2010) suggested that a family sensitive approach involving immediate (and at times extended) family, including children, be adopted to impede the transmission of negative behaviours and cognitive patterns and to increase protective factors within families. We know that children who have and/or live with a parent and/or parents with a mental illness are at risk of developing mental illness themselves, through environmental and genetic factors, yet children and family members can be supported to change their cognitive patterns, beliefs and functioning when provided with positive support and assistance (Beardslee *et al,* 2011; Reupert & Maybery, 2010). Support might include being exposed to age appropriate information around mental illness, its general course, symptoms and the impact of the parent's mental illness on the whole family (Beardslee *et al,* 2011).

Programs for families where a parent has a mental illness

There are various intervention points for families where a parent has a mental illness including the parent, the children and the extended family. Various programs with documented and varying success will be discussed further and fall under one or more of these three intervention points.

"Family sensitive" programs specifically tailored to parents who have a mental illness

Parenting programs have provided evidence-based, preventative outcomes for children of parents with a mental illness such as depression and/or anxiety (Reupert & Maybery, 2011). Most parenting programs work with parents of pre-school to middle-school aged children encouraging parents to be non-critical of their children, to spend time with their children, engage in positive activities and to provide consistent discipline within the family environment (Beardslee *et al,* 2011; Reupert & Maybery, 2011). These programs have been effective through providing parents with social and emotional skills and a support network and, they inadvertently provide the children of parents with a mental illness with an environment that encourages support and skill development for the child's own healthy affect regulation (Beardslee *et al,* 2011).

"Let's Talk about the children" (LT) is a program entailing a brief psycho-educational discussion with parents on children's psychosocial symptoms and prosocial behaviour in families with parental mood disorder (Solantaus *et al*, 2010). Parent/s and or partners are provided with information about how to communicate to their child/ren about their mental illness or their partner's mental illness and how to

support their child in the family context. The parent or parents are provided with a self-help guide called "How can I help my children, a guide book for parents with mental health problems" and an information booklet about depression. There is also a referral process whereby the family is assisted to access child psychiatric or social services if there is a need for further service involvement (Solantaus *et al,* 2010). Whilst the program is family sensitive it does not involve children directly in therapy/sessions; instead it focuses on the parent to support his or her children. The program is a component/adaptation of another family sensitive program, which includes a larger number of sessions and involves children in the process, titled "Family Talk Intervention" (FTI) which will be discussed later in this review.

Programs specifically tailored to children of parents with a mental illness

Reupert and Maybery (2009) qualitatively examined Australian programs working with children who have a parent with a mental illness and found that most facilitate peer interaction for the child, enhance coping, self-esteem, education and understanding of mental illness. Reupert and Maybery (2009) also established that programs often offer respite to children from caring responsibilities. Another study established that health professionals see education for children around the signs, symptoms and treatments of their parents as highly important (Reupert & Mayberry, 2010). In families where a parent has depression, psycho-education for the children around mood states and symptoms has been proven to have strong outcomes for children who are subsequently able to begin to identify and dissociate themselves from their parent's mental illness, affect states and behaviours (Beardslee *et al,* 2011; Reupert & Maybery, 2010).

Reupert and Maybery (2010) interviewed program facilitators working with children who have a parent with a mental illness. They observed that fifteen of eighteen facilitators interviewed, delivered psycho-education to children consisting of signs, symptoms and treatments of various mental illnesses. The theory underlying this, according to facilitators, was that "knowledge" was perceived to increase "power" in children who have a parent with a mental illness. Reupert and Maybery (2010) also observed that program facilitation and delivery usually occurred in small groups, and often age-appropriate information was given to children of different ages and stages, and specific to families/groups. Aldridge and Becker (2003) also reported that age appropriate information positively assists children and can serve as a protective factor for children who have a parent with a mental illness. Such research indicated that with age appropriate information, children are supported to understand their parent's mental illness and this can be a protective factor against the risks associated with having a parent who has a mental illness.

Programs specifically tailored to families affected by parental mental illness (FAPMI)

The "Family Talk Intervention" (FTI) is a program specifically targeted towards families affected by parental depression (Beardslee *et al,* 1997; Beardslee *et al,* 2003; Kaimal & Beardslee, 2010; Solantaus *et al,* 2010). It was developed by Dr William Beardslee based out of the Childrens' Hospital Psychiatry Faculty in Boston, and is available to families and clinicians at the Families Preventing and Overcoming Depression website www.fampod.org. "Family Talk" aims to educate parents on minimizing the psychosocial risk to their children through understanding

the impact parental depression can have on children, increasing positive activities between parents and their children and increasing knowledge and understanding of mental illness for the whole family (Beardslee *et al.,* 2003; Kaimal & Beardslee, 2010). It adopts a family-based approach and a major focus on the most high-risk age group of children who have a parent or parents with depression, adolescents (Beardslee *et al,* 2003). In essence, the programs consists of two parent sessions covering a family history and psycho-education around depression and resilience, and a child session with each child after the initial two sessions plus follow-up (Solantaus *et al,* 2010). The children's situation within the family context is "mapped" out and a planning session is conducted where parents learn to communicate about their mental illness to their child or children. In the family session, the parents respond to their children's questions and provide their children with information about their mental illness. The intervention is reviewed and plans are made for the future in a follow-up session. There are six sessions in total for a parent or parents with one child and more sessions for parent/s who have more than one child (Solantaus *et al,* 2010). As with the "Let's Talk" program discussed earlier, families are provided with a guide-book and information booklet about depression.

A longitudinal study into the effectiveness of the "Family Talk Intervention" is being conducted and preliminary results into effectiveness of the program with families affected by parental depression are yielding significantly positive results for the entire family (Beardslee *et al,* 2003; Beardslee *et al,* 2008). In addition, "Let's Talk" and "Family Talk" were compared in a randomized split sample of families with a parent with a mood disorder and both were found to be effective in decreasing

children's emotional symptoms, anxiety, hyperactivity and prosocial behaviour (Solantaus *et al,* 2010). "Family Talk" has been adapted for the Australian context and as a training program to mental health professionals working with FAPMI specifically those affected by depression and/or anxiety by the National Children of Parents with a Mental Illness (COPMI) Initiative www.copmi.net.au and renamed "Family Focus". It is currently in pilot mode and being evaluated by mental health care professionals in a research project conducted by Dr Andrea Reupert, Daryl Maybery, Titania Henderson and members from the National COPMI Initiative.

Research outcomes of parent-focused, child-focused and family-focused programs

There is a range of programs available within the community for families affected by parental mental illness including depression and anxiety. Siegenthaler *et al* (2012) conducted a meta-analysis reviewing programs targeting families where a parent had one or more of various disorders including depression, anxiety and alcohol and drug dependence disorder. The analysis, which involved a search of The Cochranem MEDLINE, EMBASE, and PsychINFO databases for randomised controlled trials of intervention programs, involved thirteen trials conducted with one thousand four hundred and ninety children. Seigenthaler *et al's* (2012) study concluded, "…interventions to prevent mental disorders and psychological symptoms in the offspring of parents with mental disorders appear to be effective…(p.12)". Significantly, across the thirteen trials it was found that interventions reduced internalising symptoms in children and "The risk of developing the same mental illness as the parent was decreased by 40%...(p.14)." Interventions examined in Seigenthaler *et al's* (2012) meta-analysis included

individual, group and family interventions using cognitive, behavioural and psycho-educational approaches. Given the value of a family sensitive approach, it is crucial that the mental health workforce is adequately trained to identify and respond to the needs of families where a parent has depression and/or anxiety and that specifically tailored, up-to-date programs are available to professionals for implementation with this client group.

