NSW Family Focused Recovery Framework 2020-2025

A framework for NSW Health services

NSW GOVERNMENT

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Tara's story demonstrates the significant difference that NSW Health workers can make to a person's recovery journey and their family's positive experiences of care.

Tara's story

"Family recovery and resilience was essential to my recovery and having that acknowledged and addressed was the only way for me to work my way back to recovery."

Parenting with Obsessive Compulsive Disorder

I was the mother who was always trying to be the perfectionist and bake cupcakes for the class and dress-up for Book Week and hat parades for my children. I also have a lived experience of mental health issues. I've had Obsessive Compulsive Disorder (OCD) issues and anxiety issues since I was a teenager and for the most part I've dealt with it myself.

Worries about losing my children

In 2013 my father died and I lost the only remaining family member from my family of origin. The OCD and anxiety began to invade my life to the point where I needed to see my GP. The fear of the stigma of mental health and the albeit irrational worry that I may lose custody of my children stopped me from continuing to seek help. I worried that if I didn't do it 'just right'...something would happen to my children.

Early in 2015, I was having panic attacks. I became obsessed with exact routines. I just kept getting worse. I was barely eating dry crackers and I spent hours trying to get things 'just right', so as to protect my family. I thought if I didn't do everything 'just right'... something would happen to my children.

My GP put me on medication but I started to feel worse. I wasn't sure if it was due to the medication but as my GP had gone on leave I didn't know where to turn. I got to the point that I begged my husband to get me help, but we didn't know where to get it from. The only help I could find was the mental health line. They said I should go to the local psychiatric hospital as there's always a local psychiatrist on duty who can review the medication I was taking.

Six weeks in hospital

The first day I tried to go to hospital I couldn't because my routines weren't right. The second day, after starting at 10am, I finally made it to Admissions at 2pm. My husband had to go because it was school pick-up time. So there I was, alone, defeated by my OCD and anxiety and unable to function. I was assessed and stayed as an inpatient for six weeks.

Losing my parenting role

My anxiety to fulfil my parental role as perfectly as possible contributed to my condition. My self-esteem was very low and my whole sense of identity and self-worth centred on me being there for my family to the best that I could. When I was admitted to hospital, I felt that was taken away from me and I had even less control. My anxiety was increasing, my mental state decreasing, all of which was exacerbated when I was in hospital by this sense of losing my parental role. My family did not know how to deal with a mental health admission which added to our stress.

My anxiety to fulfil my parental role as perfectly as possible contributed to my condition.

My family needed help

Add to that - my family had no rule book on how to cope. There was stress placed on my family, and particularly on my husband, who did not have a clear procedure for what to do when visiting with children, let alone how to explain a mental health admission to them. A major stressor was that our youngest child didn't know about my mental health issues, and we didn't want him to know. They knew I was in hospital and they visited me but they were not told specific details.

Being separated from my children

This was also the first time I'd been separated from my youngest child. He had special dietary needs that I was always in charge of. How would he have his dietary needs met? How would he get to school? How would he sleep overnight? How would he cope without me?

How health workers made a difference

They acknowledged my role as a parent and talked with me about my family and any concerns I had

Having a clinician who was understanding and acknowledged me as a parent helped me to express my fears and I really felt she wanted to help us.

So from that point on I was happy and confident to involve my son and husband in conversations regarding mental illness and plan supports for each of us.

They helped us use the family friendly visiting area

Whilst I was in the hospital we were fortunate enough to have access to the family room - a dedicated area for families to feel safe, comfortable, to connect and spend time together. Given that this was our first separation it was important for us to have a safe, child-friendly visiting space on a locked mental health unit where we could feel comfortable and have regular contact.

They gave us resources, information and helped us develop a family care plan

We as parents were given resources that included carer information and together we developed a family plan. Talking gave us answers, helped us to understand, and gave us hope and alleviated confusion and fears. It helped us to get past the stigma of mental health.

They valued our own knowledge about what we needed

We were actually listened to and our insight into our own family was valued. It helped us to be able to communicate with each other better.

Jessica's story - a story of a young carer

Becoming a young carer

I always like to preface my story with, my dad is a really great parent. He has been loving and supportive my whole life.

I'm 23 years old, I live in a small rural community, the same community I grew up in. I grew up on a farm with my parents and my brother. When I was about seven or eight, the drought started to affect our family business, and affect our whole community.

During that time, my father developed depression, which was a very confusing time for the whole family. He also had a workplace accident around that time, which really exacerbated that situation, from that experience, I became a young carer.

Acknowledging there was a problem and getting help

I started noticing he was withdrawing from doing things with us, we used to go on bike rides around the farm, he used to help me with my horses, he was finding those interactions a lot more difficult, and he was very unmotivated.

In my mind, I was thinking that I'd done something wrong. But my mum was the one that recognised that it was a problem within himself, that he needed to address.

The first step was for him to go and speak to his GP. Saying it out loud, and addressing it with people. From there, he became involved with some mental health services, where he saw a psychologist, found some medication that worked for him.

It definitely wasn't a complete upward trajectory from there. There was a lot of really tough times, especially in the beginning of the medication, trying to find what was the best fit for him. In that period, he voiced that he wanted to end his own life, which was very confronting. I was present for that.

I was recognised as being part of the process

We had a lot of conversations, within groups, about what was going on for us, and what we could do. It was very age-appropriate. I was recognised as being part of the process, I was considered a factor in it, more than just collateral information, which I really appreciated. It is really difficult, when a medical professional is sitting there telling you what to do, versus when you're with that person 24/7.

The importance of seeking help

Without seeking help, I believe that my father may not have lived. He was in a very, very difficult place, where he did want to end his own life. So, it's made the world of difference to our family. I've got to grow up with my dad, my mums got to have her husband, but it's also impacted us, in the sense that, he has become well. He's been able to make strides in his career, and be a supportive father, and give back to the community. We've been able to see someone, really, rise up against that adversity, and say, "I'm man enough to recognise that I need help, to seek that help, and then to grow from that, and help others." And, he's been a really big example for all of us. So, yeah, not just having him, but then to see him flourish, as well, on top of that, has been a really great experience.

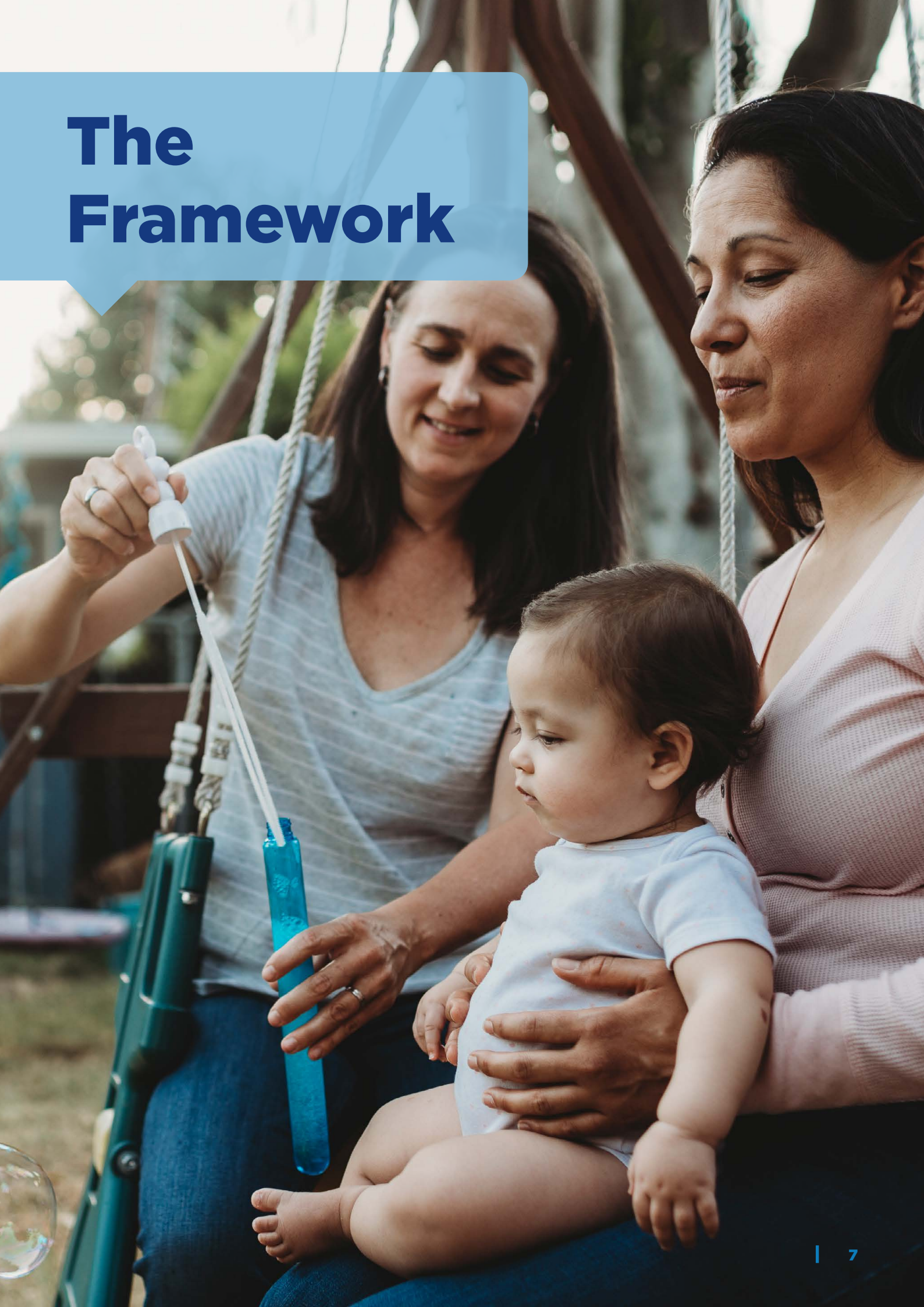
It is very difficult, but we do have a really good relationship now. I suppose, that's part of that family-focused recovery, those relationships don't have to be permanently damaged, and early intervention can maybe stop some of those bridges from burning.

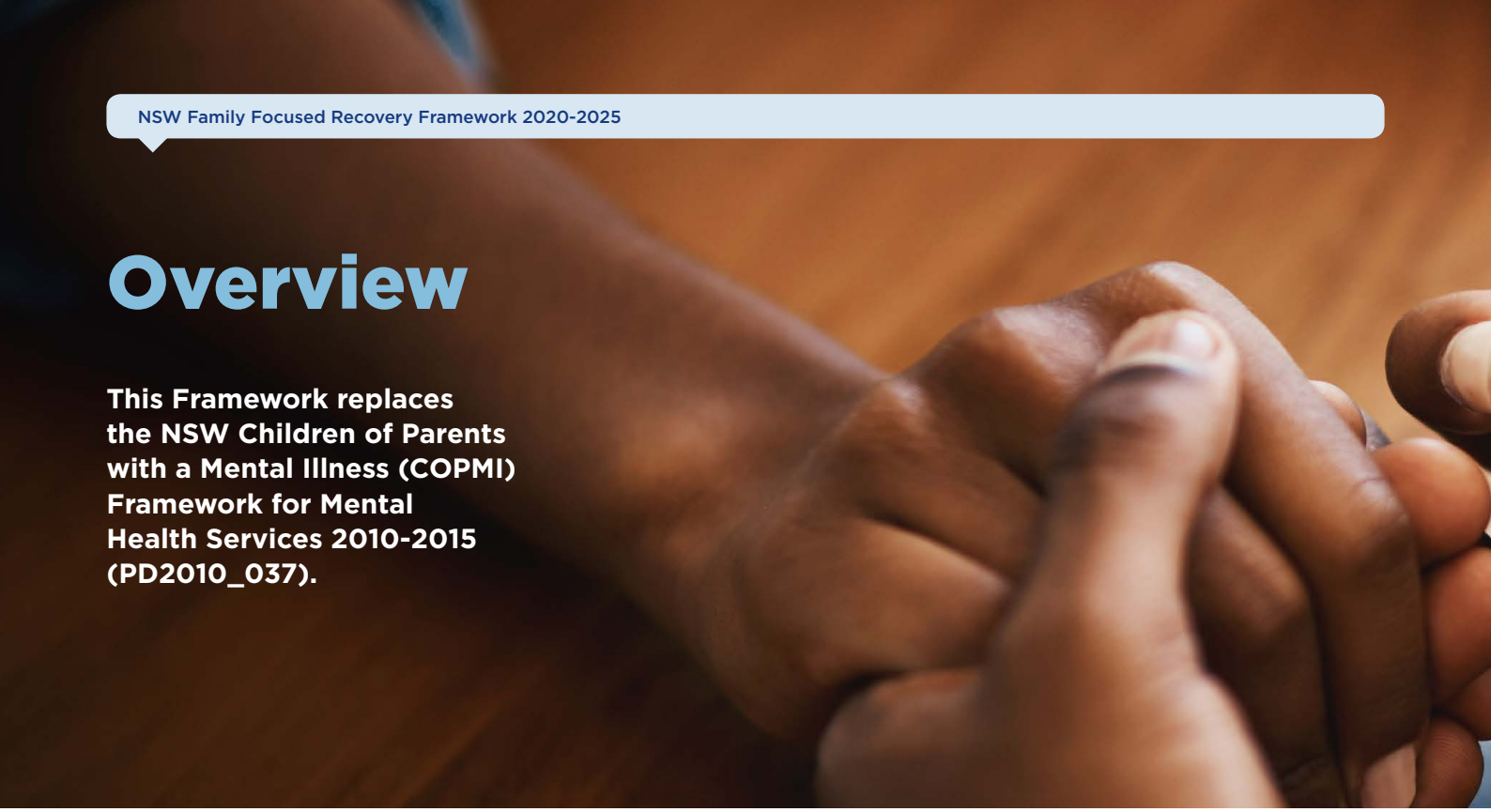
Acknowledgement

The NSW Ministry of Health would like thank Tara and Jessica for allowing their true stories to be shared to help those reading the NSW Health Family Focused Recovery Framework 2020-2025. The stories highlight the positive impact services make for parents with lived experience of mental health issues and their children and families.

