

# Goal setting in recovery: families where a parent has a mental illness or a dual diagnosis

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## ABSTRACT

Goal setting is an important element within mental health recovery models; however, parenting and children are rarely recognized in such approaches. This study outlines a family recovery planning model where a parent has a mental health or dual substance and mental health problem. The differences between family types (parent with a mental illness or parent with dual diagnosis) and family members (parent and children) are illustrated in terms of goals across 11 domains. There were a total of 33 parents and 50 children from 10 mental illness and 10 dual diagnosis families. Education and specifically mental health knowledge are important goals across all families and appear especially important for children whose parent has a dual diagnosis. Specific goals and achievement levels for each type of family and parents and children are also outlined. Clear areas for action by clinicians and family members are indicated by this study.

## INTRODUCTION

Recovery and goal setting are crucial components of services for those with a long-term mental illness (MI) and/or substance abuse disorder. However, when an individual is a parent, with dependent children, recovery processes need to acknowledge the parenting role of the individual as well as the needs of other family members, especially children. In this paper, we investigated the types of goals set by families within a recovery model of care. The differences between family types were also examined in regard to families where a parent has a MI vs. those where a parent also has a substance abuse disorder (dual diagnosis, DD).

'Recovery' describes the day-to-day lived experience of people with MI who identify themselves as leading satisfying and productive lives, despite ongoing periods of illness (Pilgrim 2008). Deegan (1996, pp. 96–97) encapsulated the definition of recovery by stating

Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear

process. At times our course is erratic and we falter, slide back, regroup and start again . . . The need is to meet the challenge of the disability and re-establish a new and valued sense of integrity and purpose within and beyond the limits of disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.

Participants often describe recovery as the process through which they make sense of their illness, and subsequently is a means of reconstructing a positive identity as someone with a long-term illness (Repper 2000). Andresen *et al.* (2003) suggest that finding hope, redefining identity, finding meaning in life and taking responsibility characterizes the recovery process. In sum, recovery approaches are now advocated by consumers as well as mental health professionals as a best practice approach to support individuals with severe and/or long-term mental health and/or substance use problems (Farkas *et al.* 2005).

Goal setting is increasingly recognized as an integral component of recovery. Health service standards now indicate that goals within individual programme plans should be routinely established (Clarke *et al.* 2009).

To this end, goals are considered to be a ‘. . . vital component of service coordination and recovery support for individuals with psychiatric disability’ (Clarke *et al.* 2009, p. 292). Individuals report goals being an important element that assists in recovery, especially when personally meaningful (Ades 2003). Clarke *et al.* (2012) assert that plans for goals need to be orientated to the individual’s own recovery vision, include strategies to achieve goals and identify indicators of achievement. Tryon & Winograd (2001) found that goal setting is more effective when the individual is an active participant working collaboratively with his or her mental health professional. Clarke *et al.* (2012) extend these descriptions when they state that goals can change over time, especially as individuals’ basic needs for physical health and basic day-to-day functioning are met, after which they aspire for higher order human needs including occupational pursuits.

Given the emphasis on hope, identity and meaning, it is surprising to find that recovery models (and goal-setting exercises within these models) rarely consider recovery within the context of parenting. An examination of several recent reviews of the recovery literature (e.g. Bonney & Stickley 2008; Leamy *et al.* 2011; Tew *et al.* 2012) indicates little mention of instances and/or examples of an individual’s parenting role and responsibilities. Instead, recovery models regularly refer to ‘people accessing mental health services’, ‘person’, ‘individual’ and ‘people with lived experience’; however, they rarely (if ever) report on ‘children’, ‘parent’, ‘parenting’ and ‘parenting and recovery’. Reference to family is usually described in terms of the family providing care and support to the person with lived experience, while the individual with MI, as a parent and contributor to family life, is not acknowledged.

There is, however, a need to incorporate parenting and family life into recovery models. Recently, it has been found that 21–23% of children live with at least one parent with MI (Maybery *et al.* 2009b) and 11.9% of children live with at least one parent who has a substance use problem (Office of Applied Studies 2009). During the financial year 2010–2011, just over 20% of service users attending an Australian state-based adult mental health service were parents with children (Maybery *et al.* 2012b). Moreover, mental health professionals made 52 665 family contacts during the year with these individuals. This is a large number of children concomitant with adult mental health services and a large number of parents who are recovering from MIs.