The need for a "collaborative" approach to service provision

The idea of professionals and allied health working "collaboratively" with one another and with the entire family unit affected by mental illness has become highly regarded and reported on in the research literature concerning service provision of this client population (Clark & Smith, 2009). Clark and Smith (2009) suggested that children who have a parent with a mental illness benefit from a "collaborative" approach being made by invested agencies where support is holistic and consistent across agencies and individual professionals. Van de Ende *et al*, (2010) designed a support program for parents who have a mental illness titled "Parenting with Success and Satisfaction". This program focused on a range of areas such as empowerment for the parent and encouragement for the parent to link in with their social network such as grandparents and extended family members. The authors argue that when stakeholders take a consistent attitude to service provision, programs such as this can have greater outcomes for families due to consistent messages being sent to families affected by parental mental illness including depression and anxiety.

Similarly, Viadair et al.'s (2010) study highlighted the importance of screening parents when their children receive a psychiatric evaluation. The findings

support mental health services addressing the psychiatric needs of the entire family within one clinical setting taking into account the risk factors to family members. If this was a consistent service provision across multiple settings, all family members, even those who are minimally affected or not affected at all by mental illness in the family, would be likely to receive more adequate support in living with a person with mental illness and/or the risk factors they might experience.

Workforce barriers identified by mental health professionals working with FAPMI

Several studies have identified workforce deficits in being able to identify and effectively respond to the needs of parents who have a mental illness, and their dependent children (Byrne *et al,* 2000; Dean & MacMillan, 2001; Korhonen *et al,* 2008; Maybery & Reupert, 2006; Maybery & Reupert, 2009; Reupert *et al,* 2011; Wynaden & Orb, 2005). Currently mental health professionals working with adult populations receive little training or guidance *specifically* regarding assessment and support of FAPMI (Diaz & Johnson, 2004). Many studies have aimed to identify barriers for mental health workers whose main consort is FAPMI and common hurdles for health professionals as has been observed through a number of studies include (1) denial of clients who are parents that they have a mental illness (Maybery & Reupert, 2006) (2) denial of clients who are parents that their mental illness adversely affects their children (Maybery & Reupert, 2006) (3) organizational structure and role constraints (Dean & MacMillan, 2001) (4) poor communication between agencies and a shortage of resources (Byrne et al., 2000) (5) deficits in knowledge and skills in working with children as well as the developmental stages of children and how they may be impacted upon at different stages of life (Maybery

et al., 2006).

Maybery *et al's* (2006) study indicated via feedback from mental health workers that deficit areas in training programs available to clinicians working with FAPMI are (1) assessment of parenting capacity (2) providing parenting advice and (3) the ability to discuss with clients the impact of parental mental illness on children empathically. In addition, they observed that Australian adult mental health clinicians report clear knowledge and skill limitations when working with clients on parenting issues, and with their client's children, though indicate a willingness to work in a family sensitive manner (Maybery & Reupert, 2006) a finding replicated in a study with Finnish psychiatric nurses (Korhonen *et al*., 2008). Some clinicians report a reluctance to work on child related issues with parent-clients due to concerns that this will disrupt the therapeutic alliance they have with their parent-client (Maybery & Reupert, 2009) and/or they perceive that involving other family members in therapy may raise client confidentiality issues (Wynaden & Orb, 2005). Mental health professionals working with FAPMI indicate clear barriers and require specialised training programs to assist them in their work with this client group.

Gaps in the service provision exampled by research conducted into the specific needs of parent-clients with mental illness from service providers, have revealed that those clients require greater availability of workers, practical and emotional support regarding parenting, support groups, childcare facilities at mental health service premises and dedicated space in hospitals for women to receive visits from their children (Diaz & Johnson, 2004) when or if they become hospitalized. These findings are consistent with those obtained in research with mental health workers (Reupert *et al,* 2011) indicating that there are clear gaps in service provision

outlined by FAPMI as well as mental health care professionals.

Outcomes of research into workforce and FAPMI barriers in service provision

The research literature indicates that training for professionals working with parents who experience mental illness needs to provide mental health care professionals with:

- Understanding of the effects and fluctuating course of mental illness (Diaz & Johnson, 2004)

- Understanding a client's mental illness in the context of the individual's self concept, parenting style and family context (Reupert & Maybery, 2011)

- Understanding of the professionals own attitudes towards parental mental illness and how this may affect the client's service provision (Diaz & Johnson, 2004)

- Knowledge of how to create readily available respite and ability to do so for parents who have a mental illness (Diaz & Johnson, 2004)

- Skills to assist professionals in educating parents about their mental illness and its effect on children (Maybery & Reupert, 2006)

- Understanding of how to assess parenting capacity and to give advice where appropriate (Maybery & Reupert, 2006)

- Understanding of children's developmental stages and appropriate information for each age group (Maybery & Reupert, 2006)

  Training requirements as indicated by mental health professionals working with FAPMI and by parents who experience mental illness themselves have begun to be implemented into training programs developing this specialized area of mental health support for families.

Specifically tailored training for mental health professionals working with FAPMI

With the prevalence of internet usage in the workforce, the need for ongoing professional development for workers, and the prevalence of workers based rurally in the community, there is a demand for up-to-date e-resources that are easily accessed by workers either through their work place or in their personal time. There are few documented training programs specifically tailored to mental health professionals working with families affected by mental illness. In 1999, a program entitled the "Koping Program", was developed by the Child and Youth Mental Health Service (CYMHS) of the Royal Children's Hospital, Queensland, aimed at enhancing service provision for parents who have a mental illness and their children (Morson *et al.,* 2009). It was reviewed according to eight national Children of Parents with a Mental Illness (COPMI) action areas: promoting wellbeing and reducing risk, support for children and families, addressing grief and loss issues, access to information, education and decision-making, care and protection of children, partnerships and cross-agency processes, workforce development and workforce reorientation. Research and evaluation outcomes concluded that it was a valuable resource for mental health workers.

"Keeping families and children in mind" is a web-based training program designed for mental health professionals working with FAPMI especially those families affected by parental depression and anxiety. The program is currently available through the National COPMI (Children of Parents with a Mental Illness) Initiative website www.copmi.org and aims to increase knowledge, confidence and skill level of professionals working with this client group and to assist facilitation of

a family sensitive approach in their practice. Reupert *et al.,* (2011) evaluated the web-based workforce resource "Keeping families and children in mind" and reported a "tentative" increase in practitioners' knowledge, confidence and skill level when working with families affected by parental depression and anxiety. The evaluation study examined the training program by including onsite workshops conducted by facilitators. Participants in the study consort were from a range of services including child and adolescent and adult mental-health agencies, nongovernment agencies and hospitals, and from disciplines including psychiatry, social work, education and consumer and carer groups (Reupert *et al.,* 2011). According to facilitators, family videos were a powerful aspect of the resource and were perceived as being an effective way to encourage participant discussion and reflection. Problems that were experienced with the resource centred primarily on facilitators' own facilitation skills (time management, co-facilitating, providing too much information, not outlining learning objectives) rather than the resource per se, which was well-received, and which yielded positive research outcomes for mental health professionals.

"Family Focus": an e-learning resource aimed at mental health professionals

"Family Focus" is a new COPMI e-learning resource developed by the Australian Infant Child Adolescent and Family Mental Health Association with funding from the Australian Government Department of Health and Ageing under the COAG New Early Intervention Services for Parents, Children and Young People measure. As discussed earlier, "Family Focus" is an Australian adaption of "Family Talk" an American e-resource developed by Dr William Beardslee at the Childrens' Hospital Psychiatry Faculty Boston, which has proven effectiveness for families

affected by parental depression (Beardslee *et al*, 2008; Solantaus *et al*, 2010). The e-learning tool has been developed according to the research literature on the success of family sensitive approaches when working with parents who experience depression and anxiety specifically, and according to the success of related programs such as "Family Talk" and the "Koping Program". The difference between these programs however, is that "Family Focus" is targeted at mental health professionals rather than families and supports workers to work with families, it is a professional development resource. "Family Focus" aims to increase knowledge, confidence and skill level of mental health professionals using the theories and resources in "Family Talk" which, in turn will hopefully improve outcomes for families yielding similar positive findings compared to "Family Talk".