The first step was for him to go and speak to his GP. Saying it out loud, and addressing it with people.

The Framework





Overview

This Framework replaces the NSW Children of Parents with a Mental Illness (COPMI) Framework for Mental Health Services 2010-2015 (PD2010_037).

Scope

Over the past decade change to incorporate family and parent focused practice has occurred but is yet to become fully embedded into mental health services in NSW.

This Framework builds on 'COPMI' learning to date and provides a fresh way forward to guide services in improving support to families where a parent lives with mental health issues and has dependent children through implementing a family focused approach.

It is acknowledged that people have many and often multiple interpersonal dependences and that these relationships may be of great personal significance to each person. Whilst the family focused nature of this framework relates to parents and dependent children, the overarching importance of all relationships is recognised, including diverse caring relationships.

Purpose

Family focused recovery practice is sometimes not well understood. This Framework explains family focused recovery practice, outlines the underpinning principles and describes how a person-centred and family focused approach can be implemented.

Actions in the Framework are designed to improve outcomes in the immediate and longer term for infants, children, young people, parents/carers and families through expanding the family focused aspect of person-centred assessment, treatment and support.

Vision

All members of families where parents live with mental health issues are safe, well and supported.

Objectives

An overview of the Framework is presented in Table 1 – the Framework at a Glance.

To improve outcomes for families impacted by parental mental health issues, the Framework outlines three objectives for mental health services. These are to:

1. Embed a family focused approach
2. Deliver evidence informed interventions to meet the needs of families
3. Coordinate treatment and support

Implementation of the **Mental Health Statement of Rights and Responsibilities 2012**, and the NSW Health **CORE values** underpin family focused recovery practice (Appendix 1).

Vision

All members of families where parents live with mental health issues are safe, well and supported.

Strategic alignment

The person-centred and family focused prevention and early intervention approach promoted in this Framework embeds the strategic directions of NSW Health's **The First 2000 Days Framework** and **Integrated Prevention and Response to Violence, Abuse and Neglect Framework**.

This Framework promotes best outcomes for vulnerable children and families in line with recommendations of **NSW Ombudsman Biennial Report of the deaths of children in NSW 2016 and 2017 (June 2019)** and the **NSW Forecasting Future Outcomes Stronger Investment Unit (2018 Insights Report)**.[1] The Insights report identifies two vulnerable groups prioritised for investment under the NSW Government Their Futures Matter (TFM) Reform:

- Vulnerable children 0-5 years (includes children with parents who have mental health issues as a risk factor)
- Children and young people affected by mental illness (their own mental health issues or parental mental health issues).

This Framework is aligned with the **National Action Plan for the Health of Children and Young People 2020-2030**, which prioritises support for parenting, parental mental health and prevention and early intervention for children, with a particular focus on the first 2000 days.

This Framework is also an action under the **NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022**: Objective Six: *Intervene early for children and young people* and guides action in line with the three goals of the Strategic Framework and Workforce Plan which are:

1. Holistic person-centred care
2. Safe, high quality care
3. Connected care

A strong emphasis of this framework is about integrating care for vulnerable and at-risk families who often have complex health and social needs. Implementing this Framework therefore supports the vision of the **NSW Health Strategic Framework for Integrating Care**.

Audience

This Framework guides the work of NSW Health services that provide clinical and non-clinical services impacting the mental health and wellbeing of families.

This Framework will directly inform the work of the following clinical services:

- Perinatal and Infant Mental Health Services (PIMHS)
- Child and Adolescent Mental Health Services (CAMHS)
- Youth Mental Health Services (YMHS), and
- Adult Mental Health Services (AMHS)

It also calls on Mental Health and general health services to develop coordinated and integrated care processes including through:

- Maternity Services
- Paediatrics
- Child and Family Health Services
- Youth Health
- Emergency Departments
- Alcohol and Other Drug Services
- General medical and psychosocial/social support services including specialty clinics for children and young people and
- Violence, Abuse and Neglect (VAN) Services.

Non-clinical services may for example provide management and oversight, develop policy, guidance and/or education and training materials.

Principles

The principles underpinning the Framework are:

- intervening early for infants, children and young people living in families where a parent has mental health issues can positively impact their health, wellbeing and life outcomes
- mental health and wellbeing outcomes for parents, children and family members are interrelated and can be interdependent
- offering parents with mental health issues support in their parenting role can improve their personal recovery as well as deliver prevention and early intervention benefits to their children
- recovery involves a social process occurring through relationships, particularly those of family
- connection to country and culture play a crucial role in recovery and wellbeing
- services play a critical role in improving outcomes for children, parents and families
- safety and risk, including child abuse and neglect and domestic and family violence (DFV), are primary considerations requiring a sensitive but proactive approach
- family-focused care recognises and respects the pivotal role of the family and the uniqueness of each consumer and family group
- services apply evidence based and trauma-informed practice that involves recovery oriented, person-centred, family focused and culturally and developmentally appropriate care
- inter-agency and cross-sector communication, engagement, collaboration and partnership are essential to meet the needs of various family members
- services use a co-design approach including people with mental health issues, families and carers when developing, planning, delivering and evaluating family focused mental health services.[2, 3]

Recovery involves a social process occurring through relationships, particularly those of family.

Implementation

Making family focused recovery a reality raises practical, professional and organisational challenges for services, but if we wish to value the family life of clients it is incumbent on services to help meet the needs of parents with mental health problems and their families.

The Framework includes a set of actions. The key task for all services is to decide which actions to focus on depending on local needs and formulate an implementation plan accordingly.

Everyone who works in the health service has a part to play. This will vary depending on your role, but we share overall responsibility. Substantial change can be achieved, albeit requiring significant dedication, commitment and determination from those involved.

The indicators of success listed here can be used by services to assess impact locally and in evaluating the impact of the framework overall.

A high-quality service that incorporates a family focused recovery approach is one where:

- Children and young people flourish despite their own or their parents' mental illness
- Parents get the support they need to cope and parent well despite their own or their children's mental illness
- Mental health services have a stronger family focus
- Individuals and families increase control over their own mental health.

Everyone who works in the health service has a part to play.

Framework at a Glance

The goals, objectives and framework scope are outlined in Table 1, the 'Framework at a Glance'. The objectives will be achieved through embedding the priority actions outlined in Tables 3, 4 and 5.

Table 1: The Framework at a glance

Vision

All members of families where parents live with mental health issues and have dependent children are safe, well and supported

	Holistic, person-centred care	Safe, high quality care	Connected care
Goals			
Objectives	**Embed a family focused approach**	**Deliver evidence based interventions to meet the needs of families**	**Coordinate treatment and support**
Scope	**Populations** • Pregnant women and partners and parents with mental health issues • Children of parents with mental health issues • People with increased vulnerabilities*	**Locations** • Hospitals • Community including community health settings • Schools and TAFE	**Service providers** • Mental Health including PIMHS, CAMHS, YMHS and AMHS • Maternity, Paediatrics, Child and Family Health • Youth Health • Emergency Departments • Alcohol and Other Drug Services • General medical and psychosocial/social support services • Violence, Abuse and Neglect (VAN) services
Action Areas	• Service Planning and Development • Resources and information • Family friendly environment • Service models • Assessment • Care planning	• Quality improvement • Interventions • Capability development	• Care pathways • Collaborative care

* **People with increased vulnerabilities**

Early intervention is important for all infants, children, young people and adults with mental health issues. Particular attention should be given to groups with additional vulnerabilities to mental health issues including, Aboriginal families,[4] people in contact with the child protection[5] and/or criminal justice systems,[6] LGBTQI people,[7] CALD families including populations who have experienced trauma,[8, 9] people who have experienced violence, abuse and neglect, and parents or children with physical health comorbidities, drug and alcohol co-occurring conditions, intellectual disability and or cognitive impairment and mental health issues.

Key terms

The Framework recognises the powerful and pervasive influences of culture, diversity, community, history, and understanding, on what are defined as 'mental health problems or illness', 'family' and 'recovery' and recommends tailoring approaches to intervention accordingly.

Children and young people

For the purpose of this document, at times, infants and children are collectively referred to as 'children' and adolescents and young people are collectively referred to as 'young people'.

Children of Parents with a Mental Illness (COPMI)

Services working to improve outcomes for children of parents with a mental illness have historically been known as COPMI services. The NSW Ministry of Health moved to using the term 'Family Focused Recovery' for its statewide COPMI program to recognise that COPMI work is focused on both parents and children where a parent lives with a mental health issue. Some Local Health Districts (LHDs) and Specialty Health Networks (SHNs) have adopted this term and others continue to use COPMI. The Framework recognises the terms as interchangeable.

Families

The Framework uses the term 'family' to encompass parents, care givers and children. It includes those nominated by the family as members of their family including people in an enduring emotionally close relationship that is marked by mutual recognition and importance in their respective lives.

The diversity of each family is recognised and acknowledged in areas including, Aboriginality, ethnicity, class, sexuality and gender identities, culture, religion, disability, age, power, status, sexual preference and family construct.

Family assessment

A family assessment involves identifying, gathering and weighing information of families to better understand the significant factors affecting their child's safety and wellbeing. Assessing family functioning can be undertaken using tools such as the North Carolina Family Assessment Scale (NCFAS).

Family focused recovery

Models of family recovery acknowledge that for many people with a mental health issue it is impossible to separate their own recovery from the functioning of their family or their responsibilities as a parent.[10]

The concept of family focused recovery expands the notion of individual recovery to include family and kinship relationships, specifically that:

- parent, infant, child, youth and family outcomes are often interdependent
- the parenting role can be central to recovery
- family recovery is facilitated by connections with the broader community
- connection to country and culture is important for Aboriginal families
- the alignment, contradictions and tensions between the values, attitudes, beliefs and emotional forces of a family, and those of the wider community, contribute to how recovery is approached.

Family focused recovery practice

Family focused recovery practice in mental health is a way of working with individuals and families that recognises and respects the pivotal role of the family. It supports family members in their natural caregiving roles, and with the consent of the consumer, encourages family collaboration and choice in treatment decisions.[11]

A family assessment involves identifying, gathering and weighing information of families to better understand the significant factors affecting their child's safety and wellbeing.

Mental health issues

The term 'mental health issues' has been used as an umbrella term to refer to people living with mental health problems or mental illness. This term was preferred by NSW stakeholders, acknowledging that public mental health services will largely be in contact with people with clinically diagnosable conditions (mental illness) and that some children will be living with parents with a range of mental health problems and conditions.

Mental health problems

Mental health problems refer to a person's diminished cognitive, emotional or social abilities but not to the extent that the diagnostic criteria for a mental illness are met.[12]

Mental illness

A clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities.[13]

Parents/Carers

For readability, the Framework uses the term 'parents' to include parents and carers who are in a parenting role.

People with lived experience

In line with the Strategic Framework and Workforce Plan, the term 'consumer' has been used to refer to people with lived experience of mental health issues using health services.