The addition of parenting support into routine adult mental health service delivery has the potential to greatly enhance recovery-focused practice. Effective parenting is intimately related to the recovery process and functioning in other major life domains (Mowbray *et al.* 2002). Nicholson (2010) found that children often give parents the strength and will to ‘keep going’ thereby promoting hope (a key element of recovery). Additionally, ‘being a parent’ and effectively assuming the parenting role, provides parents with meaning and purpose (another element of recovery; Nicholson 2010). Parenting may also contribute positively to parents’ lives in the community by providing opportunities for meaningful interactions and activities with others (Nicholson 2010). Thus, identifying and supporting an individual’s parenting role can provide hope, a sense of agency, self-determination and meaning, all consistent with a recovery approach.

A parent recovery focus also has the potential to impede the transmission of mental health disorders in families. While genetics are important in this transmission, so too are environmental influences, including parenting competence and family relationships. Importantly, the latter are malleable. Compared to other children in the community, those whose parent has a MI/substance abuse are more likely to be taken into care (Leschied *et al.* 2005), and to acquire higher rates of substance abuse (Mowbray & Oyserman 2003), MI and/or behavioural disorder themselves (Leschied *et al.* 2005). It is estimated that these children are likely to be at two and three times greater risk of developing a mental health problem than other children (Maybery *et al.* 2009a). Thus, working with families is not only beneficial to the parent’s recovery but also provides an early intervention platform for his or her children.

However, there are few studies that have examined recovery within the context of family life. In the USA, Nicholson (2010, p. 39) noted that ‘. . . the links between parenting and MI recovery have only recently been suggested’. One paper has been located that identified the recovery goals established by children and parents from complex families (mental health and/or substance abuse problems, see Maybery *et al.* 2012a). That study found that children most frequently identified goals associated with schooling and family relationships while parents established goals to improve their knowledge of mental health. The goals set by different types of families however were not identified. A similar study was undertaken by Clarke *et al.* (2012) who examined the goal records of 144 individuals and found that physical health was the

most important goal for 23% of individuals and employment and career goals were the most important goals for 14% of individuals. Of interest here was that 13% of goals were associated with relationships (i.e. friendships, social, intimate and family relationships) and 3% (six individuals from the 144 sampled) were goals in relation to parenting (Clarke *et al.* 2012).

Teasing out family life in terms of parenting roles and family needs, especially children's needs, is warranted given that a significant proportion of individuals in recovery from a MI and/or substance abuse are parents with dependent children. Accordingly, a recovery model that incorporated goal-setting activities for parents and children was trialled. The current approach emanated from the non-government organization, Northern Kids Care – On Track Community Program (NKC-OTCP), which services families with multiple problems and needs. Goal setting occurred for each child and parent, in collaboration with a case manager. The goals formed the basis of each family member's case management plan (called family care plans) and were behavioural, measureable, included short- and long-term goals, reviewed every 3–4 months and where necessary, revised in the light of new challenges or goal completion (see Reupert *et al.* 2008 for more information on family care plans). Principles underlying the approach include being family centred (Allen & Petr 1998; Reupert *et al.* 2008), strength based (Dempsey & Keen 2008) and case management focused (Dunst *et al.* 2007). The approach also seeks to mobilize a family's formal and/or informal support networks, provides a means of managing fragmented and uncoordinated services and enables the monitoring and evaluation of goals over time (White & Gundrum 2001).

This research examines the goals set by families with parents with MI and those families where a parent has a DD (a diagnosis of mental health and a substance abuse disorder). Specifically, the study sought to determine

- The most prominent goals set and achieved by family members where a parent has a MI.
- The most prominent goals set and achieved by family members where a parent has a DD.
- The similarities and differences in terms of goals set, and goals achieved, for parents and children from the different families.

Identifying family goals can assist in recovery and more broadly, provide an indication regarding the resources and supports that might be required. As Anthony *et al.* (2000) point out, the process of recovery

is an individual process and we would extend this argument by stating that recovery will differ across families as well. Notwithstanding these differences, this research aims to examine whether there are general goals for parents and children across these unique experiences, according to family groups.