As indicated through this literature review, there is a limited range of professional development programs for mental health workers who work with FAPMI as well as programs targeted at parents who have a mental illness and/or their children. All methods aiming to improve outcomes for FAPMI have indicated positive outcomes as well as a need for further development. In particular, the research literature indicates that there is a lack of documented specialized e-learning training programs for mental health professionals working with families affected by parental mental illness, particularly those affected by depression and/or anxiety. Mental health professionals, particularly those who are based rurally or those who work from home, require specialized e-learning professional development courses in order to continue to provide the most effective, evidence-based practice they can to their clients/patients.

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"Family Focus": An evaluation of an e-learning resource for professionals working

with families where a parent has anxiety and/or depression.

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ABSTRACT

One in five Australians will have a mental illness during adulthood with just over 20 percent of children growing up in households where a parent has a mental illness including anxiety and/or depression. This study describes and presents preliminary evaluation data regarding a web based training resource "Family Focus" designed to assist clinicians who work with families where a parent has depression and/or anxiety. Evaluation data were collected using pre and post training questionnaires (using the "Family Focused Mental Health Practice" Questionnaire) as well as one-to-one telephone interviews to ascertain potential changes in knowledge, confidence and practice. Questionnaires were analysed using paired-sample t-tests, while a thematic analysis was conducted on the interview data. The findings demonstrated improvements in clinicians' knowledge, confidence and skill after training.

Key words: family focus, resource, parental mental illness, web based workforce training, children, families, evaluation, COPMI, FAPMI, depression, anxiety

INTRODUCTION

Mental illness affects a large number of Australians, many of whom have children. In 1993, a three-year study revealed that across Australia, 27,000 children were living with a parent who had a serious mental illness such as schizophrenia, psychosis or bipolar disorder (Ladd, 2007). Another study found that 23% of families consisted of a parent with a mental illness and approximately 60, 000 children were living with a parent diagnosed with a severe mental illness (Maybery *et al*., 2009). Many children living with a parent or parents who have a mental illness, including a variety of diagnoses, are at greater risk of receiving low levels of physical care and supervision compared to their same age peers who do not have a parent with a mental illness (Ladd, 2007). Moreover these children may take on greater responsibilities in caring for their parent/s and/or siblings (Aldridge, 2006; Aldridge & Becker, 2003; Cowling, 1999). Mental health clinicians working with parents and families affected by parental mental illness (FAPMI), require a range of additional skills for working with this client population. Accordingly, the present study describes and evaluates a web-based training resource "Family Focus" that aims to provide training to mental health clinicians working in primary health care settings with FAPMI, specifically those families affected by parental depression and anxiety.

A number of studies have been conducted reporting on the physical and psychological impact on children who have a parent with a mental illness including anxiety and/or depression (Aldridge, 2006; Aldrige & Becker, 2003; Cowling, 1999, Ladd, 2007, Maybery *et al,* 2009). Although it is not always the case, depression can render parents emotionally and physically unavailable to their children and anxiety

can cause parents to be over-involved and over protective (Aldridge, 2006; Cowling, 1999) negatively affecting children's self-efficacy, interpersonal relationships and cognitive development as well as the demands placed on them, such as caring for their parents or negotiating their parents affect/mood states (Aldridge & Becker, 2003; Macfie & Swan, 2009). Research in this area also suggests that having a parent with a mental illness puts children at increased risk of developing a mental illness themselves, on both genetic and environmental grounds (Harold *et al*., 2011). Young caregivers of parents with a mental illness often experience developmental issues, academic problems, social, emotional and psychological problems (Mechling, 2011) and they might assume greater responsibilities in the home such as paying bills, shopping, cooking and taking care of younger siblings (Ladd, 2007).

Several studies have identified workforce deficits in being able to identify and effectively respond to the needs of parents who have a mental illness, and their dependent children (Diaz & Johnson, 2004; Korhonen *et al,* 2008; Maybery & Reupert, 2006; Maybery & Reupert, 2009; Reupert & Maybery, 2011; Wynaden & Orb, 2005). For example, Australian adult mental health clinicians report clear knowledge and skill limitations when working with clients on parenting issues, and with their client's children, though indicate a willingness to work in a family sensitive manner (Maybery & Reupert, 2006) a finding replicated in a study with Finnish psychiatric nurses (Korhonen *et al*., 2008). Some clinicians report a reluctance to work on child related issues because of concerns that this will disrupt the therapeutic alliance they have with their parent-client (Maybery & Reupert, 2009) and/or may compromise client confidentiality issues (Wynaden & Orb, 2005).

Nonetheless, a family sensitive approach is an effective early intervention

approach that has the potential to impede the transmission of mental illness in families (Franic *et al,* 2010). A recent meta-analysis reviewed programs targeting families where a parent had one or more of various disorders including depression, anxiety and alcohol and drug dependence disorder (Siegenthaler *et al,* 2012). The analysis, involving 13 trials conducted with almost 1500 children concluded, "…interventions to prevent mental disorders and psychological symptoms in the offspring of parents with mental disorders appear to be effective" (Siegenthaler *et al,* 2012, p.12). Significantly, across the 13 trials it was found that interventions reduced internalising symptoms in children and "The risk of developing the same mental illness as the parent was decreased by 40%..."(p.14). Given the value of a family sensitive approach, it is crucial that the mental health workforce is adequately trained to identify and respond to the needs of families where a parent has depression and/or anxiety. It is within this context that the resource "Family Focus" was developed.

The research literature indicates that training for professionals working with parents who experience mental illness needs to provide mental health care professionals with understanding of the effects and fluctuating course of mental illness (Diaz & Johnson, 2004), understanding a client's mental illness in the context of the individual's self concept, parenting style and family context (Reupert & Maybery, 2011), understanding of professionals' own attitudes towards parental mental illness and how this may affect the client's service provision (Diaz & Johnson, 2004), knowledge of how to create readily available respite and ability to do so for parents who have a mental illness (Diaz & Johnson, 2004), skills to assist professionals in educating parents about their mental illness and its effect on

children (Maybery & Reupert, 2006), understanding of how to assess parenting capacity and to give advice where appropriate (Maybery & Reupert, 2006), and understanding of the developmental stages of children and appropriate information for each age group (Maybery & Reupert, 2006). Collectively this research and evaluation trials of other training programs contributed to the development of a new online training program for mental health professionals working with FAPMI entitled "Family Focus", especially those effected by parental depression and/or anxiety.

"Family Focus" was created by the National Children Of Parents with a Mental Illness (COPMI) Initiative, a not-for-profit organisation funded by the Australian Government consisting of a small team employed by AICAFMHA (the Australian Infant, Child, Adolescent & Family Mental Health Association). The e-learning resource supports clinicians to gain knowledge and develop specialised intervention skills to effectively identify and work with children and families where a parent is living with depression and/or anxiety. The resource is based on the "Family Talk" intervention (Beardslee *et al.,* 1997; Beardslee *et al,* 2008; Beardslee *et al,* 2011; Kaimal & Beardslee, 2010) but has been adapted by the national COPMI initiative for the Australian context. "Family Talk" aims to educate parents on minimizing the psychosocial risk to their children through understanding the impact parental depression can have on children, increasing positive activities between parents and their children and increasing knowledge and understanding of mental illness for the whole family (Beardslee *et al,* 2011; Kaimal & Beardslee, 2010). The "Family Focus" program is based on the same principles.

The "Family Focus" e-learning training resource encourages the

implementation of a systemic, family sensitive approach to working with families and is made up of six interactive learning modules encouraging reflective practice and the development of personalised strategies to working with both parents and their children, carers and other supports. The six modules include:

Module 1: Interactive videos, PDF handbook on risks and protective factors, "Day in the life" audio recording, assessment questions, downloadable info sheets.