Personal recovery

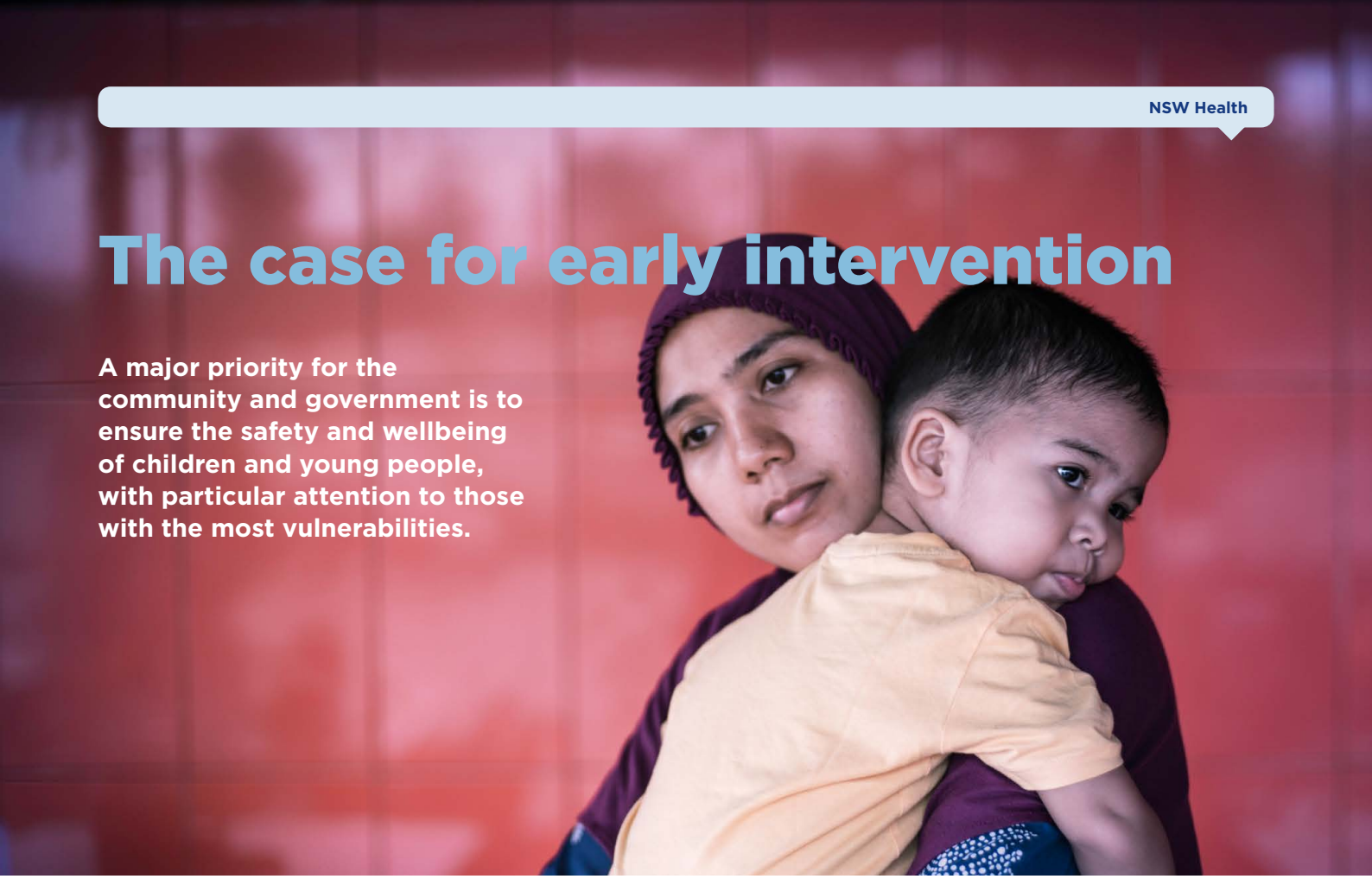
Personal recovery refers to being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues.[14]

Recovery oriented care

Recovery oriented mental health care recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues. It supports self-determination and self-management and assists families to understand the challenges and opportunities arising from their family member's experiences.

Through applying recovery oriented practice, staff assist consumers to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations.[15]

The case for early intervention



A major priority for the community and government is to ensure the safety and wellbeing of children and young people, with particular attention to those with the most vulnerabilities.

Many parents with mental health issues are capable parents and require little or no assistance with their parenting role and some children and young people will not be negatively impacted by the effects of their parent's mental health issues.

However, some parents with mental health issues will require support in their recovery as well as help for their children. It is not the parental mental illness in itself that is problematic for the child, but the episodic or enduring nature of serious mental illness can impact a parent's ability to function well on a consistent basis.

The prevalence of mental health issues and trauma in families with high levels of stress, as well as other risk factors such as domestic and family violence, sexual assault, drug and alcohol use, and stigma and discrimination are all factors that can create difficulties for a child.

Timely mental health treatment for parents, support for their parenting and preventative interventions for children and young people can significantly reduce the risk of mental health issues for children and young people.[16]

To avoid or minimise harm, vulnerable families and children at risk need NSW Health services to take a family focused approach to identify support needs and provide assistance as early as possible.

A data based snapshot of the issues

Data are not routinely collected on many of the indicators relevant to family focused recovery such as rates of children living with one or more parents with a mental illness, rates of young carers for parents with a mental illness and rates of consumers of public mental health services with dependent children.

Table 2 provides a brief overview of the available data on mental health issues for children, young people and parents.

Mental health prevalence rates

Many people are impacted by mental health conditions. The mental health prevalence rates for children and adolescents are around 14%[17] and for adults are approximately 20%.[18] Mental health services consistently reported that between 70 and 90 per cent of their patients have a history of violence, abuse and neglect.[19]

Families with a parent with mental health issues

Nearly a quarter (23%) of Australian children live in households where at least one parent has a mental illness.[20]

Parents with mental illness and their children constitute one of the most vulnerable families in society. In such families, the adults generally have poor health, economic problems and lower social status than in families without mental health issues.

These factors can collectively or individually increase the risk of affecting children negatively. Children who have a parent with a mental illness have a high risk of developing a mental illness or a serious socioemotional disorder themselves (41-77%).[21]

There are higher rates of Australian parents with mental health issues who live with children 0-14 years in single parent (35.6%) and Indigenous (25.2%) families compared to the average (16.3%). Couple families had the lowest rate (14.2%).[22]

The Longitudinal Study of Australian Children (LSAC) found one in five children lived in a family where at least one parent reported moderate/high levels of psychological distress. Children living in families where both parents have high levels of psychological distress, lone-parent families where the parent has a mental health issue and is without adequate support and families where unemployment is a factor, are likely to be more vulnerable.[23]

Parental psychological distress is known to be associated with poorer parental functioning including lower parental warmth and higher rates of hostile/ irritable parenting than for parents without mental health problems.

The LSAC found the following rates of hostile/ irritable parenting in 2011:

	Moderate/ high levels of psychological distress	Low levels of psychological distress
Mothers	33-41%	17-19%
Fathers	31-41%	18-19%

Multidimensional impact of mental illness on family members

Mental illness often has a 'ripple effect' on families, creating tension, uncertainty, troubled emotions and big changes in how people live their lives. Different family members are likely to be affected in different ways.

The impact of severe mental illness on family members can include physical health problems (sleeplessness, headache and extreme tiredness), psychological difficulties (depression and other psychological problems) and socioeconomic drift (less likely to marry, higher divorce rate and greater food insecurity). Impacts on children included higher mortality, poor school performance and nutritional problems.[24]

Impacts for Aboriginal families

National data confirm that Indigenous families are more likely to be impacted by parental mental health problems than non-Indigenous families. Indigenous adults have nearly three times the rate of moderate to high levels of psychological distress and twice the rate of hospitalisations for mental health conditions than non-Indigenous adults.[25]

NSW data indicate Aboriginal people are overrepresented in public mental health services. In the year ending June 2018, 3.41% of the NSW population aged 64 and under identified as being Aboriginal. In the same time period, 11% of consumers of NSW public inpatient and community based mental health services aged 0-64 years identified as being Aboriginal.[26]

NSW data indicate Aboriginal people are overrepresented in public mental health services.

Child safety and wellbeing are key concerns when a parent's ability to care for their children is impaired because of their mental wellbeing.

Parenting with severe mental illness

An Australian study by Morgan and colleagues in 2011, found parents receiving care from public mental health services for a severe and complex mental health issue were often the primary carer for children (1 in 4 mothers and 1 in 18 fathers). Child safety and wellbeing are key concerns when a parent's ability to care for their children is impaired because of their mental wellbeing.

Around a quarter of parents in the study were rated by interviewers as having "obvious or severe impairment in their ability to care for their children". Around one quarter of parents with dependent children in this cohort had contact with child protection services in the previous year.[27]

Young carers

Although there can be a difference between living with and caring for a person with a mental illness, as living together does not always involve an active caring role, there has been increasing recognition of the caring role that many children play in supporting a parent with a mental illness.

Children and young people are frequently carers for someone with a mental illness (2.6% of children 0-14 years and 12.1% of young people 15-24 years) and a proportion of these care recipients will be parents.[28]

Children and young people want the best for their parents, and in serious and long term illness, often take on major caregiving tasks in order to make the family life run normally. These tasks may in some cases impact the child's own wellbeing, schooling and leisure time.

Impact of mental health on parenting behaviour and the parent child relationship

Parenting behaviour is an important predictor of child health and developmental outcomes. Children with secure attachment tend to do better academically, socially, and have better language and cognitive skills.[29] Children of parents with mental health issues are generally at greater risk of poor parent-infant attachment, compromised mental health and delays in development.

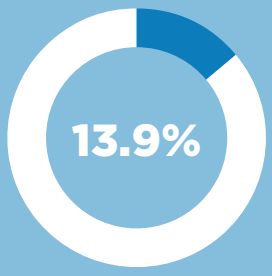
A review by Bromfield and colleagues for the Australian Government summarised how unmanaged parental mental health issues can impact parenting behaviour and child outcomes.[30]

The review noted that parental mental health symptoms varied depending on the illness and at times when symptoms are not well managed, a parent may:

- have problems with perception, cognition and communication
- be emotionally unavailable, withdrawn, unresponsive, overly critical, disorganised, inconsistent, tense, less happy and active with children
- have difficulty controlling emotions and become unnecessarily angry with their children
- have difficulty getting out of bed in the morning to take their children to school
- lose motivation in performing basic tasks such as doing housework or the shopping
- lack responsibility in the areas of safety; hygiene; nutrition; responsive nurturing of feelings; dealing adequately with illnesses and physical injuries; and managing money for household goods
- be fearful of abusing their children and so become withdrawn, or alternatively feel an intense need to protect their children and so appear intrusive and anxious.

Table 2: Snapshot of mental health issues for children, young people and parents

Prevalence rates



In 2013/14, **13.9%** of **Australian children** and **adolescents (4-17 years)** had a **mental disorder** (2013/14), and 1 in 7 of those (14.7%) had a **severe disorder**[31]

Around

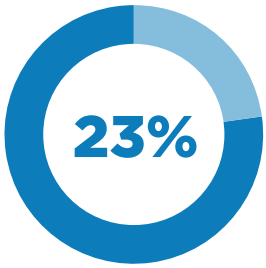
1 in 5 (20%)

of adults aged 16-85 years will have experienced a **mental disorder** in the previous 12 months. **3.1%** will have experienced a **severe mental disorder**[32]

Young carers

In 2012, **2.6% of Australian children and adolescents** (0-14 years) and **12.1% of young people** (15-24 years) were **carers** for someone (parent, sibling or other) living with a **mental illness**[33]

23% of **Australian children live** in households where **at least one parent** has a **mental illness**[34]

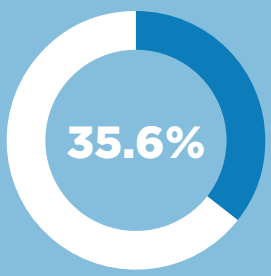


41-77%

Children of parents with a mental illness are at **41-77%** risk of developing a **mental illness** or a **serious socioemotional disorder**[35]

Higher parental mental health rates

In 2017, there were higher rates of parents with mental health issues with children 0-14 years in **single parent (35.6%)** and **Indigenous (25.2%) families** compared to all families **(16.3%)**[36]



Parents with severe mental illness

Parents

1 in 8 parents being treated for **psychosis** in the Australian public health system in 2010 had dependent children living with them **(1 in 4 females, 1 in 18 males)**

1 in 8

Caring impairment

Of those who were the primary carer for their children, around a **quarter (24.8%)** were rated by interviewers as having **obvious** or **severe impairment** in their ability to care for their children **(21.3% of mothers and 28.3% of fathers)**

1 in 4

Child protection contact

One quarter of parents with dependent children **(25.9% of mothers and 23.3% of fathers)** had contact with their state department of family/ community services in the past year[37]

1 in 4

2.7 x

Aboriginal families

Indigenous adults were nearly three times as likely to have **high** or **very high levels** of **psychological distress** than non-Indigenous people **(2.7 times)** and were hospitalised for mental health conditions at twice the rate of non-Indigenous people[38]

Aboriginal people are **overrepresented** in **NSW public mental health services**. In the year ending June 2018, 3.41% of the NSW population aged 64 and under identified as being Aboriginal. In the same time period, 11% of consumers of NSW public inpatient and community based mental health services aged 0-64 years identified as being Aboriginal[39]

Impact of parental mental health on children's outcomes

The Bromfield review also found that children of parents with poorly managed mental health symptoms can:

- face a higher risk of physical neglect as basic needs such as having regular healthy meals and clean clothes may not be met
- feel isolated and lack trust in parents if they fail to attend to children's emotional needs
- be at higher risk of physical and psychological abuse, if symptoms of the parent's illness contribute to the parent being violent, reactive or punitive
- be at risk of perinatal complications due to possible side effects of medications during pregnancy and high maternal stress levels
- experience attachment difficulties, particularly for children of mothers with maternal mental health problems such as depression
- become 'parentified' and assume the role of a carer for an ill parent or sibling.