## METHOD

### Participants

The participants were drawn from 57 families from NKC-OTCP, during July 2008 through to June 2010. This paper reports on the goal-setting information from the first 20 families (10 with a parent with a MI; 10 with a parent with a DD), who completed three reviews of goals over a 12–18-month period. In the 10 MI families, there were 18 parents and 24 children and in the 10 DD, families, there were 15 parents and 26 children. This project was approved by the university ethics procedures (MUHREC approval CF08/3100: 2008001528). The characteristics of these families are outlined in Table 1.

### Procedure

NKC-OTCP provides a home visiting programme using a recovery framework for families. Goals for each willing family member were collaboratively negotiated in a variety of areas and these goals were recorded in a family care plan. Initial goal setting was undertaken with the case manager and family members in the first month of the programme. While children and parents were asked generally what they wanted to work towards, specific questions were framed around 11 domains consisting of family connectedness, mental health knowledge, child development, education, interpersonal skills, substance abuse, lifestyle, diet and exercise, community and social connectedness, finances, family health and well-being, and accommodation (see Table 2). These domains were used as a prompt for goal setting with no compulsion for goals to be set unless personally relevant. The domains were developed by the case managers on the basis of the literature as well as their experiences of working with families. For example, rather than 'health' (as per Clarke *et al.* 2012), goals were discussed in relation to the physical health and well-being of each family member (and so were titled 'family health and well-being'). See Table 2 for selective examples of goals for children and parents, as

**Table 1** Demographic and well-being characteristics of families that completed all goal reviews in the recovery model

Demographic item	Families with parent MI	Families with parent DD
Number of parent-client	10	10
Number of partner	8	3
Number of parent/partners setting goals	18	15 (includes goals set for action by one non-resident father and one grandparent)
Mean age of parent-client	41.4 years	36.3 years
Gender of parent-client	9 females, 1 male	8 females, 2 males
Ethnicity of parent-client	All white Australian	8 white Australian, 1 Aboriginal and 1 part-Aboriginal
Parent diagnosis	2 schizophrenia, 2 bipolar, 1 depression, 1 anxiety PTSD depression, 1 anxiety/psychosis, 1 anxiety depression borderline PD, 1 anxiety/PTSD, 1 depression/anxiety	2 schizophrenia, 2 depression, 2 bipolar, 1 bipolar/depression, 1 bipolar/ADHD, 1 drug-induced psychosis, 1 anxiety/depression/OCD/agoraphobia
Parent substance abuse issue	Nil	5 marijuana, 2 alcohol, 2 alcohol/marijuana, 1 heroin
Presence of family violence	5 with history of family violence in last 3 years	3 with history of family violence in last 3 years
Total children in households	24 (10 boys, 14 girls)	30 (19 boys, 11 girls)
Mean number of children in house	2.4 children	3.0 children
Number of children who set goals	24 (10 boys, 14 girls)	26 (16 boys, 10 girls)
Mental health/substance issue in children/partner	1 depression, 1 bipolar, 1 alcohol	1 depression/marijuana, 1 unspecified drug use

recorded in family care plans. While not exhaustive, goals were focused on issues associated with the ‘illness’ (e.g. management of substance abuse) but more commonly on ‘strengths’ (such as educational aspirations). Goals for the parent and each child were written collaboratively between the case manager and the family and included short- and long-term goals. Goals were reviewed every 4 months.

While this paper is specifically oriented to family goal setting and recovery, it should be clearly noted that the general model employed was also individually recovery oriented for the parent with the health concern. As with the child and family, this also employed a strength focus, was person and goal centred and employed a case management approach that was predicated by a mental health plan initiated by a local general practitioner or psychiatrist. In this paper, we chose to illustrate the adult in recovery goal setting according to how their goals related to family and children; however, many goals were also individually focused and personal to their recovery. For instance, goal content areas in Table 2 that could be considered more individual recovery focused include mental health knowledge, education, interpersonal skills, substance abuse, lifestyle, diet and exercise, community and social connectedness, finances, and accommodation. Goals relating specifically to indi-

vidual adult recovery (not closely related to family) are also shown in the third column of Table 2. For example, ‘Improve ability to identify early warning signs of illness by identifying and reporting signs of self-isolation’ (mental health knowledge) and ‘(adult) Mum explore further education options for herself’ (education) and ‘Improved ability to deal with anger in a healthy way’ (interpersonal skills).

At each review, established goals were rated according to achieved (3), good progress (2), some progress (1) or goal not achieved (0). This enabled an assessment of change (achievement) in goals, a comparison between achievements in goal areas, a comparison between the two types of families and between parents and children. The scale was rated jointly by case managers and family members.