Module 2: Interactive videos with experienced mental health professionals.

Module 3: Audio on adapting communication to the different ages and stages of children.

Module 4: PDF handbook on family focused approach, assessment questions.

Module 5: Video on resilient supervision, professionals speak about their experiences, demonstration of family psycho-education and discussing family concerns, concluding the family meeting and parent interview, assessment questions.

Module 6: Video on reviewing goals, concluding family focus, reviewing family focus, family functioning, final parent interview, reviewing goals, information sheet on follow-up, assessment question.

The present study chose primary health care settings as the site for recruiting clinicians, due to the documented nature of mental health help seeking behaviour of people with anxiety and/or depression in Australia (Thompson *et al,* 2004). Several studies indicate that people experiencing hardship often discuss their concerns and/or physical symptoms of mental illness with their General Practitioner (GP). For example, Thompson *et al,* (2004) found that 71% of the study consort approached a

GP as their first point of call for assistance with their mental health problem/s rather than see a mental health professional directly. In Australia, mental health interventions such as counselling therapy and assessments are covered by the National Insurance Scheme. A Mental Health Plan and referral to a mental health practitioner such as a psychologist or mental health social worker, is provided to patients by their GP. Patients are then able to access support at little or no out of pocket cost. In this way, GPs are important "gate keepers" (Meister & Trotter, 2010) in the mental health help-seeking process in Australia. As well, primary health care settings are less stigmatizing places to provide early interventions to parents and their children, an established barrier to health seeking behaviour in the literature (Rickwood & Braithwaite, 1994).

The aim of this study was to determine if and to what extent the e-learning resource improved clinicians' knowledge, confidence and skill level for working with FAPMI, in particular families affected by parental depression and/or anxiety. The study also sought to ascertain how clinicians engaged with the resource and how useful it was to them. The objective of this paper is to present preliminary efficacy data from the piloting of the e-learning resource.

METHOD

Evaluation data were drawn form two sources pre and post completion of the "Family-Focused Mental Health Questionnaire" (Maybery *et al*, 2011) and from individual telephone interviews, conducted two to three months after the clinician had completed training. Ethics approval was provided by the Monash University Human Research Ethics Committee (MUHREC) (see Appendix A).

Procedure

Participants were recruited from primary mental health care settings across Australia and from disciplines including psychology, social work, counselling and mental health nursing. Information about the pilot evaluation was disseminated via email to primary health care organisations across Australia with interested participants invited to contact a member of the research team. Once informed consent had been provided, participants were instructed to logon to the "Family Focused Mental Health Questionnaire", and once this was completed they were then provided with links to the online resource. At the end of the resource, participants were invited to complete the same "Family Focused Mental Health Questionnaire" again, the post questionnaire also containing some additional open-ended questions at the end. At this point, participants were given information about and were invited to participate in an optional one-to-one telephone interview.

Participants were paid for their involvement in the training ($300) and for questionnaire completion at pre and post time periods ($50). An additional payment of $100 was provided to those participants who participated in a follow up, one-hour telephone interview.

Participants

Twenty-seven participants (twenty-four females and three males) completed the training as well as the pre and post questionnaires. As shown in Table 1, thirteen of the twenty-seven participants were from rural areas consisting of eight female rural psychologists (five psychologists, three clinical psychologists), and five female rural allied health professionals (one occupational therapist, one mental health social

worker, one counsellor, two mental health nurses). Fourteen of the twenty-seven participants were urban mental health clinicians. These consisted of ten psychologists (two male psychologists, six female psychologists, two female clinical psychologists), and four allied health professionals (one female mental health social worker, one female mental health nurse, one male social worker, one female couple therapist).   Twenty-five of the initial twenty-seven participant's pre and post questionnaires were matched and analysed in the present study, two sets of data could not be matched due to incomplete responses.

Table 1. Settings and professions from which participants were drawn:

Profession	Urban	Rural
Psychologist	8	5
Clinical psychologist	2	3
Counsellor	1	1
Mental Health Nurse	1	2
Social Worker	2	1
Occupational Therapist	0	1
Total	14	13

Fifteen of the initial twenty-seven participants (thirteen females and two males) completed a follow up telephone interview two to three months after completing the post questionnaire. This sample included four rural psychologists (two female clinical psychologists, two female psychologists), four urban psychologists (three female psychologists, one male psychologist), three rural allied health professionals (one female counsellor, one female occupational therapist, one female mental health social worker) and four urban allied health professionals (one male mental health

social worker, one female couple therapist, one female mental health nurse, one female mental health social worker).

Questionnaires

Twenty-five participants (twenty two females and three males) completed the "Family Focused Mental Health Questionnaire" at pre and post training times. The "Family Focused Mental Health Questionnaire" (Maybery *et al,* 2011) measures workers confidence, knowledge and skill when working with clients on parenting issues, and with their client's dependent children and families. The questionnaire has good content and construct validity, and previous research indicates good internal reliability of subscales ranging from Cronbach alphas of 0.87 to 0.72 for relevant subscales (Maybery *et al*, 2011). Participants are instructed to respond on a scale from one ("strongly disagree") to seven ("strongly agree") for each item, with "not applicable" response also an option. Participants were invited to use a nickname or code, at both times, to allow matching of pre and post data for analysis. As well, at the post time trial, additional open ended questions relating to participants' experience of the resource were asked, for example, asking participants what they found most and least useful about the e-learning tool.

Interviews

The purpose of the interviews was to extend the questionnaire data, and further explore participants' experiences of the resource and in particular whether they believed they could sustain family sensitive practice in the longer term. Accordingly, sample questions included,

- What did you learn if anything, as a result of doing the training?
- Has the resource changed any attitudes you had? If so, in what way?

- Has the resource changed your practice? If yes, in what way?

With participant permission, interviews were audio taped and subsequently transcribed (see Appendix D for example). Interviewees were then emailed a copy of the transcription so they could add, delete or change any of their responses they believed to be potentially identifiable or incorrect (respondent validation).

Thematic content analysis was conducted on interview transcripts (see Appendix D for example), which is a systematic and objective means of describing and quantifying phenomena, a useful process for the exploratory phase of broader research tasks (Merriam, 1998). In this process, data were analysed using an open coding system, attaching labels to lines or paragraphs of data and then describing the data at a concrete and then more conceptual level (Anfara *et al.* 2002) for the final themes reported here. Appendix D contains a de-identified example interview transcript, which has been coded according to the themes that were identified in the study using thematic content analysis.

RESULTS

Questionnaires

Table 2 presents participant mean scores, standard deviations and paired sample t-statistics for pre and post responses to items about clinicians' confidence, knowledge and skill concerning working with FAPMI. All but two items consisting of participant responses pre and post training moved in the expected direction (note that some items are negatively worded) and showed a significant change. Those items that did not move in the expected direction did not show a significant change. Items shown in **bold** are significant at .05 level and actual p-values are shown in the right hand column for each item.