Children experiencing supervisory neglect can also be at risk of abuse (e.g. sexual abuse) from extra-familial perpetrators.

Impact of parenting on parental mental health

The demands of parenting can be challenging for any parent, but particularly stressful for parents with vulnerabilities such as a mental illness. It is important that mental health services for adults ask about the impact parenting is having on the person's mental health.

Parents who have children with special needs for example as a result of mental health issues, physical and/or intellectual disabilities or other issues (such as challenging behaviours) are likely to require additional supports to be in place.

It is also important that specialty clinics for children (such as Cystic Fibrosis, Diabetes and other physical health clinics) ask whether parents live with a mental illness. These families may benefit from mental health consultation liaison, community based support and family based groups to assist with parenting strategies and other supports.

Risk and protective factors

Risk and protective factors at individual, family, community and society levels, can influence the course of infant and child development through their cumulative impact across time.[40]

These factors include:

- heredity (genetics/epigenetics)
- family functioning
- temperament
- social supports
- coping strategies
- school practices
- parenting
- environment and community
- family environment
- adverse childhood experiences

There is typically no one driver or no single point of intervention that can ensure positive child development. Combinations of risk and protective factors can create developmental pathways, leveraging and building resilience or exposing or escalating vulnerabilities.

Parents, play and home environments are critical to child development, health and wellbeing outcomes. Parenting is so influential that it can moderate the impact of social and economic disadvantage.[41]

Emily 17 years

"My grandmother's mother committed suicide which was, like, a hundred years ago probably but like, that affected my grandmother which affected my mum and it's weird to think about something so long ago that had to do with mental illness affects me now 'cause my mum wouldn't be the way she is if something like that hadn't happened ages ago..."[42]

Intervening early

The first 2000 days period from conception to a child's fifth birthday provides a crucial window of opportunity to shape long-term trajectories, particularly given the brain development occurring over the period of 0-3 years. Brain development during adolescence presents another window of influence as the brain continues to grow at what is a time of transition from family to increasing peer influence, and exposure to risky behaviours increases.[43]

Universal services that provide holistic health, learning and parenting support, along with early identification of potential risk factors and comprehensive support for families with established risks and low protective factors are important in this period. The aim of this work is to prevent negative trajectories escalating by employing proportionate universalism (resourcing and delivering universal services at a scale and intensity proportionate to the degree of need) to respond to early signs of vulnerability and disadvantage.[44]

Links between adverse childhood experiences and mental health

Adverse Childhood Experiences (ACEs) refer to some of the frequently occurring sources of stress that children may suffer early in life. These include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.[45]

Research is showing cumulative relationships between ACEs and a wide range of health outcomes across population groups and locations.[46] Over the last ten years, there has been growing evidence on the damage that ACEs can have on child development, adult health and life opportunities. Advances in neurodevelopmental and epigenetic research have shown how ACEs can create lasting changes in the developing neurological and physiological systems of children and how these in turn can embed susceptibility to mental illness, chronic disease and health-damaging behaviours.[47, 48]

The ACE study found exposure to one or more maltreatment-related ACEs accounted for 54% of the population attributable risk (PAR) for depression, 67% of the PAR for suicide attempts and 64% of the PAR for addiction to illicit drugs. Exposure to five or more ACEs was associated with a 2, 3, 10 or 17 fold increase in risk for being prescribed an anxiolytic, antidepressant, antipsychotic or mood-stabilising medication, respectively.[49]

Trauma-informed care and parenting

Effective responses to infants, children, young people and parents with a history of ACEs include providing trauma-informed care and support for the development of resilience. The key principles of trauma-informed care are: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical, and gender issues.[50]

Mental health services need to embed a culturally responsive, trauma-informed approach to care to maximise outcomes for consumers of all ages. It is important to attend to the impacts of childhood trauma as well as current experiences of trauma (such as DFV) and ensure care is integrated for families with multiple and complex needs.

Stigma and discrimination

People exposed to stigma and discrimination often experience higher levels of trauma than the rest of the population. This includes groups identified in Table 1. Aboriginal families, people in contact with the child protection and/or criminal justice systems, LGBTQI people, CALD families and people with addictive behaviours and/or various disabilities.

It is important that mental health services partner with health and social service providers to offer tailored and integrated care. Engaging interpreters, Aboriginal Health staff, disability support, cultural and diversity services and other support services is essential in providing holistic, culturally responsive care to families.

Mediating negative early experiences

Stable, caring relationships: The strongest building block for childhood resilience known to mediate the effects of negative early experiences, is the availability of stable, caring relationships with family members or other significant adults.[52] Family focused recovery practice engages the person and their natural support systems and ensures follow up for family members who require it.

Self-determination, codesign and links to culture: Other key factors supporting childhood resilience include interpersonal skills, a sense of control over personal circumstances and strong links to cultural traditions.[53] Partnering with consumers in codesign and collaborative treatment planning is empowering for children, parents and families. Mental health services should support consumer and family rights, autonomy and choice.

Eliza 15 years

"My mum suffers from depression and PTSD. I don't know when it started, I guess I've just grown up just learning how to deal with it, how to overcome everything that she's been through, to overcome everything that I've been through.

Through my dad leaving that made me develop anxiety, through domestic violence, and my mum was really affected by that and that affected my whole family, it affected my grandparents."[51]

Working with families from culturally diverse backgrounds

Family focused recovery needs to be implemented differently depending on the context, there is no "one size fits all" approach. Each family and community is unique and will require a thoughtful context driven approach. Mental health services should be familiar with diverse cultural characteristics and tailor approaches so that care and treatment is delivered in a culturally appropriate manner.

Working with Aboriginal Families

The number of Aboriginal children living with a caregiver experiencing mental illness or social, emotional difficulties is not known. We do however know that Aboriginal people are significantly over-represented as consumers of mental health services.

The Framework recognises that Aboriginal people share an understanding of wellness as embedded in culture, tied to the land, and deeply rooted in family, community and self-determination. Services need to develop knowledge and competencies to engage with Aboriginal families and ensuring family focused practice is responsive to Aboriginal people's unique circumstances and contributions.

The **Building Strong Foundations program** service standards recommend that services working with Aboriginal families:

- recognise and respect the unique knowledge and ways of being and doing that inform Aboriginal families' child rearing practices
- focus on community strengths and needs
- recognise that Aboriginal culture is a strength and protective force for children and families.

The NSW Health Services Aboriginal Cultural Engagement Self-Assessment Tool is a helpful resource in making meaningful changes to organisational activities, structures and behaviours to make hospitals and health services culturally safe and respectful for Aboriginal patients, clients and staff.

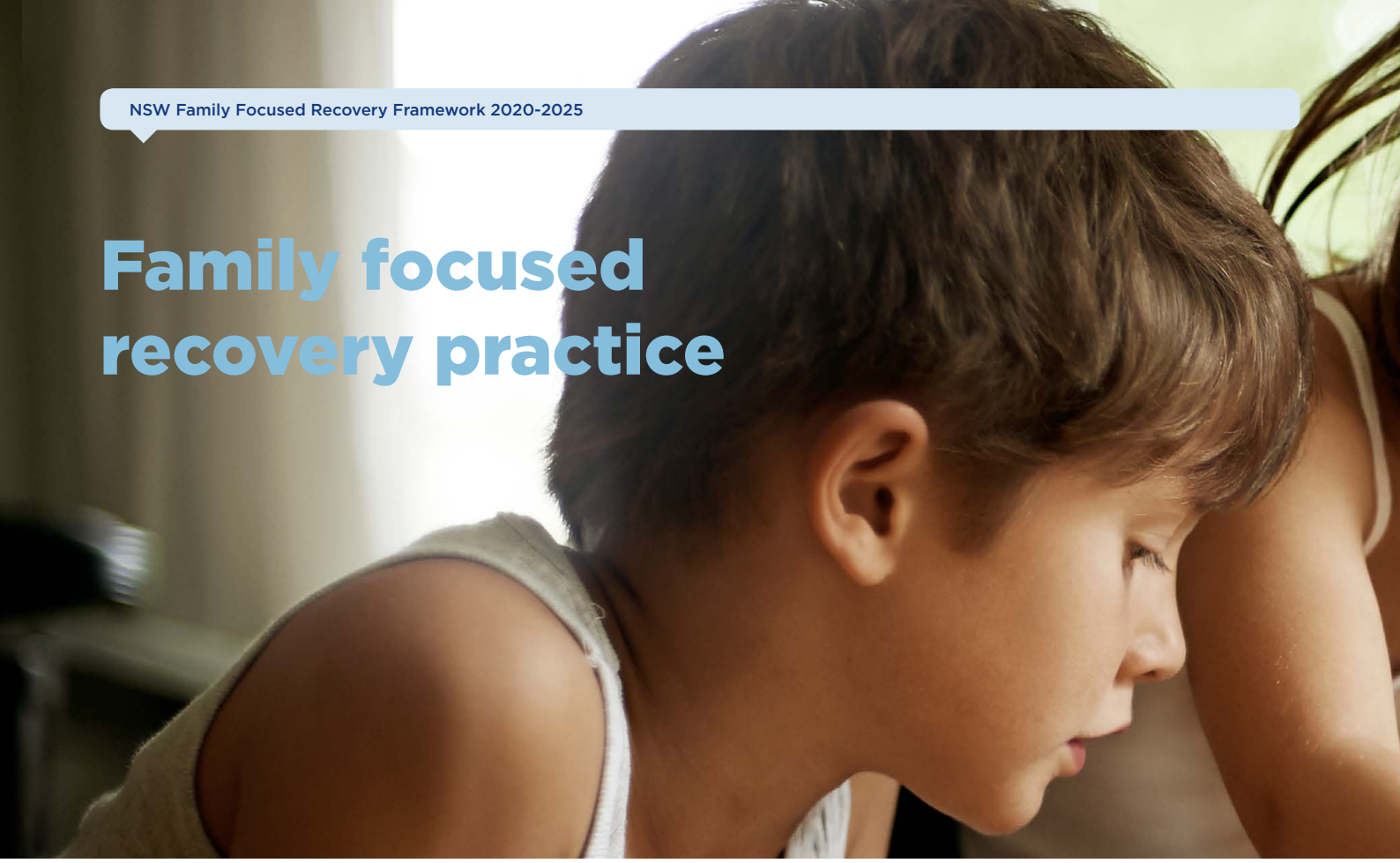
The **Working with Aboriginal People: Enhancing Clinical Practice in Mental Health Care** video and discussion guide are designed to assist health services in gaining knowledge and skills in working with Aboriginal people. The resource highlights the importance of culture, family, community and spirituality in the healing journey for Aboriginal people. It can assist services in designing, delivering and evaluating care that improves mental health and wellbeing outcomes for Aboriginal children, youth and their families.

The **Working with Aboriginal People and Communities: A practice resource** provides key facts and information relevant to working with Aboriginal Communities in NSW.

Interventions with a higher level of evidence of impact

NSW Health services play an important role in intervening early for families, delivering services for children, supporting parent-child and family relationships and helping parents with mental health issues strengthen their parenting capacity.

A rapid review undertaken by ARACY in 2015[54] noted parenting and mental health interventions were consistently identified as having high levels of evidence of impact for all age groups. These interventions include maternal mental health interventions, parenting skills development, social and emotional wellbeing development, mental health promotion and suicide prevention. Examples of programs noted include: Triple P, Tuning in to Kids, Circle of Security, Parent Child Interaction Therapy (PCIT), The Good Behaviour Game and Functional Family Therapy.



Family focused recovery practice

It doesn't have to be complicated

The needs of family members who are impacted upon by a member's mental illness should be attended to in their own right. This is in contrast to many current responses by mental health services that only consider these needs in relation to how they may benefit their unwell family member. For example many adult mental health services do not, or have only recently begun to, record whether their clients have children. Similarly, CAMHS have low rates of reliably recording whether their clients have parents with a mental illness and how their needs are addressed.