When goals were initially established, each goal was scored as a 0, signifying a base level of non-achievement. While some goals were smaller components of larger goals – that could be rated as at least somewhat achieved – it was decided to establish each individual goal, initially as 0, not achieved. This decision was made for three reasons:

1. Each goal (even if part of a larger goal) was established as needing improvement.
2. This ‘anchored’ the goals baseline when it was established.

**Table 2** Actual examples of goals for parents and children from MI and DD families

Goal content	Child examples	Parent examples
Family connectedness	Develop relationship with siblings (MI)	Barriers to dad spending time with the older boys is identified and addressed (DD)
	Improve relationship with dad (DD)	Mother to develop a shared interest with each child (MI)
Mental health knowledge	Learn about mum's physical and mental health issues and the difference between the symptoms (MI)	Parent to learn coping strategies to manage mental health by going for regular walks and maintain regular exercise (MI)
	To learn how to talk about how her mum's illness impacts on her (DD)	Improve ability to identify early warning signs of illness by identifying and reporting signs of self-isolation: (1) sunglasses inside, (2) stop going outside, (3) retreat to own bedroom (DD)
Child development	To stop soiling pants at school (MI)	Work with outside agencies to improve developmental outcomes for child (MI)
	To walk to school on own (DD).	Understand normal child development milestones (DD)
Education	Attend school on a regular basis (MI)	Mum explore further education options for herself (MI)
Interpersonal skills	Obtain support for doing homework (DD)	Support children in going to school (DD)
	For child to feel safe to express himself without aggression or judgement (MI)	Parents to demonstrate to children respect and an ability to negotiate (M)
Substance abuse	Express frustration in an appropriate manner. Work with child in identifying triggers of anger and identify a more appropriate response and on her self esteem (DD)	Improved ability to deal with anger in a healthy way (DD)
	Provide child with education on substance use (MI)	Parent to use alcohol in moderation (MI)
Lifestyle, diet and exercise	Children to have an understanding of the methadone programme (DD)	Parents ensures children are not exposed to drug use (DD)
	Actively participate in school sport and activities (MI)	Parent to attend ceramics classes on Mondays (MI)
Community and social connectedness	Increase healthy ways to release energy and remain stimulated (get information on local hip hop, gymnastics/martial arts classes) (DD)	Maintain good eating habits (DD)
	Attend ballet classes and have home and away sleepovers (MI)	Attend choir at community house (MI)
Finances	Child to attend peer support groups offered by NKC (DD)	Parent to participate in the local community (activities listed here) (DD)
	Child to receive pocket money (MI)	Access financial counselling support (MI)
Family health and well-being	Child to earn some money for his money box (DD)	Parent to put money aside for family activities (DD)
	Child to have a tonsillectomy (MI)	Mother to manage her arthritis by regular doctor appointments (MI)
Accommodation	Child to learn better dental hygiene (DD)	Attend grief and loss counselling (DD)
	Child to have her own room (MI)	Work with community housing to get house (MI)
	Child to keep his room tidy (DD)	Mother to maintain an organized and clean home environment (DD)

3. This reduced confusion among families when setting goals and made it easier to track changes in goals over time.

Consequently each goal, even if part of a larger goal, was established on the basis of needing improvement. This 'anchored' the goals baseline when it was established and reduced confusion among families when

setting goals, also making it easier to track and score changes in goals over time.

**RESULTS**

As outlined above, goals were initially established as not achieved and scored as 0 and were considered as an

individual's baseline for that goal. The change scores outlined below were calculated based on the final review score for each goal for each individual as progress related to the initial base line (i.e. 0). For example, once established, a single goal may have been reviewed and scored for its achievement up to three times during the course of the programme; however, the goal change score was calculated based upon the difference between the baseline and the final goal review achievement score. This enabled an assessment of change in goals (achievement) and the collated and averaged achievement scores are shown in Table 3.

The goals of the two groups of families were compared on completion of the home visiting service. We focused on 'completers' as this allowed a comparison of 'like' families when attempting to determine differences in the two types of family groups, especially in regard to goal achievement.