Table 2 Scores and paired sample t-statistics for pre- and post- responses to items regarding sample of 25 workers' confidence, knowledge and skill when working with FAPMI

Question item	Pre M (SD)	Post M (SD)	M diff	t	Df	*P*
I am knowledgeable about how parental mental illness impacts on children and families	5.28 (1.34)	6.48 (0.51)	-1.20	-4.33	24	0.00
I am able to determine the developmental progress of the children of my consumer-parents	5.04 (1.46)	5.28 (1.67)	-0.24	-0.62	24	0.54
I regularly have family meetings (not therapy) with consumer-parents and their family	3.20 (2.14)	4.52 (2.31)	-1.32	-2.93	24	0.01
I am not confident working with consumer-parents abut their parenting skills	3.20 (1.94)	2.12 (1.69)	1.08	2.09	24	0.05
I don't provide information to the carer and/or family about the consumer-parent's medication and/or treatment	4.60 (2.04)	3.68 (2.27)	0.92	1.88	24	0.07
Many consumer-parents do not consider their illness to be a problem for their children	4.48 (1.56)	3.72 (1.77)	0.76	2.13	24	0.04
Working with other health professionals enhances my family-focused practice	5.88 (0.83)	6.48 (0.59)	-0.60	-2.88	24	0.01
I do not have the skills to work with consumer-parents about how parental mental illness impacts on children and families	3.20 (1.80)	1.36 (0.49)	1.84	5.26	24	0.00

I am not able to determine the level of attachment/bond that consumer-parents have with their children	3.08 (1.73)	1.80 (1.00)	1.28	3.77	24	0.00
I am not experienced in working with child issues associated with parental mental illness	3.72 (2.09)	2.48 (1.42)	1.24	2.35	24	0.03
I am not able to determine the level of importance that consumer-parents place on their children maintaining strong relationships with others outside the family (e.g. other children/peers, school)	3.16 (1.65)	1.80 (1.38)	1.36	3.52	24	0.00
I provide written material (e.g. education, information) about parenting to consumer-parents	5.12 (1.71)	5.76 (1.59)	-0.64	-1.50	24	0.15
I am not confident working with families of consumer-parents	3.24 (1.74)	2.20 (1.58)	1.04	3.57	24	0.00
Rarely do I advocate for the carers and/or family when communicating with other professionals regarding the consumer-parent's mental illnesses	2.72 (1.88)	2.28 (1.72)	0.44	1.90	24	0.07
Discussing issues for the consumer-parent with others (including family) would breach their confidentiality	4.64 (1.68)	4.08 (1.89)	0.56	1.33	24	0.20
Children and families ultimately benefit if health professionals work together to solve the family's problems	6.52 (0.65)	6.24 (1.36)	0.28	0.94	24	0.36

I am skilled in working

with consumer-parents in relation to maintaining the wellbeing and resilience of their children	4.76 (1.48)	5.76 (0.97)	-1.00	-4.47	24	0.00
I am able to assess the level of children's involvement in their parent's symptoms or substance abuse	4.88 (1.88)	6.00 (0.65)	-1.12	-2.88	24	0.01
I regularly provide information (including written materials) about mental health issues to the children of consumer-parents	4.00 (2.26)	5.08 (2.12)	-1.08	-2.65	24	0.01
I am not confident working with children of consumer-parents	3.32 (2.02)	2.08 (1.58)	1.24	3.19	24	0.00
I am not knowledgeable about the key parenting issues for consumer-parents	3.16 (1.52)	2.24 (1.90)	0.92	2.52	24	0.02
Rarely do I consider if referral to peer support program (or similar) is required by my consumer-parent's children	2.56 (1.50)	2.60 (2.55)	-0.04	-0.06	24	0.95
The children often do not want to engage with me about consumer parents' mental illness	4.08 (2.24)	3.36 (2.33)	0.72	1.60	24	0.12
I am skilled in working with consumer-parents regarding their parenting	4.52 (1.81)	6.00 (-0.65)	-1.48	-5.02	24	0.00
I am knowledgeable about the key things that consumer-parents could do to maintain the wellbeing (and resilience) of their children	4.80 (1.53)	6.36 (0.49)	-1.56	-5.01	24	0.00

I am able to determine the level of importance parents place on their children maintaining attendance at day to day activities such as school and hobbies	5.24 (1.09)	6.16 (0.37)	-0.92	-4.43	24	0.00
Team working skills are essential for all health professionals providing family-focused care	6.40 (0.58)	6.72 (0.54)	-0.32	-2.88	24	0.01
I don't feel confident to counsel consumer-parents about parenting and their mental health problems	3.20 (1.87)	1.68 (1.03)	1.52	4.01	24	0.00
I often consider if referral to parent support program (or similar) is required by consumer-parents	5.24 (1.23)	6.12 (0.78)	-0.88	-3.56	24	0.00
I am able to determine the level of importance that consumer-parents place on their children maintaining strong relationships with other family members e.g. other parent, siblings	5.00 (1.12)	6.2 (0.58)	-1.20	-5.20	24	0.00
I want to have a greater understanding of my profession in a healthcare team approach to working with children and families	6.52 (0.59)	6.00 (0.87)	0.52	2.90	24	0.01
I am not skilled to facilitate family meetings	3.92 (2.10)	2.56 (1.85)	1.36	3.10	24	0.00
I provide education sessions for adult family members e.g. about the illness, treatment	5.16 (1.90)	5.60 (1.89)	-0.44	-1.06	24	0.30

Almost all variables moved in the expected direction pre to post. Notably twenty-

four of the thirty-three items from the questionnaire showed significant change after

being exposed to the web materials. These changes were all in the expected

direction. This suggests that the materials had a significant impact upon clinicians'

skill, knowledge and confidence.

Interviews

As indicated above, fifteen interviews (thirteen females and two males) were

undertaken with participants. There were three broad themes identified, along with

various subthemes, as outlined in Table 3 and further elaborated below.

Table 3 Interview Themes

Theme	Subthemes
Participants' views on the resource	A helpful resource
	Easy to navigate and use
	Technical issues associated with online delivery
	Assessment items
	Too much material/repetitive
Impact on attitude and practice	Increased confidence
	Reinforced the need to work systematically
Suggestions for future training	Modifications to enhance utility
	Incorporate specific techniques/focus on age/client groups

1. *Participants views on the resource*

Overall, participants were positive about the resource, and indicated that they found

the video clips, discussions and case profiles especially useful:

I think the videos and the actual, I guess they're simulated type intervention sessions with the family and, well we got a guest, actors I think that, that was really valuable video content. And also the video content of consumers, there were all these exerts that they talked about in terms of their journey as well, I think was really valuable.

...they were really very accurate. I thought they were really well done, very well put together...

As well, participants found the resource easy to navigate and use, with the following

identified as being particularly useful.

I thought the self-directed learning program was quite user friendly and engaging.

*I quite liked the mix of things that you would read verses things that you would listen
to and things that you would watch and listen to, so there was audio as well as the
video tracks.*

*The way it was set out was good in that you could go further into different parts if
you wanted more information.*

The content and mode of delivery was really good.

Having access to learning when based rurally was important to participants.

*But the other advantage is particularly working and living in a regional area, it was
– really increased access to training.*

Some participants experienced technical issues, primarily due to internet connection

issues.

*…you really need high speed internet to be able to really run the program and run
the videos…*

Some participants reported that at times there was too much material and/or too

much repetition of material.

Okay, I know this, I know this, I've read this or this has been said before

...there was so much material it's almost overload...

2. *Impact on attitude and practice*

Many participants indicated that the training changed their knowledge and awareness about the need to work systemically with all family members:

...it's changed my awareness of – well it open me up to, oh my God, how could I not be thinking about that!

It gave me more insight into the effect of mental illness on the whole family.

I think it certainly gave me a better appreciation of the impact of mental health issues that parents are having, on younger people.

...until I did this training I really didn't lift my head very much, unless they asked their partner or their family, and particularly with kids...I think that I hadn't really taken the whole family into account enough, and this gave me an approach that I could see was – well, if their can't necessarily implement it within our homing package as a whole project, I can at least be more aware of that process when I'm working with [families]...

Several participants described how the resource has changed the way they work with clients who are parents, and when working with the whole family.

[I now see the need] to bring the family together and to work with the family at times, and it has a sort of whole impact that's set up separately to their counselling... I think it probably has [changed my practice], in terms of there's been a couple of young people that I've seen that have had a parent with a mental illness and I think I really have looked at that more thoroughly. And looked at that impact of a family more thoroughly and thought about it more and there's [now] more questions and support in their direction.