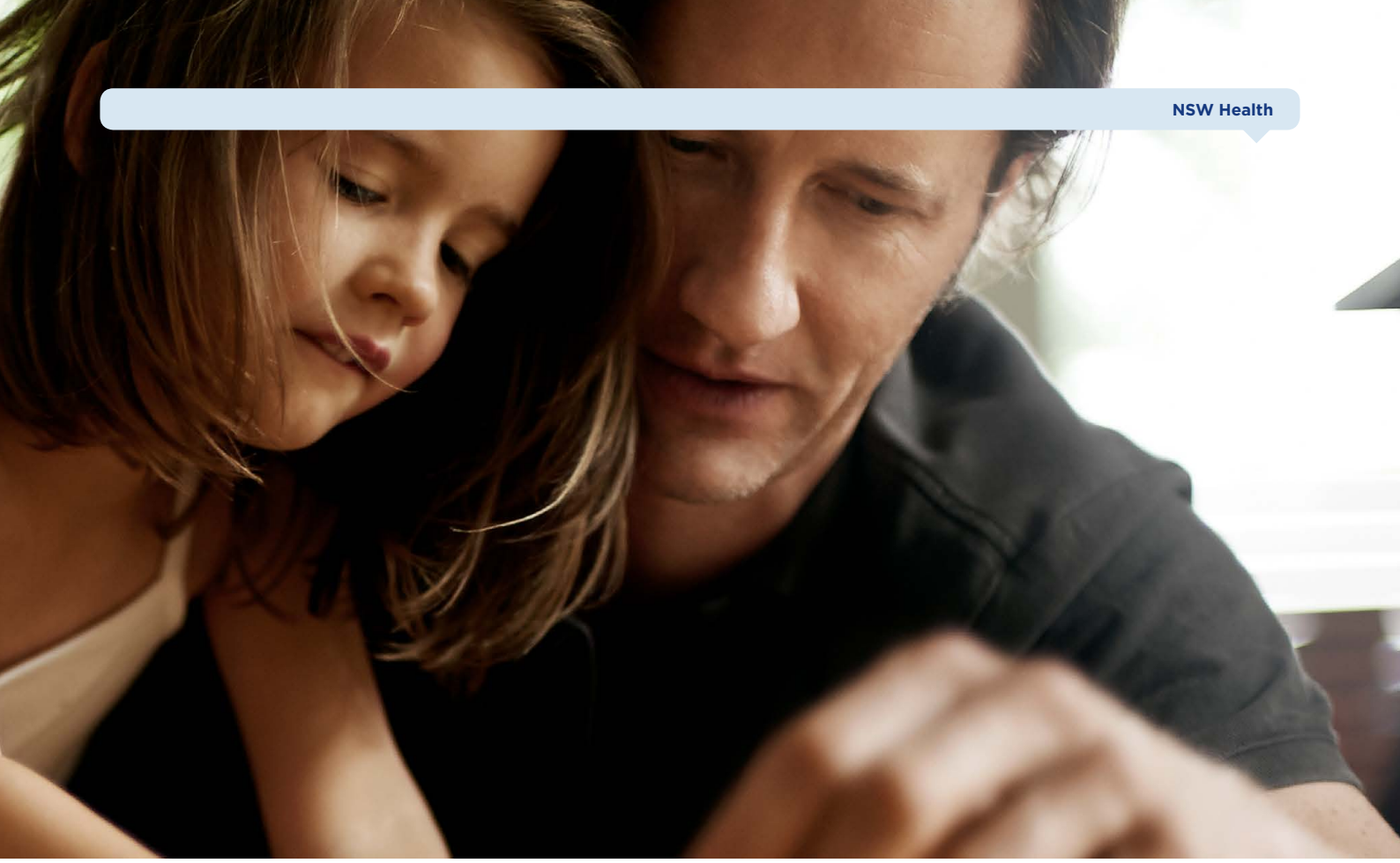
Although there can be challenges, a shift of focus to families doesn't have to be complicated and many studies have shown that health professionals would like to have more knowledge, skills and confidence in working with families where there is a mental illness.

The range of family focused recovery interventions a health worker will offer will depend on their role, their capabilities and their confidence in working with infants, children, young people, adults and families.

Health workers can support healing and recovery in families affected by parental mental illness through simply:

- understanding that recovery occurs in a family context
- focusing on strengthening parent–child relationships
- supporting families to identify what recovery means for them
- acknowledging and building on family strengths, while recognising vulnerabilities
- assisting family members to better understand, and communicate about, mental illness
- linking families into their communities and other resources.[55]

Tables 3, 4 and 5 outline priority actions for the health workforce. All workers have a responsibility to attend to child safety and wellbeing.



Child safety and wellbeing

NSW Health has clear policies and guidelines for how to respond to child safety, welfare and wellbeing.

The **Child Wellbeing and Child Protection Policies and Procedures for NSW Health** outlines NSW Health worker responsibilities.

The **NSW Health (PARVAN) website** provides a central portal for child protection legislation, resources and service contacts.

The online **Mandatory Reporter Guide (MRG)** guides decision making about the level of risk to a child, young person or unborn child and what initial action to take. This includes whether or not a child protection report is required.

The NSW Health Child Wellbeing Unit provides specialist advice for NSW Health workers (and other prescribed bodies including GPs) for assistance in determining the level of risk of harm, planning next steps and responding to the needs of vulnerable children, young people, pregnant women and families.

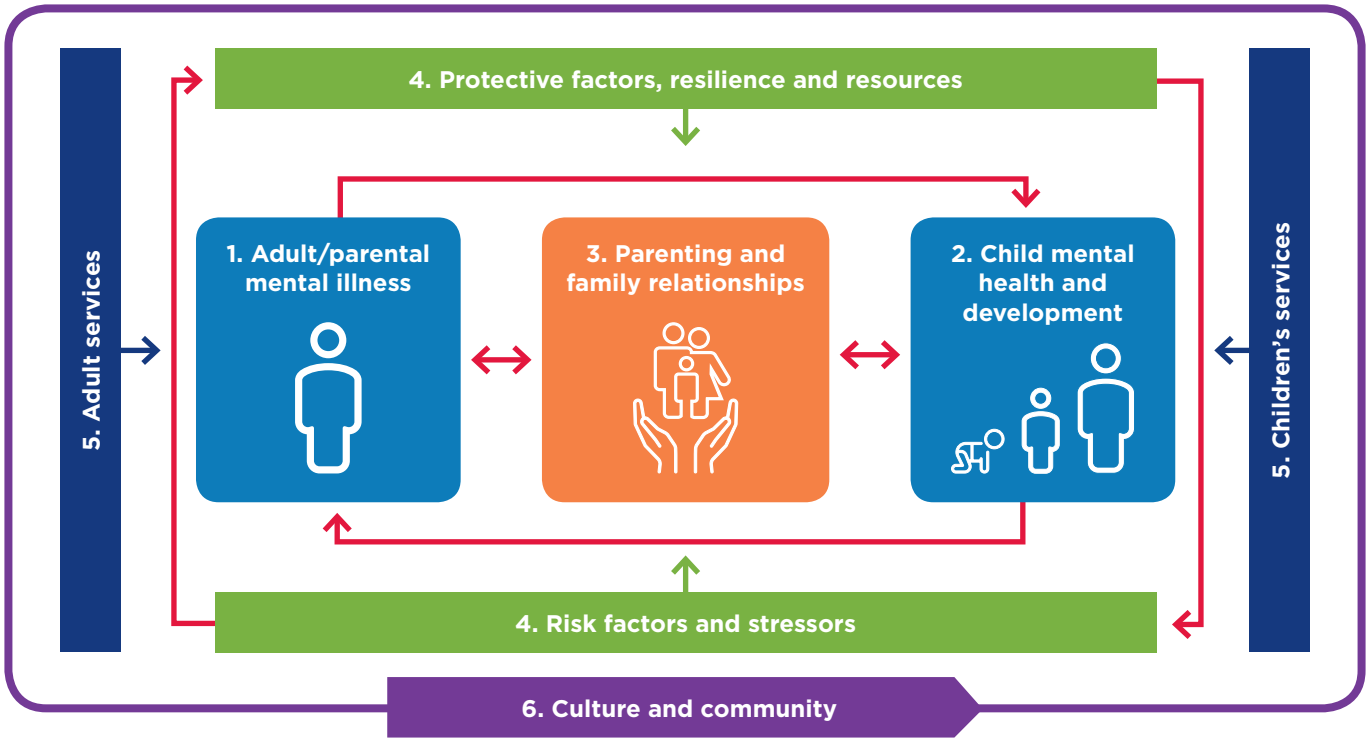
The needs of family members who are impacted upon by a member's mental illness should be attended to in their own right.

Understanding intersections

All health workers should understand that the mental health and wellbeing of infants, children, young people and adults within families in which an adult parent is living with a mental illness are intimately linked.[56] The family model (Figure 1) shows the common intersections across time and generations. The areas of influence are:

1. ***Individual adult experiences (adult/parent-to-child influence):*** Adult/parental mental illness can adversely affect the development, mental health and, in some cases, the safety of infants, children and young people.
2. ***Individual child/young person experiences (child-to-parent influence):*** Caring for Infants, children and young people, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill-health in parents/carers.
3. ***Linking adult/parent and child/young person experiences (family relationships - childhood-to-adulthood family lifespan influence):*** Growing up with a parent living with a mental illness may have an adverse influence on the quality of that person's adjustment in childhood and/or adulthood, including their transition to parenthood.
4. ***Strengths and struggles (environment-to-family influence):*** Adverse circumstances (such as poverty, lone parenthood, social isolation or stigma and genetic liability) can negatively influence both adult/parent and child mental health but resilience means that negative outcomes are not inevitable.
5. ***Adult and Infant/Child/Youth services (service-to-family influence):*** The quality of contact/engagement between individuals, families, practitioners and services is a powerful determinant of outcome for all family members.
6. ***An ecological frame (a broader, more distal, environment-to-family influence):*** The above five influences and their interactive relationships all occur within a broader social network encompassing cultural, diversity and community impacts.

Figure 1: The Family Model



Source: Adapted Falkov 2012

A continuum

Family focused recovery practice exists on a continuum of increasing intensity ranging from identifying parental status at registration/admission and ensuring dependent infants, children and young people are safe, to undertaking family care coordination and intervention with all members of the family.[57, 58]

The following lists provide examples of activities along the continuum, from highest to lowest intensity. The lists are not all inclusive.

Examples of the continuum of policies and actions

Accommodation for children, parents or other family members

Policies that support family focused practices

Providing a family friendly visiting area

Policies that support parent engagement

Identifying parents and children, relationships, roles, safety and wellbeing

Examples of the continuum of clinical family focused practices

Undertake family case management and work across teams in an integrated way

Implement family focused interventions such as Let's Talk About Children or Family Therapy

Hold family meetings with relevant members

Provide psychoeducation for parents, children and other family members

Talk to parents about their children; and children and young people about their families

Systems that support family focused recovery practice

A literature review identified a range of system supports that need to be in place to enable health workers to engage in family focused recovery practice.[59] These include:

Orientation

A staff induction/orientation program that includes a component on family focused recovery practice and related core workforce competencies.

Data and record systems

Access to data systems and tools that identify parents and their children.

Procedures

Clear procedures for working with parents who experience mental illness and infants, children and young people that outline:

- the types of services and interventions to be offered
- local referral pathways
- the resources available to parents, children, young people and families.

Workforce development

Access to training that promotes skills, confidence and knowledge in:

- legislation and policy related to family sensitive practice
- identification and assessment of the strengths and vulnerabilities of parents who experience mental health issues and children and young people living with parental mental health issues
- evidence based, recovery oriented interventions or, in the absence of such evidence, interventions that provide emerging positive outcomes for parents living with mental health issues and their children
- Allocation of time and resources to allow clinicians to participate in training and on-going practice development
- Access to practice support structures and supervision processes that address family focused recovery practice.

Resources

Access to appropriate resources and local referral pathways for parents who experience mental health issues, and their children, young people and families.

Guidance for NSW implementation

The **Royal Australian and New Zealand College of Psychiatrists (RANZCP) Position Statement 56 'Children of Parents with Mental Illness 2016'** provides an outline of the factors involved when parents are affected by mental health issues and describes some of the evidence based approaches that should be available to families.[60]

Many PIMHS, CAMHS, YMHS and AMHS have embedded family focused practice as part of routine care. The **NSW Child and Adolescent Mental Health Services Competency Framework 2011** and **National Practice Standards for the Mental Health Workforce 2013** outline a range of practice standards and workforce competencies involved in family focused recovery practice.

The *Families where a Parent has a Mental Illness* (FaPMI) Program in Victoria has developed a set of detailed family sensitive minimum practice standards to articulate and assist services integrate the **FaPMI Service Development Strategy** actions into practice.[61] These standards may also assist NSW LHDs/SHNs in developing local Family Focused Recovery Implementation Plans (Appendix 2).

Key areas include:

- recovery focused and trauma-informed care
- importance and benefits of prevention and early intervention, including the importance of the early years, key transition points and risk and protective factors for infants, children, young people, and families
- child-centred and family focused practice
- parenting
- infant, child, adolescent and youth development
- child protection
- culturally safe and competent care for Aboriginal infants, children and young people, families and communities
- meeting diverse needs – social, cultural, linguistic, spiritual, gender diversity, rainbow families
- integrated care, partnership and collaboration.

Family focused recovery practice in Child and Adolescent Mental Health Services (CAMHS) and Youth Mental Health Services (YMHS)

CAMHS and YMHS have traditionally taken a systems based approach to assessment and care, recognising that the child or young person is part of a range of networks and systems.