Parents set on average 2.48 (approximately 30%) more goals than children and the DD parents set more goals than their MI counterparts. The MI children set slightly more goals compared to the DD children. The most notable difference was that DD parents set almost 50% (3.83) more goals than their children. However, those same children scored greater goal achievement than their parents and the MI children. All children reported being more likely to achieve their goals than their parents. The notable difference was that the children with DD parents scored higher on goal achievement, than children with MI parents (0.26 higher). There was minimal difference in achievement scores for the different groups of parents. The goals and change scores for each of the specific goal areas are shown in Tables 4 and 5.

Across the two groups of children, goals were mostly set in seven areas, namely, education, interpersonal

**Table 3** Number of child and parent goals set, reviewed and mean change score, for 20 families who completed the home visiting programme

Families (n = 20)	Parent disorder	Total goals set	Average goals per person	No. of goals reviewed			Average change score
				First review	Second review	Third review	
Children (n = 24)	MI	192	8.00	93	59	59	1.88
Children (n = 26)	DD	189	7.27	96	62	55	2.14
Children (n = 50)	Total	381	7.62	189	121	114	2.00
Parents (n = 18)	MI	165	9.17	89	52	44	1.75
Parents (n = 15)	DD	165	11.00	86	66	49	1.78
Parents (n = 33)	Total	330	10.00	175	118	93	1.77

Goal area	Goal no. (%)		Change score*	
	MI	DD	MI	DD
Family connectedness	25 (15)	23 (13)	1.40	2.42
Mental health knowledge	24 (14)	24 (14)	2.25	2.21
Child development	16 (10)	14 (8)	1.88	2.43
Education	26 (15)	34(20)	1.81	2.29
Interpersonal skills	26 (15)	24 (14)	1.85	1.67
Substance abuse	2 (1)	5 (3)	2.00	2.40
Lifestyle	16 (10)	22 (12)	1.88	2.09
Community and social connectedness	13 (8)	16 (9)	2.15	2.13
Finances	7 (4)	2 (1)	2.14	1.00
Family health and well-being	9 (5)	6 (4)	1.44	1.33
Accommodation	4 (2)	1 (1)	2.75	3.00
Total	168 (100)	171 (100)	1.88	2.14

**Table 4** Children – number and proportion (%) of goals set and average change score for each goal area from two types of families who completed the home visiting programme

\*The mean change score was calculated based on 168 and 171 goals completed – not the total goals set.

**Table 5** Parents and partners – number and proportion (%) of goals set and average change score for each goal area from two family groups who completed the home visiting programme

Goal area	Goal no. (%)		Change score*	
	MI	DD	MI	DD
Family connectedness	22 (15)	14 (9)	1.36	1.71
Mental health knowledge	32 (21)	26 (17)	1.84	2.12
Child development	8 (5)	9 (6)	2.12	1.78
Education	13 (9)	16 (11)	2.08	1.81
Interpersonal skills	25 (17)	17 (11)	1.44	1.35
Substance abuse	3 (2)	17 (11)	2.33	2.18
Lifestyle	11 (7)	15 (10)	1.73	1.27
Community and social connectedness	17 (11)	12 (8)	2.06	1.92
Finances	10 (7)	12 (8)	1.70	1.67
Family health and well-being	7 (5)	5 (3)	1.71	1.88
Accommodation	2 (1)	7 (5)	2.00	1.71
Total	150 (100)	150 (100)	1.75	1.78

\*As with the children, the mean change scores were calculated based on 150 and 150 goals – not the total goals set.

skills, mental health knowledge, family connectedness, lifestyle, child development and community, and social connectedness. Family connectedness, mental health knowledge, education and interpersonal skills were the most common goals set by children whose parent had a MI. They were also common for the children whose parent had a DD; however, their most common area was education with 34 goals (20%) set.

As noted above, children whose parent had a DD had higher overall change scores for their goals (0.26 higher on average than children whose parent had a MI), signifying greater progress towards goals. In addition, these children had comparatively higher goal change scores for specific goals, e.g. family connectedness (1.02 points higher), child development (0.65 higher), education (0.48) and substance abuse (0.40 but a small number of goals). These children were more likely to report greater achievement of these goals than were the children whose parent had a MI. Conversely, there were two goal areas where children whose parent had a MI scored substantially higher (e.g. interpersonal [0.18] and finances [1.14 but note the small numbers of goals]).