I make sure that I talk to parents a bit more regularly about how the children are going for starters. I talk to them earlier on about some of the cognitive programs for children and so on, and I talk with them a little bit more about the research on involving children and making sure children are part of conversations about their parents and that they learn more and that they're involved and ask questions and fill in the gaps in their knowledge, so a bit more about the effects of that – the positive effect of that…

…it's certainly helped me to think more clearly and specifically about how I involve children or how I could involve children, the types of family meetings I could have and so on.

One participant described working to initiate organisational change as a result of the training:

I'm going to a staff meeting next week and I'll be talking about it with my other staff members and talking about whether this is something that extra funding could be put towards.

One participant who described already working with families reported that the resource provided an additional "framework" to her work, pragmatically and conceptually:

I'd already involved children and talked with the parents about the children etc, or if it was the other way around – if the children were the first clients I would work with – I would talk to the parents about you know how their mental health was going, but it gave me I suppose more of a framework as well as a practice framework, how that could work a little bit – efficiently is not quite the work but work a little bit more specifically on making sure the children are involved and that they build resilience and understanding.

Some reported no change to practice, primarily because they were already working in a family sensitive manner as this one psychologist reported.

I don't think…[this has changed my practice] not a great deal, I'm pretty much aware – yeah I mean especially working in child psychiatry we deal with families, we don't just look at the client which is a bit different in adult mental health, so I suppose I've always meaning worked in child psych so I have that family focus anyway.

Similarly, others, for example, social workers, reported having been trained to work "holistically" and so already worked in a family sensitive manner. For some, the resource assured workers that they are currently providing effective practice and so validated their current practice.

…a lot of the training – a lot of the content I already knew. I guess what it did was it confirmed for me that I was doing what other people are…so to me that's enough – that was nice.

Similarly, others also stressed how their confidence had increased, post training.

…even thought you know you've got experience and whatever you always sort of think "I could learn more or I could do it better" type of stuff and so I sort of though to myself "Oh, no there's probably a lot of stuff that I don't know that other people do" – but by the time I had finished the assessment I thought, "No, I'm pretty confident that I know what I'm doing here.

Others reported changes to technique and skills that involved family members, especially dependent children.

I make sure that I talk to parents a bit more regularly about how the children are going for starters. I talk to them earlier on about some of the cognitive programs for children and so on, and I talk with them a little bit more about the research on involving children and making sure children are part of conversations about their parents and that they learn more and that they're involved and ask questions and fill in the gaps in their knowledge…

3. *Suggestions for future training*

Participants identified several directions for future training.

[It would be good to include] a forum for people to discuss any fears they might be having.

...a contact number of someone that was quite experienced in the program [would be good to include]

Some suggestions were provided for training to work with specific client groups and/or ages.

…[how to manage] some less compliant clients…there's going to be a couple that say "Oh, leave me alone, I'm already worried enough"

…hints and strategies for engaging different age groups…

Another also indicated a need for specific assessment tools:

...tools that might be useful for assessing mental health and wellbeing in the kids

Overall, participants found the resource useful and thought it would be easily implemented for use with a range of clients including those presenting with anxiety, depression and other diagnoses such as Post Traumatic Stress Disorder (PTSD). One participant mentioned that it may not be suitable cross-culturally due to differences in concepts of family, for example, for indigenous groups. Participants indicated that it would be suitable for families who desire help and are motivated to engage with

the therapist and program, families where the parent with a mental illness is not in crisis, and, in the words of one participant, for families not in a state of "*shattering*".

DISCUSSION

"Family Focus" is a free, interactive training course for mental health professionals that will be available in an online format through the National Children of Parents with a Mental Illness (COPMI) Initiative website. It utilises a range of multimedia resources including video sessions with mental health professionals working in a family sensitive manner, demonstrating the intervention, and in the form of interviews with consumers and carers. Overall, results from pre and post questionnaires as well as post training interview data indicate that after training in "Family Focus", mental health clinicians reported increased knowledge, confidence and skill when working with families affected by parental anxiety and/or depression. This study showed that the resource led to significant improvements on 24 survey items on the post questionnaire (from a possible 33). As ascertained from the questionnaire, significant improvements can be identified in terms of participants':

- knowledge regarding how parental depression and/or anxiety impacts families,

- family sensitive practice (for example, holding family meetings),

- skill level when working with families (e.g. assessing the impact of illness on children), and

- confidence level when working with families of their clients who are parents.

Overall the training led to significant and positive changes in mental health clinicians' knowledge, behaviour and confidence when working with families affected by parental anxiety and/or depression. These changes are also highlighted in the qualitative (interview) data, whereby participants described a greater awareness

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of the needs of parents with anxiety and/or depression and their dependent children. How professionals might work with clients around parenting issues, and involve and communicate the whole family were other identified practice changes. For some who had previous experience and/or training in this area, the resource affirmed and validated their current practice, in terms of working with clients in a family sensitive and holistic manner.

In terms of pedagogy, professionals found the e-learning resource useful for their practice and the materials easy to navigate and use. They especially appreciated the video content consisting of simulated therapy sessions and interviews with experienced mental health practitioners. Some participants directed criticism regarding the length and repetition of content in the resource and identified technical difficulties associated with internet connection issues. In addition, participants were clear that the resource was suited best for families who were not in a state of crisis. Participants suggested improvements for the training program around working with specific client groups i.e. tailoring the program as well as assessment tools for children such as age-appropriate handouts for children to complete.

There were several limitations to the study, including a small sample size. Additionally, it should be noted that multiple t-tests were performed on the quantitative data collected from pre and post questionnaire questions, which can potentially result in type I errors. Follow up questionnaires and/or observations are required to ascertain whether the changes identified here are sustained in the longer term. Finally, this is a self-selected group of participants, who might have volunteered due to pre-existing interest and motivation in working with families. Other clinicians, who are perhaps less interested and/or motivated to work with

families, might well have different experiences of the resource. Whitman *et al.,* (2009) found that clinicians from different disciplines have varying training needs when working with families where a parent has a mental illness, and so future training and subsequent evaluation might need to be mindful of these differences.

In this study, participants reported an increase in knowledge, skill and confidence for working with families where a parent has depression and/or anxiety, after training in "Family Focus". Preliminary evaluation of the e-learning training program "Family Focus" suggests that it is a helpful and effective, interesting and easily accessed program for mental health professionals across Australia. The evaluation data collected in this study will be used by The National Children of Parents with a Mental Illness (COPMI) Initiative in fine tuning the program before it is available on their website.

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Appendix A: Ethics Approval

CF11/2820 - 2011001658: Family focus: an evaluation of an e-learning resource

Dear Researchers

Thank you for submitting a Request for Amendment to the above named project.

This is to advise that the following amendment has been approved and the project can proceed according to your approval given on 9 November 2011:

Change to personnel - adding student researcher, Ms Titania Henderson.

Thank you for keeping the Committee informed.

Professor Ben Canny
Chair, MUHREC

Human Ethics
Monash Research Office

Our aim is exceptional service

Appendix B: Explanatory Statement

MONASH University

Explanatory Statement

22.02.12

To: Mental health practitioners working in primary health care settings

Title: Family focus: an evaluation of an e-learning resource

This information sheet is for you to keep.

My name is Titania Henderson, and I am conducting a research project with Dr Andrea Reupert (senior lecturer in the Faculty of Education) towards a Master of Psychology (Counselling) at Monash University. This means that I will be writing a thesis which is the equivalent of a short book.

This project has funding from the national COPMI initiative, (AICAFMHA) via the Australian Government to evaluate an exciting new training resource, called Family Focus, specifically designed for mental health professionals working in primary health care settings in regard to families affected by parental mental illness. Your input into this project will be used to assist the COPMI initiative to further refine the resource.