These systems include family, school, social networks, cultural groups, sporting and other interest groups and the broader communities children and young people live in.

The most influential system for many children and young people is the family, although peer and work systems become more influential as young people move through adolescence and into adulthood.

CAMHS and YMHS typically assess children and young people's strengths and vulnerabilities within a developmental and cultural framework and attend to child safety issues. The NSW CAMHS Competency Framework outlines the workforce capabilities required to deliver safe, high quality mental health assessment and care for children, adolescents and families.[62]

An Australian study found that around 30% of parents of CAMHS clients identified as having a mental illness and more were frequently identified during the course of engagement with CAMHS.[63] When parents with mental health issues are well, they are more likely to be able to provide a safe and nurturing environment for their children.

Identifying parental mental illness and young carers

CAMHS and YMHS approaches most often include taking an extensive individual and family history. This includes asking whether parents or other family members have mental health issues and whether children are carers for a parent with a mental health issue.

Following the initial assessment, it is common practice for CAMHS and YMHS staff to meet with parents separately and ask if they are connected to necessary supports and providing supported referrals when needed. Some services also have formal processes for family assessment.

CAMHS and YMHS often partner with education services to ensure supports are available for the young person that consider their home environment and any caring responsibilities.

Prevention - reducing risks of child mental illness

Siegenthaler and colleagues (2012) conducted a systematic review and meta-analysis of randomised control trials of interventions to prevent mental disorders and development of psychological symptoms in children of parents with mental disorders.

Interventions included cognitive, behavioural and psychoeducational components and targeted both internalising and externalising disorders. The review found that interventions appeared to be effective and had the potential to decrease the risk of children developing a mental health issue by 40%.[64]

Family focused interventions

CAMHS and YMHS interventions are often tailored to individuals, dyads and families. The **Werry Centre workforce development website** provides a summary of effective evidence based interventions used in CAMHS and YMHS. Dyadic and family interventions range from psychoeducation and brief family interventions such as single session family consultation (SSFC)[65, 66] through to multi-session models such as Parent Child Interaction Therapy (PCIT) and a range of family therapy interventions.

Children and parents with mental health issues also come into contact with NSW Health services through clinics for children with comorbid chronic physical health conditions. CAMHS consultation liaison services are often the mental health contact for these families. Children with chronic conditions often have complex treatment regimens and parents need to support the young person's treatment compliance so they can remain physically and mentally well. This can be more challenging for parents with mental health issues, who may need individual or group parent training or support to help them develop their confidence and skills.

Emily H 18 years

"When my family members are admitted to hospital it puts a lot of stress on me as I have to keep up with housework. I have also felt like I had to manage a lot of schoolwork on my own with little help. One of the things that I did was tell my teachers at school what was going on at home. It did take a while for me to open-up because I didn't like talking about it or telling others that I was caring for an unwell family member; but after I told my teachers they were very understanding and willing to help me out by checking in and asking if I was OK. They would come to the school counsellor with me when there was an incident at home; they would give me space and time to do my assignments and study."[67]

The review found that interventions appeared to be effective and had the potential to decrease the risk of children developing a mental health issue by 40%.[64]

Families with a child or young person experiencing MH issues

Mental health problems are not uncommon in people under the age of 25 years. Some of these problems may be relatively mild and short-lived and others may cause considerable distress to children, young people and their families over a longer period of time and may be both a cause and a consequence of family/relationship difficulties.

A significant part of the caregiving role falls on family members, especially for more serious mental illnesses. This role is often undertaken by parents. It can, for some be rewarding and a source of achievement, but also difficult and burdensome.

There is consistent evidence that caregiving is associated with poorer mental health and as such the mental health needs of parents should be identified. If left unaddressed it may have long term ramifications for both their own wellbeing and that of their children.

Online treatment options

There is a growing evidence that online interventions, both self-directed and therapist-assisted are shown to improve mental health in parents and children equivalent to face to face sessions. Importantly family members report high levels of satisfaction with these telehealth services.

Online delivery is one way to increase program reach particularly for those living in rural and regional locations.[68]

NSW Health programs supporting children, young people and parents

NSW Health has expanded investment in mental health programs for children, young people and families including;

Getting on Track in Time – *Got It!*

Got It! is a school-based specialist mental health early intervention and prevention program, delivered by NSW Health in partnership with NSW Department of Education. The program is for children in Kindergarten to Year Two and their families, aiming to reduce behavioural concerns and emerging conduct probelms. This program has been shown to improve child mental health outcomes and parenting capacity.

Aboriginal – *Got It!*

This is a culturally adapted version of the *Got It!* program being piloted in South Western Sydney, aiming to promote access, support Aboriginal children and families and improve outcomes for the Aboriginal community by reducing behavioural concerns and emerging conduct problems.

Youth Community Living Support Service (YCLSS)

YCLSS is a NSW Health funded community-based psychosocial support service for young people aged 16 to 24 experiencing severe mental health problems. YCLSS is delivered by Community Managed Organisations (CMOs) in five locations across NSW. The services work with young people and their families and carers to minimise the risk of chronic disability by engaging with resources in the local community and providing recovery treatments.

Family focused recovery practice in Perinatal and Infant Mental Health Services (PIMHS)

NSW Health support for families experiencing mental health issues in the perinatal period and early childhood years is delivered through a combination of mental health services, maternity services and child and family health services.

Mothers with mental health issues

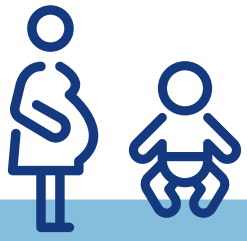
The first three months after birth are associated with an elevated risk of maternal mental illness.[69] A UK study found that at least 10% of recently-delivered women experienced a new episode of affective disorder, 15 to 20% had a mild anxiety or depressive disorder, 10% had major depression, 0.2% had puerperal psychosis and a small proportion required referral to psychiatric services (2%).[70]

The study found that despite its rarity (2 per 1,000 births), women were at higher risk of experiencing psychotic disorder in the first three months after childbirth. Women with a previous episode of serious affective disorder, particularly bipolar disorder, were at an increased risk of recurrence, even if they have been well during pregnancy and for many years.[71]

Women who have experienced trauma (e.g. domestic violence, childhood abuse) are also at heightened risk of perinatal mental illness.[71, 73]

LGBTIQ parents with greater exposure to life stressors may also be at higher risk for mental health issues in the perinatal period as they can face discrimination relating to parenting roles, rights and conception methods.[74]

Severe and complex mental health conditions can develop suddenly and if untreated can have a long lasting impact on women, the parent-infant relationship, development of the infant and their families. The most tragic consequence of perinatal mental illness is maternal suicide, which was one of the three leading causes of maternal mortality (< 42 days of the end of pregnancy) between 2008-2017 in Australia.[75] Infanticide is also an associated rare but real consequence of severe perinatal mental illness.



The perinatal period generally refers to the time spanning pregnancy, childbirth, and the first postnatal year.

Fathers with mental health issues

Most of the existent research on parental mental illness has focused on mothers, but depression and anxiety during the perinatal period are also common for fathers. Systematic reviews have found depression was evident in about 10% of fathers during the perinatal period[76] and anxiety was present for around 4-16% of fathers during the prenatal period and between 2.4-18% of fathers in the postpartum period.[77]

Men are also less likely than women to access health services relating to their mental health and when they do, tend to use different language, present with different symptoms, and have different needs. While there are a handful of clinical interventions designed specifically for parents with a mental illness, they are comparatively rare, and most do not target or attract fathers.

It is important to consider fathers and partners when providing parental mental health care to women. This is to improve partner health as well as outcomes for women and children. Partner health and resilience affects the mother's health and recovery and the health and wellbeing of their children. For example, paternal depression has been found to have a specific and persisting detrimental effect on children's early behavioural, emotional and language development, whether or not their mother is affected by perinatal mental problems.[78, 79]

Research on father's experience of parenting with a mental illness spoke of hardship, stress and dysfunction, but the sense of meaning and purpose that their children had brought to their lives, as well as how the expectations and structures associated with family life had been important factors in their efforts towards recovery.[80]

Fathers and the service system

A number of studies have found that negative or ambivalent attitudes are common in the service system and there is still much work to be done before services can be called father-focused.

Fathers can be a potential resource within families, the involvement of a supportive father in the lives of children and young people is positively linked with their overall life satisfaction and wellbeing and can be seen as a protective factor, even if their mother is affected by depression.

There are many social-cultural and service factors that act as barriers to fathers' engagement with services, so it is unsurprising that there is recent data from Australia showing that fathers participate at quite low rates in interventions for child mental health, compared to mothers. When fathers are involved, outcomes are better. A recent Australian study also showed that fathers participating in purely online parenting programs (Parentworks) was associated with better father mental health and better child outcomes.[81]

Early parent-infant attachment

The quality of early parent-infant attachment affects the physical structure, or architecture, of a baby's brain.[82, 83] Secure parent-infant emotional connection has a positive impact on infant brain development. It is therefore essential to identify problems early and offer effective supports in a timely manner.

It is important to consider fathers and partners when providing parental mental health care to women.

NSW Health programs which support parents, infants and young children

NSW Health has a range of universal, culturally safe and/or targeted early intervention services that support infants, children and families where a parent needs support, and/or the parent has a mild/moderate mental health issue through to families where a parent has a severe and complex mental health issue. These include but are not limited to:

Child and family health nursing services
Child and family health nurses have knowledge and skills in child development, family functioning, infant mental health and perinatal mental health. They work in a variety of settings including home visits, community health centres, telehealth, specialist day stay and residential family care centres.

The SAFE START initiative offers antenatal and postnatal mental health and psychosocial screening and referral from public maternity and Child and Family Health Services for pregnant women and new mothers. A pilot study is underway trialling the mental health screening for new fathers.

Sustaining NSW Families (SNF) operates in nine locations in NSW for families with children up to two years of age who meet eligibility criteria which include mothers experiencing mild anxiety and or mild depression and circumstances known to have an impact on the family.

Aboriginal Maternal and Infant Health Services (AMIHS) provide a continuity of care model where midwives and Aboriginal Health Workers collaborate to provide a high-quality maternity service that is culturally safe, women-centred, based on primary healthcare principles and provided in partnership with Aboriginal people.

The **Building Strong Foundations for Aboriginal Children, Families and Communities program** (across 15 locations) provides early childhood healthcare for families up until the child goes to school.

Specialist Perinatal and Infant Mental Health Services (PIMHS) is a state-wide community-based service for pregnant women and mothers/families and their infants (<2 years) who experience severe and complex mental illness. PIMHS provides care across a range of contexts such as home visits, clinics, hospital in-reach as well as consultation liaison. The service works closely with psychiatrists and offers women mental health assessment and interventions while supporting infant early caregiving, parent-infant relationship and the partner/family.

There is a PHIM service for perinatal women within Justice Health and Forensic Mental Health Network to support women detained in prison.

The **Statewide Outreach Perinatal Service for mental health (SwOPS-mh)** provides telehealth delivered perinatal psychiatry consultation for rural and remote districts. Hosted by Western Sydney Mental Health Services, the clinical team offers pre-conception counselling, client assessment, treatment plans and education/supervision and capacity building.

The Mums and Kids Matter program is for mothers experiencing severe or complex mental illness and psychosocial needs who are current clients of public mental health services and have a young child/children (0-5 years) in their care. Through MaKM women can access either residential care or in-home support packages in their community. Each package offers a combination of mental health, parenting and psychosocial supports.

Family focused recovery practice in Adult Mental Health Services (AMHS)

Adult mental health services have a unique opportunity to provide tertiary mental health services to parents that improve parental mental health and wellbeing outcomes and at the same time deliver prevention and early intervention benefits to their children.

Family focused practices

Focusing on providing support for a person's valued parenting role has been found to contribute to their recovery journey as well as to child outcomes.

Research identified the following practices for adult mental health workers in working with a parent with a mental illness assist family focused recovery.[84] These practices build on current mental health care in working with adults and are not intended to replace them.

Intake

Identify and record:

- The parenting status of mothers and fathers including pregnancy status
- Dependent children either living with the family or not

Assessment and care planning

Assess and record:

- The strengths and vulnerabilities of adults living with mental illness specifically in relation to their functioning as parents (including impact on child safety, welfare and wellbeing) in the context of their mental health treatment and rehabilitation
- Children's strengths and vulnerabilities, within a developmental and cultural framework and in consideration of their possible caring role
- Care planning should include negotiating a care plan/recovery plan that includes parenting and family goals.

Intervention

Provide recovery orientated and where possible, evidence based interventions that acknowledge and incorporate the parenting role and responsibilities of mothers and fathers (including partners if appropriate) parenting supports. Practices should be informed by an awareness of, and sensitivity to cultural and gender diversity, in order to be relevant and accessible to many different types of families.