Generally, parent goals were set across multiple goal areas for mental health knowledge, interpersonal skills, family connectedness, education, community and social connectedness, lifestyle, and finances. Mental health knowledge (21%), interpersonal skills (17%) and family connectedness (15%) were the most common goal areas for parents with a MI; while mental health knowledge (17%), substance abuse (11%) and interpersonal skill (11%) were most commonly pursued by parents with a DD.

While the average change score across all goals was equivalent for the two groups, parents with a DD scored more highly on family connectedness (0.35) and mental health knowledge (0.28), whereas the reverse was found for child development (0.34), education (0.27), lifestyle (0.46) and for accommodation (0.29) with parents with a MI scoring more highly. Of interest was that both groups scored interpersonal skill goals to quite a low level (1.44 and 1.35) – indicating some progress towards the goal (1) rather than good progress (2).

## DISCUSSION

Recovery models and goal-setting exercises rarely focus on parenting and family life. This paper illustrates goal setting in a model of recovery for all family members. To the best of our knowledge, this paper is the first to offer an insight into the types of goals established and achieved by family members in a recovery model. This offers an insight into the goals and needs of all family members when a parent is in recovery.

In terms of the bigger picture, the findings beg the question of how well can family goal setting be integrated within a recovery paradigm? Clarke and colleagues recently summarized 14 goal domains (see Clarke *et al.* 2012, p. 300) within a taxonomy of recovery goals for individuals. Many of the goal areas are similar to those identified in Table 2 in this paper. For example, Clarke and colleagues illustrate psychological health, house and home, education, and family relationships as goal categories. These goals map

closely to mental health knowledge, accommodation, education and family connectedness in the current study. There appear to be many domains similar in the two studies and at a concrete level, a family-focused approach would appear a 'natural fit' within a recovery paradigm.

At a theoretical level, recovery models focus upon hope, identity and meaning, and the data from the present study suggests that when asked, parents will focus upon parenting, children and family as an important element of their recovery. As suggested by Nicholson (2010), this gives parents the strength and will to sometimes 'keep going', to focus upon a key part of life that gives meaning and purpose and/or contribute to providing opportunities for meaningful interactions and activities with others (Nicholson 2010). Thus, identifying and supporting an individual's parenting role can provide hope, a sense of agency, self-determination and meaning, all consistent with a general recovery approach for individuals.

However, there may be at least one key problem with integrating family goal setting within a recovery paradigm. That is, when different individuals' goals conflict. This was recently identified as an issue by the Victorian State (Australia) government, who suggested while discussing family and person-centred practices in regard to children with disabilities that '... young people, sooner or later, will make a choice, take an action or express a preference that conflicts with the preferences of their family of origin.' (2011, p. 49). In regard to a family recovery approach, tensions may sometimes arise between the competing needs of the parent in recovery and the needs of their children. For example, the parent may require respite from children to improve their mental well-being; however, at the same time, the child may need additional time and comfort with their parent to meet their attachment needs. In such circumstances, integrating family goal setting within a recovery paradigm may lead to conflict that requires ongoing negotiation and attention.

In regard to the current group of participants in this study, education was the most important goal set by children whose parents have a MI, which included regular school attendance and passing assessments. Equally important for children was building family connectedness and relationships, acquiring knowledge about mental health and well-being, and developing their interpersonal skills with friends and family. The most important goal for parents with a MI was acquiring knowledge on mental health and well-being (which also included understanding how their MI

impacted on children and the family) with other important goals being to develop interpersonal skills and enhance connectedness with families. These goals are in sharp contrast to that of Clarke *et al.* (2012) who found that physical health goals and employment and career goals were the most important goals for those with a mental health problem. In this study, employment goals were incorporated into community connectedness (rated 11%), and physical health goals was considered in family health (5%). Such a result indicates that those with a MI and who are also parents of dependent children might well establish different goals than those without children, and that these goals have a greater focus on family dynamics and their MI. In terms of achievement, children made good progress on goals related to acquiring mental health knowledge, though less progress on their other goals. Parents made only some progress on acquiring mental health knowledge and developing interpersonal skills.

For children whose parents had a DD, the most important goal was education. Other goals were around developing interpersonal skills, family connectedness and acquiring knowledge around mental health. Parents in these families predominately established goals in acquiring mental health knowledge, with other goals on substance abuse (in terms of managing it) and developing interpersonal skills with friends and family. This is again different from the Clarke *et al.* (2012) study, perhaps because the present group of individuals included those with substance abuse as well as mental health difficulties. Children made good progress on all of their most prominent goals, while parents made good progress on acquiring mental health knowledge and managing their substance abuse.