You have been identified as a mental health professional working in a primary health care setting. Many people with depression and/or anxiety visit their GP; moreover many of these people have children. Hence, it is important that practitioners, such as yourself, have the skills and knowledge to intervene appropriately with clients who are parents and their families. We would like to offer you the opportunity to be involved in training in this area, and the accompanying pilot evaluation.

The training: Family Focus

An e-learning resource has been developed, Family Focus, which will take approximately six to ten hours to complete. Family Focus outlines the various skills required to support a parent, who has a mental illness, and presents how a practitioner might work with the children of a client as well as other key family members. The resource is self-paced, and interactive, and uses audio and video material, over several modules.

As the resource is still being developed, in order to undertake the training you also need to be available in the evaluation component of the project.

The Evaluation for Family Focus:
You would be asked to complete the workforce questionnaire before you undertake the training. You will be asked to complete the same questionnaire, immediately after training. The questionnaire asks you a series of questions about your knowledge and skill regarding working with families where a parent has a mental illness. Each questionnaire takes about 15 minutes to complete so doing the two will take approximately 30 minutes.

We would also like to run a one hour focus group, sometime after you complete the training. The focus group will be run with other practitioners such as yourself at a time and place to be negotiated. With your permission the interview will be audio taped. We will be offering refreshments to interested participants. Sample questions include:

- What did you learn, if anything, as a result of doing the training?
- Has the training changed any attitudes or ways of looking at clients you previously had, if at all?

Being in the training and the evaluation is voluntary and you are under no obligation to consent to participate. If you do consent to participate, you may withdraw at any time. However, it is not possible to withdraw any taped comments that are provided in the focus group. Regarding the questionnaire, you are not able to withdraw once the questionnaire has been electronically submitted.

All information reported will be de-identified and at no times will names or the names of organisations be reported.

If you are in private practice or doing this outside of your regular work hours, we would like to partially reimburse you for your time. We are prepared to pay you $300 for undertaking the training, $50 for doing the questionnaires (pre and post) and a further $100 for your participation in the focus groups. We appreciate that this does not cover the money you would have earned in private practice but hope it does acknowledge the time and effort you are contributing here.

Storage of the data collected will adhere to the University regulations and be kept on University premises in a locked cupboard/filing cabinet for 5 years. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

If you would like to be informed of the aggregate research finding, please contact Dr. Andrea Reupert at andrea.reupert@monash.edu The findings are accessible for 12 months only.

If you would like to contact the researchers about any aspect of this study, please contact the Chief Investigator:	If you have a complaint concerning the manner in which this research **CF11/2820 – 2011001658** being conducted, please contact:
Dr. Andrea Reupert, Senior lecturer and psychologist Institute of Human Development & Counselling Krongold Centre Faculty of Education Clayton Campus Monash University, Vic 3800 Telephone: 03 9902 4587 Fax: 03 9905 5127 andrea.reupert@monash.edu	**Executive Officer Monash University Human Research Ethics Committee (MUHREC) Building 3e Room 111 Research Office Monash University VIC 3800** **Tel: +61 3 9905 2052 Fax: +61 3 9905 3831 Email: muhrec@monash.edu**

If you are interested?

If you are interested in undertaking this training and participating in the evaluation, please complete the consent form and email/send to me.

Thank you, we appreciate your time in this study.

Yours,

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Appendix C: Consent Form

MONASH University

Consent form

To: Mental health practitioners working in primary health care settings

Title: Family focus: an evaluation of an e-learning resource

NOTE: **This consent form will remain with the Monash University researcher for their records**

I agree to take part in the Monash University research project specified above. I have had the project explained to me, and I have read the Explanatory Statement, which I keep for my records. I understand that agreeing to take part means that (Please tick your response:)

I agree to undertake the Family Focus training	☐ Yes ☐ No
I agree to complete the workforce questionnaire before and after the training	☐ Yes ☐ No
I agree to be interviewed by the researcher	☐ Yes ☐ No
I allow the interview to be audio-taped	☐ Yes ☐ No

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project. I understand that I can only withdraw prior to the focus group commencing, without being penalised or disadvantaged in any way. I understand that any data that the researcher extracts from the focus group interview for use in reports or published findings will not, under any circumstances, contain names or identifying characteristics. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. I understand that data from the project will be kept in a secure storage and accessible to the researcher. I also understand that the data will be destroyed after a 5 year period unless I consent to it being used in future research.

Participant's name:

Contact details

Phone: **Email:**

Signature   **Date**

Please email back to me at andrea.reupert@monash.edu.au

Appendix D: Example Analysed Interview Transcript

Interview:

AR_TH_elearning_- (participant's name here)

Participants:

Q: Interviewer

A: Participant

Key:

Example 1.B means theme 1, 2nd subtheme in theme 1

Example 2.A means theme 2, 1st subtheme in theme 2

Q: Hello. Is that (participant's name here)?

A: Yes it is.

Q: Hi. This is Titania calling from Monash.

A: Hi Titania. How are you?

Q: Good, thank you. How are you going?

A: Good, thanks.

Q: That's good. So are you ready to start our interview?

A: Yep.

Q: Yep, okay. So I need to emphasise that I'm an external evaluator to the program and that your responses won't impact in any way your participation in further research. And every effort will be made to de-identify your responses.

A: Okay.

Q: Even though I understand that you've already provided written consent to having the interview taped, I'll just ask again. Are you happy for it to audio taped?

A: Yes.

Q: Great, thank you. So just to start with we have a bit of demographic information. So I'll just grab your age.

A: I'm (participant's age here).

Q: And postcode of main place of work?

A: (participant's postcode here).

Q: Are you full time or part time or other?

A: Full time.

Q: What's your main profession?

A: Psychologist.

Q: Are you a registered Medicare Primary Health Care provider?

A: Yes.

Q: And how many years of experience have you in mental health?

A: 20. 25.

Q: And just lastly, what's your highest qualification?

A: Masters.

Q: Okay. So with regard to the e-learning training, the interview is in 2 parts. The first part is with regard to your experience of the e-learning. And then the second part is your experience of working with people with depression and anxiety. So with regard to the e-learning, what were your general thoughts about the training in terms of the content and how it was delivered?

A: I found it – besides the frustration that it wasn't finished, I found it quite easy to navigate and to use (1B). And there was lots of good links to back up the information (1.A & 1.B). As I said, because the bits that weren't there or that didn't sort of work, I found that a bit frustrating (1.C). But the other advantage is particularly working and living in a regional area, it was - really increased access to training (1.A & 1.B).

Q: Has the resource changed any attitudes that you had?

A: I wouldn't say it's changed attitudes but it's reinforced the importance of working systemically (2.B).

Q: Has it changed your practise in any way?

A: It's made me aware of another resource.

Q: What was especially valuable, if anything, in the resource, did you think?

A: I think the structure of it in that you could go deeper into different areas if you needed – like all the links and the different research (1.B).

Q: Was there anything that you think should be included in the program? Or is there anything that you think should be excluded?

A: I assume that the bits that I couldn't use, like the videos of clients or actors being clients – I think were particularly – would be particularly good to sort of give you that live demonstration. So I'd just go, "Yeah, they should be able to use them." But no, I can't think of anything else in particular. Maybe if there could be – well, I think there were – from memory there were links that took you into places to find local resources maybe linking it with the Mental Health Professionals network in your area or something.

Q: Would you change anything in the resource?

A: No, other than just making all of it available. So I assume they were as valuable as they appeared.

Q: What clients do you think you'd most likely use it with?

A: Probably because I have sort of an area of speciality that it would sometimes be relevant for - but mainly for the clients that I'm referred from GP's under a Medicare Mental Health plan.

Q: And generally what sort of clients are they?

A: They're a range but a lot of people with anxiety and depression symptoms.

Q: So are there any differences in terms of diagnosis in terms of the clients that you think it would be most suited to?