Consistent with recovery orientations, these services need to be parent-led, strength-based and responsive to the unique needs of parents and children. Interventions may include:

- Addressing a family's basic needs such as housing
- A parent led discussion of the strengths and vulnerabilities of their children and any concerns they may have regarding their parenting role
- Skill building to manage their illness and meet family needs
- Enhancement of support networks, both natural and formal.

Nurse in an adult acute inpatient unit

"One of the things that I think is most important about the nursing role is to be able to maintain contact with family... so they can maintain a connection with their loved one that's in hospital.....we do want patients to be connected to family. Connection is the biggest thing"[85]

Effective interventions for parents

Mental health interventions for adults are known to improve the symptoms and impact of the illness on daily living. Parenting interventions can improve a person's parenting skills and positively impact the parent-child relationship and parent-infant attachment.

Evidence is emerging for interventions delivered in adult mental health services, designed to positively influence the recovery journey of a parent with a mental illness through a focus on their parenting role.

For example, a review of **Let's Talk about Children** found the interventions lead to improvements in:

- multiple aspects of parent's wellbeing (e.g. self-acceptance, general wellbeing, confidence in the future)
- parenting (sense of adequacy, ideas for parenting)
- children's wellbeing (e.g. emotional symptoms, anxiety, prosocial behaviours)
- family relationships (e.g. couple relationship, parent-child relationship)[86]

Let's Talk about Children

Let's Talk is a brief, evidence based two/three session intervention. The intervention focuses on the professionals having a structured discussion with parents who experience mental health issues about parenting and their child's needs. The intention is to make these conversations a routine part of the alliance between parents and professionals where they can explore the wellbeing and development of children and how the parent's mental illness is understood by their children.

Let's Talk has been introduced in a number of NSW Health adult mental health services. The self-paced elearning module is currently free through the Emerging Minds (National Workforce Centre for Child Mental Health). The training attracts Continuing Professional Development (CPD) Points for some professions and takes between five to ten hours to complete.

Child of a parent in an adult inpatient unit

"You shouldn't be left in the dark because you're a kid and maybe they don't give us credit... you can handle it. It is much more scary not knowing"[87]

Integrated family mental health models

Whole Family Teams (WFTs) provide specialist in-home and community based interventions for children and families with complex mental health and drug and alcohol issues where the children have been identified as at risk of significant harm. Referrals from the NSW Department of Communities and Justice (formerly Family and Community Services) are prioritised. WFTs are located in regional, rural and metropolitan LHDs. The model of care adopts a systematic integrated service model whose main focus is to keep children safe from harm and to provide intensive specialist care to the whole family. The service was successfully evaluated in 2014 and 2019.

The evaluation found WFTs were highly successful in delivering clinically significant improvements in parental mental health including:

- a reduction in parental daily tobacco and alcohol use
- in all domains of family functioning (parenting, family relationships and child wellbeing)
- in child safety with substantial reduction in the rate of ROSH reports to Community Services for children in families who completed the WFT program (58.4%).

The evaluation found WFTs were highly successful in delivering clinically significant improvements in parental mental health.

Action Tables

Goal 1: Holistic, person-centred care

Framework actions outlined in Tables 3, 4 and 5 build on and do not replace current mental health care. They are designed to improve outcomes in the immediate and longer term for infants, children, young people, parents/carers and families through expanding the family focused aspect of person-centred assessment, treatment and support.

Family focused recovery practice is offered on a continuum, depending on consumer (infants, children, young people and parents) need and the role of the health worker and their capabilities in working with families.

Table 3 focuses on achieving holistic, person-centred care through embedding a family focused approach.

Table 3: Goal 1 - Holistic, person-centred care

Objective 1. Embed a family focused approach	
Level	**Priority action**
State and Local	1.1 Service planning and development
	1.1.1 **Treatment and care responsibilities to the consumer also considers the needs of the person's family and support systems through co-design in:** • service, workforce and infrastructure planning • mental health policy, procedure and guideline development • planning, monitoring and evaluating mental health services and initiatives
	1.2 Resources
	1.2.1 **Culturally appropriate and accessible mental health resources and information are developed and tailored for families**
Local	1.3 Environment
	1.3.1 **Family involvement is encouraged through family friendly visiting hours, culturally safe family friendly waiting areas, play and meeting spaces (inpatient and community settings), and accommodation for family members (where appropriate) supported by local relevant policies and procedures**
	1.4 Service models
	1.4.1 **Public mental health models of care are oriented to the needs of both individuals and families**
	1.4.2 **Services offer shared care models operated through strong partnerships with key partners (Examples of key partners are listed on page 45)**

Objective 1. Embed a family focused approach	
Level	**Priority action**
Local	**1.5 Assessment** **1.5.1 Services routinely offer individual as well as family assessments** **1.5.2 Mental health assessments identify, document and respond to:** • the consumer's parenting roles, capacity and caring responsibilities • pre-existing support systems • any child safety risks • any child wellbeing needs • the impact of trauma and/or risk on the consumer and family (including DFV, childhood abuse) • issues of consent related to family and carer involvement • any family member mental health issues requiring referral or support
	1.6 Care planning **1.6.1 With consent, mental health care plans are developed jointly with and incorporate the views and needs of the consumer's family including what will happen to the child if the parent becomes unwell or unavailable** **1.6.2 Mental health care plans incorporate actions to support consumers in their parenting role and articulates any impact of parental mental illness on parenting and impact of parenting on illness** **1.6.3 Mental health care plans incorporate actions to support consumers including children and young people in their caring roles** **1.6.4 Assist families to access relevant and appropriate wellbeing supports** **1.6.5 Where children and parents are both attending mental health services, ensure mental health care plans for children and their parents have complimentary goals and plans** **1.6.6 Joint care planning with CMO, NDIS and private service partners engage supports for consumers in their parenting and/or carer roles**

The suite of **Mental Health Outcomes and Assessment Tools (MH-OAT)** provides a standard format for clinicians recording and planning for the mental health, safety and wellbeing needs of parents and their children. Use of the clinical documentation suite and associated outcome measures (clinician and self-report) informs family focused recovery practice.

Guidance in responding to child safety, welfare and wellbeing needs is provided in the **child wellbeing and child protection fact sheet for NSW Health workers** and the online **Mandatory Reporter Guide (MRG)** tool supports decision making.

Goal 2:
Safe, high quality care

Intervening early has proven benefits for individuals, families and communities. To assist family members (infants, children, young people and parents) to get the right care at the right time and in the right place, NSW Health services must offer a range of effective evidence informed or evidence based interventions (Table 4) and have established and effective pathways to care in place (Table 5). Pathways are required across health subspecialties and between partner human services agencies.

Interventions exist on a continuum and staff will implement different levels of family focused care depending on their role and capabilities. The Actions in Table 4 focuses on delivering safe, high quality care through evidence based interventions to meet the needs of families.

Table 4: Goal 2 - Safe, high quality care

Objective 2: Deliver evidence based interventions to meet the needs of families	
Level	**Priority action**
State and Local	**2.1 Quality improvement** **2.1.1 Data and information are routinely collected, reviewed and used to inform the delivery of mental health care for infants, children and young people, parents and families, for example:** • mental health outcome measures (clinician and self-report) • experience of care measures (including Your Experience of Service [YES] and Carer Experience of Services [CES]) • carer responsibilities (including young carers) • routine administrative data and mental health assessment information including parenting role and dependents • other relevant data sources and family focused measures
Local	**2.2 Interventions** **2.2.1 Mental health services offer evidence based, accessible and culturally appropriate interventions for families including:** • preconception counselling (perinatal specialists) • psychoeducation for family members • parenting education and resources • parenting interventions (eg Let's Talk about Children) • group mental health and parenting interventions (eg Tuning into Kids/Teens) • dyadic and family based interventions (eg Systemic Family Therapy) • referral for peer support, respite and family support programs, COPMI camps and mentoring programs, and parenting/relationship building programs such as Parent Child Interaction Therapy (PCIT) (these are often CMO-led)

Objective 2: Deliver evidence based interventions to meet the needs of families	
Level	**Priority action**
Local	2.3 Capability development **2.3.1 All mental health workers are orientated, trained, supported and competent in:** • applying a family focused approach • applying family focused recovery principles • talking with individuals about their children and families • identifying and responding to child safety • identifying and responding to child wellbeing concerns **2.3.2 Mental health workers are trained, supported and confident to deliver family assessments and evidence based interventions for families** **2.3.3 Staff in designated COPMI/FFR roles are trained and equipped to facilitate capacity building in FFR practice**

In AMHS or PIMHS, this might range from taking a family focused approach and asking the adult about their parenting role, to offering preconception counselling, using a standardised family assessment, delivering a brief intervention such as **Let's Talk about Children**, through to implementing a targeted dyadic intervention with a mother and infant that is inclusive of partners. The parenting role needs to be fully embedded into adult mental health care planning.

In a CAMHS or YMHS service, a family focused approach might range from asking about family mental health history, linking young carers to supports and/or ensuring parents currently in need of mental health care are connected to services. Interventions might range from providing psychoeducation for children, young people and parents, through to delivering specialist family therapy and group interventions.

Goal 3: Connected care

Providing families the right care as close to home and community as possible minimises disruption and increases the access to natural supports available to family members. If an inpatient admission is required, NSW Health services should coordinate with a consumer's existing local supports and/or engage new or additional supports to assist the consumer's transition back to community. For Aboriginal people with extended family Aboriginal Community Controlled Health Services (ACCHSs) play an important contributing role.

In addition to NSW public mental health services, a range of supports may be required to improve a consumer's general health and/or parenting capacity, the functioning of the family, and to support children's developmental, safety and wellbeing outcomes.

Referral to support services may be required, including for example, parenting programs, NDIS supports, mental health supports, housing and social supports, education and vocational programs. It is essential that effective care pathways are established across mental health services and with partner providers to support seamless, holistic, connected care. Table 5 focuses on connected care through coordinating treatment and support for individuals and families.

Table 5: Goal 3 – Connected care

Objective 3: Coordinate treatment and support	
Level	**Priority action**
Local	**3.1 Care pathways**
	3.1.1 Establish relationships with partner services including parenting and family support services and clearly documented care pathways
	3.2 Collaborative care
	3.2.1 Clearly define shared care roles and responsibilities of the various mental health and key partner services involved with individuals and families
	3.2.2 Establish and record integrated cross team and interagency care planning meeting for families

Important mental health partners

COPMI/FFR, Family and Carer Mental Health Program and NSW School-Link Coordinators are invaluable resources for the mental health workforce and for families where parents have mental health issues and children and families need extra support.

COPMI/FFR Consultants/Coordinators provide a range of services across LHDs/SHNs, working across child and adolescent, youth and adult mental health services to support the needs of children and families where a parent experiences a mental illness. Services may include but not be limited to consultation, brief interventions, joint assessments, and the provision of education, resources and supported referral.

The NSW Family and Carer Mental Health Program is a statewide program aiming to improve the wellbeing of families and carers of people with mental health issues. Family Friendly Mental Health Services support local service improvements by enhancing the skills of mental health service staff to work with families and carers as partners in care.

NSW School-Link is a statewide function of NSW CAMHS and facilitates collaboration between Education, Health and other services to support school-aged children and young people to achieve optimal mental health and remain engaged in education. The initiative focuses on early intervention, increased collaboration, capacity building and improved delivery of coordinated care.

Key partners

Relationships with the following key partners are essential to providing safe, high quality care:

Health partners: maternity services, child and family health, youth services, paediatrics (including paediatric specialty clinics), general medical and psychosocial/social support services, social work departments, drug and alcohol services, Aboriginal Community Controlled Health Services (ACCHSs), Transcultural Mental Health, Justice Health, NSW Ambulance, private health service providers including GPs and Violence, Abuse and Neglect (VAN) Services (including Child Protection Counselling Services (CPS), Sexual Assault Services (SAS), domestic and family violence services, New Street Services, and Safe Wayz - a service for children under ten with problematic or harmful sexual behaviours).

Interagency partners: NSW Police Force, Corrections, Department of Education, early childhood services, Department of Communities and Justice, Culturally and Linguistically Diverse (CALD) services, LGBTQI services, NDIS and other CMO service providers.

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Appendices

Appendix 1: Mental Health Rights and Responsibilities

The Framework applies a values-based approach founded on the NSW Health **CORE values** of collaboration, openness, respect and empowerment and supports the delivery of compassionate care.

The NSW Strategic Framework and Workforce Plan (pp 66-73) outlines how to apply the values and principles in recovery based, trauma-informed and culturally appropriate mental health practice.