Similarities and differences across family types were also sought. Improving education as well as acquiring mental health knowledge was a goal established by children from both family types, with mostly good progress made in these goals. In terms of mental health literacy, multiple studies (and interventions) now incorporate the notion that 'knowledge is power' (Reupert & Maybery 2010). More specifically, educating children about their parent's substance or mental problem in an age appropriate manner is thought to provide 'power' to the children, in that such knowledge can alleviate unnecessary fears about the illness and reduce confusion (Beardslee & Poderefsky 1988). Children need to be supported in their educational aspirations, and families need to be encouraged to have discussions about the parental disorder and

the impact of the disorder on children (see for example, Solantaus *et al.* 2010).

While young people of parents with a DD established the least number of goals they did however achieve, on average, the highest change scores for their goals. This was 0.26 points higher than the MI children and 0.36 higher than their parents who had a DD. Perhaps this result indicates a need to reduce the number of goals and to ensure that they are achievable within a certain time frame; or alternatively that more time is required for parents to achieve goal completion. Children from families where a parent has a DD also achieved greater progress in regard to family connectedness, child development and education goals compared to children whose parent had a MI.

Another significant finding is that while family connectedness (including a focus on enhancing family interactions and family problem solving) was an important goal established for parents and children across both family types, relative to other goals, achievement was low (with the exception of children whose parents had a DD). While there have been repeated calls to support the relationships between family members where a parent has a mental health or substance abuse problem (e.g. Nicholson 2010), this might well be a difficult and long-term goal to achieve. Why children whose parents have a DD progressed reasonably well in this goal is unclear and requires follow up investigation.

Parents with a MI achieved greater progress than parents with a DD on child development, education, lifestyle and accommodation goals. The most important goals established for parents with a DD were for mental health knowledge, substance abuse and interpersonal skill; they achieved greater progress than parents with a MI on family connectedness and mental health knowledge. Interestingly, both groups of parents considered that they needed more education and knowledge about mental health issues – this has implications for clinicians in terms of providing ongoing education for parents in recovery.

Another finding from parents was the relatively high goal achievement score of parents with a DD on MI knowledge and substance abuse goals. Both goals were above a score of 2 (good progress), and higher than other goals. Alternatively, parents with a MI were perhaps notable for both high and low scores. They indicated good progress (above 2) on five goal areas but perhaps most interesting was the lower progress scores on family connectedness and interpersonal skills. Notably, these latter goals were the second and third most attempted goal areas.

Not every family will have the same needs nor goals, even if they have a parent with a MI or substance abuse problem. This research does however indicate that some goals might well be more important than others for some families. The need for mental health professionals to engage with consumers about the needs of their families and their parenting responsibilities is underscored in this paper, possibly with goals established around those areas, especially in terms of family connectedness and mental health knowledge. At the same time, mental health professionals need to be also mindful that some goals will take considerable longer for families, especially parents, to achieve.

A possible limitation to the interpretation of the data presented here is that the establishment, monitoring and assessment of goals relied on the consistency of approach of the case manager and the parents and children, leading to a possible bias. For example, some case managers could have (unconsciously) been biased towards goals that they were more familiar with, and felt more able to assist parents and/or children to achieve. The same potential bias applies to those goals a case manager is not familiar or comfortable with (e.g. a case manager may not want to address difficult drug and alcohol issues and instead focus on children's needs). Similarly, families might have chosen goals they were more able to achieve – to perhaps more easily satisfy expectations placed upon them. In addition, it was assumed that goals started with a baseline of 0. However, some goals were at least somewhat achieved and others were sub-goals of other goals that were also partly achieved.

The findings have important implications. With family members setting between 7 and 11 goals each and consistently monitoring them during up to an 18-month period, goal setting appears an important ingredient in a recovery approach. This was also highlighted by, on average, good progress made by families reaching these goals. Education and specifically mental health knowledge, in particular, appears important especially for children whose parent has a DD. For parents, the prominent goal areas are mental health knowledge, interpersonal skills, family connectedness, education, community and social connectedness, lifestyle, and finance goals. Such data provide clear areas for action by family members and others implementing a family-orientated recovery approach.

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