A: I think clients with sort of significant suicidal ideation - so depressive disorders.

Q: Yeah. You think it would be good to use with depressed clients?

A: Yeah. Well, particularly with families concerned about how to respond and concerned around potential self harm.

Q: And specifically do you think that what you learnt could be applied to families where a parent has depression without anxiety? I know that they normally come together. And depression where the parent has anxiety with no depression?

A: Yeah. I think the general principles and there was enough information that you can pick and choose. You could apply it – I mean to my mind it's the principle of working systemically and encouraging conversations in the family. But you could use it really with anybody.

Q: Great. So are there any other further comments, positive or negative, about the e-learning resource?

A: I'm just looking at my notes and trying to remember what I wrote in the – I thought the information and the take home strategies for families were really good. And making it clear that it wasn't a treatment intervention but it was more an intervention for, I guess, information and discussion points for families. I'm not sure, I guess, about how it translates across different cultural populations. We have a significant Indigenous population in (participant's location) so I'm not quite sure how it would translate there, given the sort of broader concept of family that often implies a community.

Q: Yeah, that's a good point, actually. Because yeah, families are different, aren't they? Especially in Aboriginal community - like there's more of a community – like the family is the community as well, isn't it?

A: Yes, yeah.

Q: Because you've got Elders and – yeah. Okay. So the second part of the interview focuses on your experiences of working with parents who have depression and those who have anxiety. And as you're aware, many people have both. However, for the following questions we ask that you try to distinguish any differences that you recognise between clients with anxiety and those with depression. And we're most interested in your opinion on how the specific disorder, anxiety or depression, impacts on things such as the clients ability to parent, how they function generally including how they function with the other parent. And keeping in mind that we're interested also in how children are impacted by parental mental illness. So yeah, are there any important behaviours that you see that parents with anxiety do that impact on the family, the other parent and the children?

A: I suppose it's their response to – like can be heightened to various situations. So it's hard for the children in particular to predict how the parent might respond in a certain situation because that varies depending on how well they are or where their levels of anxiety are. Sometimes parents – maybe not with anxiety – we're talking about anxiety at the moment, aren't we?

Q: Yep sure.

A: Sort of not being comfortable to necessarily have parents come to school or to sporting events or have other children home because they might think their parents'

behaviour's embarrassing or strange. And in terms of partners dealing with those behaviours, I think sometimes that can impact on the quality of the relationship.

Q: In what sorts of ways, do you think?

A: Frustration - maybe sometimes leading the partner to insist that the other – the partner with the mental health issues, goes and sees their psychologist - but like a demand that they fix it. So there's often forced motivation.

Q: And what about with regards to depression?

A: I think depression is that sort of lack of availability sometimes to meet the needs of the smaller children or any children, really, they're nurturing. Lack of availability for intimacy in – between the parents. And sometimes I think – I'm thinking of a particular client of mine who is a young person, because I work a lot with young people. He's almost the parent in the house. He's left with a lot of caring for his younger siblings. Their mum is particularly unwell and she'll just spend days in her bed or with the computer. Like just that sort of cut off – being unavailable emotionally and sometimes physically. And the fear of suicide.

Q: Do you think that that affects the other parent or the children?

A: Depending on the age of the children and what the children are aware of and how the parents have talked to them. So definitely on the children but definitely on the partner – a feeling of responsibility like – let's say there's another issue but I wouldn't want to bring that up in case it makes it worse for them or I'm worried what he might do those sorts of issues. So sort of preventing them, I guess, engaging in conflict resolution sometimes. It's sort of that fear of, "Oh, I'd better not upset them."

Q: In your experience, what supports do you think the 2 groups of parents most need and is there a difference?

A: I think the difference more relates to the individual than the actual clinical presentation. So some might have a good informal network whereas others that don't, I think we need to develop their community connections and other levels of support. And I think that's more dependent on the history and the style of the person than their actual presentation. I think a good GP or psychiatrist in terms of medication is particularly critical. And I think that crosses over both of them. I often find that there's not much differentiation in prescription between the 2 presentations. And I think that if you can have a good relationship with a prescriber and get that medication just right for the particular person, that's a really useful component of the intervention. And particularly for people with depression, that sort of very - level of personal support but maybe motivates to actually get up and do when they're particularly lethargic, lacking in motivation. And with people with

anxiety that are unable to access the community because of their anxiety - to have a personal support type worker, I think is really helpful, particularly for addressing things at an early stage rather than them becoming quite unwell.

Q: In your experience, are there differences in the ways you might engage with parents with depression versus parents with anxiety?

A: Probably focus a lot more on assisting the people with anxiety with regulations, so breathing – to then engage cognitively. And the depression - I probably want to have a good awareness of who is there as a support role if the person was particularly isolated.

Q: In your experience, do parents with depression see themselves differently to parents with anxiety?

A: Once again, I think it's more individual difference within those things than the actual presentation. But I think depression, because of the increased community awareness and focus on depression in the community, maybe seems better understood and more tolerated than perhaps anxiety which sometimes can be sort of misconstrued. I work a lot with forensic populations so some of the behaviours are – like those with anxiety; their behaviour is more likely to impact on others than those with depression.

Q: Do you think the parents with anxiety seek out support differently to parents with depression? Are they more likely or-?

A: Maybe because there's more recognition and acceptance in the community. Maybe-

Q: Around depression?

A: But - yeah. But because I guess I'm not usually the first port of call since Medicare – tends to be a GP - I don't know what the variation is in terms of seeking support.

Q: So in your practice how do you assess for parenting competency if at all? And does it differ with parents with depression and parents with anxiety?

A: In the generalist client, I guess I'm just aware of how they're describing their day to day life and what their capacity would be to be caring for the children. And I will often ask who else is available - get a sense of how they're dealing with the times that they're unable to provide appropriate levels of support to their children. If I'm particularly concerned I might communicate with the GP who referred them or if they're a DHS referred client, their DHS worker usually has some access to the home. Many - I suppose I'm looking in terms of safety and protection of the

children. I'll be maybe finding or suggesting that their partner comes in. I guess normally I wouldn't unless there was significant concern. I wouldn't necessarily engage in like a family intervention strategy. I do in my other work but that's usually because I'm working with a young person and their behaviours are concerning and then it's always working with the family.

Q: How might treatment generally be different for parents with depression versus those with anxiety?

A: I suppose, as I said before, the focus on assisting the person with anxiety to increase their ability to regulate. Whereas the depression I, if it's appropriate, would be working more cognitively around the depressive thoughts. But with the anxiety also challenging thoughts but a bit more behaviour rehearsal and regulation with the anxiety. Once again individual difference.

Q: Do you think treatment should be different for kids whose parents have depression versus kids whose parents have anxiety?

A: I don't know that the kids need treatment but sort of intervention or support to the children I think is understanding their particular parent's presentation. So it would vary, yeah.

Q: And do you have any other comments that you'd like to make regarding working with parents with depression and parents with anxiety?

A: Maybe – and I guess currently is not the time when people are looking about - at the flexibility of Medicare funding but it's quite difficult to work systemically under a mental health care plan because really you're only funded to see the patient that's referred. So it's somehow being more flexible with that funding so that you can provide the support to the family. And perhaps like services or CANS are a better place to do that but they don't seem to do much work. I don't know if it's the same in every region but certainly in Gippsland it's very hard to get them actively involved. But it's more around resourcing so that you can work in the best way because usually they're the things that prohibit it, unless the family is resistant. I also – because so much of my work is forensic, the client's often resistant anyway. I work for Youth Justice a lot and I always work with the family if they're willing to engage - quite a lot of encouragement to do so. But some of them just don't want to engage so there's no mandate or no reason – no ability to engage them. But I think it would be really useful. And particularly when within the family there may be one parent with mental illness or – so I think that it would be useful but it's just more whether the resources or the family are willing.