This Framework supports the rights of mental health consumers in line with the **Mental Health Statement of Rights and Responsibilities 2012**, including:

- **a)** respect for their individual human dignity and worth at all ages and stages of life
- **b)** respect for their privacy and confidentiality
- **c)** respect for their health, safety and welfare
- **d)** equal enjoyment of the highest attainable standard of physical and mental health
- **e)** equal recognition before the law and the equal protection of the law
- **f)** an adequate standard of living and social protection
- **g)** equal opportunities to access and maintain
  - **a.** health and mental health care
  - **b.** housing
  - **c.** education and training
  - **d.** work and employment
  - **e.** legal services
  - **f.** income maintenance
  - **g.** insurance
- **h)** respect for their family life
- **i)** have their sexual orientation, gender and gender identity taken into consideration when receiving social support, health and mental health services
- **j)** have their social, economic, cultural background and family circumstances taken into consideration when receiving social support, health and mental health services
- **k)** contribute to and participate in the development of social, health and mental health policy and services.[88]

Appendix 2: Glossary and Acronyms

Glossary

Term	Meaning
Diversity	Diversity is acknowledged and respected in areas including, Aboriginality, ethnicity, class, sex, sexuality and gender identities, culture, religion, disability, age, power, status, sexual preference and family construct.
Rainbow family	is a same-sex or Lesbian, Gay, Bisexual, Transgender, Intersex, Queer (LGBTIQ) parented family
Trauma	a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual wellbeing[89, 90]
Trauma-informed practice	a strengths-based service delivery approach grounded in an understanding of and responsiveness to the impact of trauma. It involves recognition of the lived experience of trauma and the particular 'triggers' that may lead to re-traumatisation and uses evidence based and promising practices that facilitate recovery from trauma. Safety, Choice and Empowerment, Trustworthiness and Collaboration are key principles underpinning trauma-informed care and practice[91, 92]

Acronyms

Term	Meaning
AMHS	Adult Mental Health Services
ACCHS	Aboriginal Community Controlled Health Service
CAMHS	Child and Adolescent Mental Health Services
CES	Carer Experience of Service
CMO	Community Managed Organisation
COPMI	Children of Parents with a Mental Illness
DFV	Domestic and Family Violence
FFR	Family Focused Recovery
HETI	NSW Health Education and Training Institute
IDMH	Intellectual Disability Mental Health
LGBTIQ	Lesbian, Gay, Bisexual, Trans/Transgender, Intersex and/or Queer
LHD	Local Health District
MH-CYP	Mental Health Children and Young People, Mental Health Branch, Ministry of Health
NDIS	National Disability Insurance Scheme
PHN	Primary Health Network
PIMHS	Perinatal and Infant Mental Health Services
SHN	Specialty Health Network
YES	Your Experience of Service
YMHS	Youth Mental Health Services

Appendix 3: Families where a Parent has a Mental Illness (FaPMI) Practice Standards

The tables below outline the FaPMI practice standards[93] by stage of mental health care.

Stage 1 – Referral and Screening

Essential	Recommended
Primary Client: • Next of Kin identified and contact details recorded. • Legal status is identified and recorded. • Current family and other supports are identified and recorded. • Pregnancy status is identified and recorded. **Dependents:** • Dependent children are identified, recorded and their whereabouts ascertained. • Caring responsibilities are identified and recorded (both for dependents and others). • Risks to dependents identified.	• Identify who primary client would like involved in their care (family, carers, children). • Provide client with an orientation to the service regarding family inclusive practices. • Identify clients' intent in planning to have child.

Stage 2 – Entry into Service

Essential	Recommended
Assessment: • Assessment of family vulnerability to risks of family violence, child protection issues, victimisation, community context. • Legal status of dependants identified including custodial issues. • Current involvement with Child Protection/Child First/Integrated Family Services ascertained and recorded. • Genogram including: all DOBs, full names, identifies living arrangements, 3 generations. • Child wellbeing is assessed.	**Assessment:** • Identifies existing supports for all family members. • Strengths of family identified. • Family history of MI identified. • Identification of parenting responsibilities and caring roles of all family members, including children. • Identification of impact of the trauma. • Identify all services involved for each family member.
Orientation to service: • Copy of service/recovery plan provided and explained and includes opportunity for a subsequent family meeting. • Service/recovery plans include ongoing opportunity for family meeting at the appropriate time.	**Orientation to service:** • Pathways of care identified. • Identify need for case conference with relevant services.
Psychoeducation: • Parenting and Mental Illness information provided and explained to primary client.	**Psychoeducation:** • Family/Carer literature provided and explained to all family members.
Consent: • Consent obtained to share information with identified supports. • Referral to new support are identified and presented. Referral is facilitated.	

Stage 3 – Negotiating Recovery Plan Care

Essential	Recommended
Service/recovery plan: • Provides an opportunity for primary client to identify who is to be included in care planning. • Identify individual family member's needs. • Identifies actions to address each family member's needs. • Identifies who is responsible for each action. • Identifies key contact person for the service and other relevant services. • Identifies contact details for service including after-hours contact. • Identifies & considers parental status. • Crisis strategy is documented.	• Family members have opportunity to address concerns for others. • Plan articulates any impact of parental mental illness on parenting and impact of parenting on illness. • Identifies frequency of planned contact. • Provides a family care plan (e.g. alternative childcare arrangements, school attendance).

Stage 4 – Implementing Treatment

Essential	Recommended
Service Delivery (includes inpatient care if relevant): • Acknowledges caring roles of client (including parenting role/responsibilities) and offers support to these roles. • Offers ongoing psychoeducation to primary client. • Family aware of how to access crisis supports. • Regular review of risks to children/family members occurs. • Offers regular liaison and collaboration with existing supports. • Offers support to the identified needs of dependent children.	• Is inclusive of all family members. • Offers opportunity to meet with all family members. • Offers ongoing psychoeducation to all family members. • Identifies and offers other supports as required to all family members. • Identifies any emerging/change in parenting/ caring role for any family members and offers support to this. • Referral to peer support programs for children and young people is considered. • Referral to parenting supports is considered.

Stage 5 – Monitoring and Evaluating Care

Essential	Recommended
Regular review: • Support the primary client to have regular conversations with their children/family about any concerns they may have. • Status of family members is regularly reviewed and updated (including genogram). • Consent to share information with identified supports is reviewed and updated.	• Family, including children, are included in any review of treatment or service/recovery/care plan. • Any family member in a parenting/caring role is offered the opportunity to provide feedback to the service about their experience of the service. • Family members are informed of changes to service eligibility and the availability of services. • Regular review of strengths and vulnerabilities is articulated.

Stage 6 – Transfer of Care

Essential	Recommended
Discharge Planning: • Ongoing supports are clearly identified and documented. • All family members are advised on process for re-entry to service. • Written confirmation of discharge from service provided to Primary Client and nominated family members.	• All family members' needs are planned for and appropriate referrals have been made as needed. • Family members are consulted with regards to discharge from service. • Nominated services/supports advised of discharge from service with consent.

Appendix 4: Policy context

The Framework aligns with and has been informed by the following legislation and guidance.

Legislation

Mental Health Act 2007 (NSW) - establishes the legislative framework within which care and treatment can be provided for persons with a mental illness in NSW.

Carers (Recognition) Act 2010 - recognises carers and includes the NSW Carers Charter containing 13 principles addressing issues of significance for carers including: respect and recognition, inclusion in decision-making and access to services they may need.

Children and Young Persons (Care and Protection) Act 1998 (section 8c) - the objectives of this act are to provide that appropriate assistance is rendered to parents and other persons responsible for children and young persons in the performance of their child-rearing responsibilities in order to promote a safe and nurturing environment.

Guidance

International

The Universal Declaration of Human Rights 1948 - sets out the fundamental, universally protected human rights of all persons.

Reports of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2015 and 2017) - *A/70/213 July 2015* - the right of children to thrive and develop in an holistic way to their full potential and enjoy good physical and mental health; early childhood as a crucial time for effective investments in individual and societal health and *A/HRC/35/21 March 2017* - the right of everyone to mental health and some of the core challenges and opportunities, including that the promotion of mental health is addressed for all ages in all settings.

National

National Standards for Mental Health Services (2010) - recognise that mental health services provide services to individual consumers, carers and where developmentally appropriate, families and also support communities.

Protecting Children is Everyone's Business-National Framework for Protecting Australia's Children 2009-2020 - details a number of high-level and supporting outcomes and strategies to be delivered through a series of three-year action plans and monitored via detailed indicators of change.

National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families (2016) - articulates a vision, principles and approaches for the delivery of child and family health services to Aboriginal and Torres Strait Islander people to guide policy and program design.

A National Framework for Recovery Oriented Mental Health Services – guide for practitioners and providers (2013) - describes the practice domains and key capabilities necessary for the mental health workforce to function in accordance with recovery oriented principles. It provides guidance on tailoring recovery oriented approaches to respond to the diversity of people with mental health issues, to people in different life circumstances and at different ages and stages of life.

National Practice Standards for the Mental Health Workforce 2013 - address the shared knowledge and skills required when working in an interdisciplinary mental health environment and make explicit the shared capabilities that all mental health professionals should achieve in their work. Of particular relevance is Standard 2: *Working with people, families and carers in recovery focused ways.*

Contributing Lives, Thriving Communities – Report of the National Review of Mental Health Programmes and Services (2014) - of particular relevance are the recommendations under Dimension 5: *Promote the wellbeing and mental health of the Australian community beginning with a healthy start to life*.

A Practical Guide for Working with Carers of People with Mental Illness 2016 - recognises carers are a crucial component of any partnership approach to service delivery. It outlines *Six Partnership Standards* that can be applied across all settings and incorporates age-related and cultural needs.

Fifth National Mental Health and Suicide Prevention Plan 2017-2022 – sets out a national approach for collaborative government efforts in mental health and suicide prevention.

National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health & Suicide Prevention Strategy: A New Strategy for Inclusion and Action (2016) - a plan for strategic Action to prevent mental ill-health and suicide, and promote good mental health and wellbeing for lesbian, gay, bisexual, transgender, and intersex (LGBTI) people and communities across Australia.

State

The **NSW Aboriginal Health Plan 2013-2023** sets the key strategic directions for the health system in NSW, including mental health services, to close the gap in mental health outcomes between Aboriginal and non-Aboriginal people.

NSW 2021 – A Plan to make NSW Number One - NSW Government's 10-year plan to guide policy and budget decision-making and deliver on community priorities. Of particular relevance is Goal 13 *Better Protect the most vulnerable members of our community and break the cycle of disadvantage*.

NSW State Health Plan: Towards 2021 - provides a strategic framework which brings together NSW Health's existing plans, programs and policies and sets priorities across the system for the delivery of 'the right care, in the right place, at the right time'.

NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 - provides the overarching framework for NSW Health action in mental health. The Family Focused Recovery Framework responds to Objective Six: *Intervene early for children and young people.*

NSW Health Strategic Framework for Integrating Care (2018) - sets an overarching vision for how NSW Health approaches integration of care and recognises this is vital to improving outcomes for vulnerable and at-risk populations and people with complex health and social needs including people living with a mental illness.

Strategic Framework for Suicide Prevention in NSW 2018-2023 - guides activities in NSW until 2023 and marks the beginning of the journey towards zero suicides in NSW.

NSW Health Recognition and Support for Carers Key Directions 2018-2020 - guides NSW Health employees to recognise and support carers and engage with them as partners in care. People who have a carer or are a carer will be recorded in the NSW Health Patient Administration System.

NSW Aboriginal Health Plan 2013-2023 - acknowledges the significant health disparities between Aboriginal and non-Aboriginal people in NSW and outlines the principles and strategies NSW Health will implement to "close the gap".

The First 2000 Days Framework (2019) - outlines the importance of the first 2000 days in a child's life (from conception to age 5) and what action people within the NSW Health System need to do to ensure that all children have the best possible start in life.

NSW Youth Health Framework 2017-24 - supports NSW Health services to acknowledge and consider the health, wellbeing and involvement of young people aged 12-24 years when planning and delivering services.

NSW Health Integrated Prevention and Response to Violence, Abuse and Neglect Framework (2019) - outlines the vision, guiding principles, objectives and strategic priorities to strengthen NSW Health services in responding to violence, abuse and neglect in NSW.

Child Wellbeing and Child Protection Policies and Procedures for NSW Health (2013) - the tools and guidance for Health workers to meet their legal and policy responsibilities within the NSW Government Child Protection System.

NSW Supporting Families Early Package - SAFE START Strategic Policy (2009) - promotes an integrated approach to the care of women, their infants and families in the perinatal period.

NSW Child and Adolescent Mental Health Services (CAMHS) Competency Framework (2011) - articulates the subspecialty work of CAMHS and describes particular competencies for working with infants, children, adolescents and their families and carers.

Living Well: A Strategic Plan for Mental Health in NSW 2014-2024 - sets out the directions for reform of the mental health system in NSW over the ten year period 2014-2024. Of particular relevance are sections 3.3 *Prevention and early intervention for children and young people*, 4.1 *Families and Carers*, 4.2 *Engaging consumers and carers in service design* and 4.4 *Build the capacity of services to respond therapeutically.*

NSW School-Link Strategy and Action Plan 2014-2017 - describes the strategic aims and actions for the Department of Education and NSW Mental Health services in delivering the NSW School-Link initiative.

NSW Whole Family Team Guidelines (2020) - articulates an updated Whole Family Team (WFT) model of care targeted at WFT clinicians and their Managers.

Notes

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