

Mind the Gap

The National Illicit Drug Strategy (NIDS) Project to Improve Support for Children from Families where there are Mental Illness and Substance Abuse (MISA) Issues

Literature Review

Prepared by Michelle Hegarty for the NIDS MISA Project

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Dual diagnosis refers to the co-existence of any psychiatric disorder and substance use disorder in an individual (Rassool, 2002), and became clinically apparent in the early 1980s (Pepper et al., 1981; Caton, 1981, cited in Drake et al., 2001). Substance abuse is the most common comorbid condition among people with a severe mental illness (Siegfried, 1998), and yet service delivery systems often fail to adequately meet the needs of this group (Burdekin, 1993, cited in Tobin et al., 2001).

What is becoming apparent, in both health and child protection fields, is that an increasing number of people with mental illness and substance abuse are also parents, which has pertinent implications for service delivery. There is little, if any, recognition of the complex needs of these families, and possible risks for their children. In fact, there is only recently emerging evidence in the mental health and drug and alcohol fields to indicate an awareness of children whose parents have either of these disorders, reinforcing the suggestion that these are “the invisible children”, because they are not recognised in service delivery.

In NSW, the National Illicit Drug Strategy has funded the MISA Project – to improve support for children in families affected by parental “dual diagnosis” of mental illness and substance abuse. This review attempts to inform the MISA Project by: identifying the impacts, clarifying the needs of children and families affected, and recommending appropriate support systems and practices.

Terminology

The ‘adult’ dual diagnosis literature is predominantly North-American, with very few studies conducted in Australia. Despite this, the Burdekin Report (1993) determined that the prevalence of dual diagnosis in Australia would be comparable to the United States of America (NSW Parliament Legislative Council: Select Committee on Mental Health, 2002). Wide variations in research method, definition, samples and assessment procedures (de Lima et al., 2002) also make comparison of outcomes difficult.

Simply defining 'dual diagnosis' or 'comorbidity' is difficult, with no universal definition in existence. Studies employ a range of terms such as substance use, abuse, alcoholism and drug addiction, interchangeably across studies which further compounds the problem of definition (Gelles, 1993, cited in Tomison, 1996a). Similarly, the mental health literature interchanges terms like mental illness, disorder and mental health problem. Throughout the *NSW Parliament Select Committee Inquiry into Mental Health Services*, the comorbidity of mental illness and substance abuse was a recurring issue. To avoid confusion with the term describing other 'dual diagnoses', the Committee adopted the term 'mental illness and substance abuse' (MISA), as referred to in the Burdekin Report of 1993 (NSW Parliament Legislative Council: Select Committee on Mental Health, 2002). For the purpose of this review, 'dual diagnosis', or 'comorbidity' of mental illness and substance abuse will be referred to as 'MISA'.

MISA is not a homogenous condition (Todd, Sellman & Robertson, 2002). Individuals with dual diagnosis are unique because co-occurring mental illness and substance abuse issues vary along the dimensions of severity, chronicity, degree of functional impairment (Patrick, 2003), mental illness diagnosis and substances of abuse. Despite these limitations, there is consensus among most studies regarding prevalence rates and treatment (Siegfried, 1998), and smaller scale Australian studies have replicated prevalence rates and comorbidity rates (ie. mental illness type with substance of abuse) from the North American literature (Fowler et al., in press, in Siegfried, 1998).

Prevalence

Substance abuse in Australian society is a recognised problem that is increasing. The common substances abused include alcohol, marijuana, heroin, amphetamines, ecstasy and inhalants (Richardson, Bolisetty & Ingall, 2001). People living with a mental illness are at an increased risk of developing problematic alcohol or drug use (Commonwealth Department of Health & Aged Care, 2000). In the general population, the Mental Health and Wellbeing Profile of Adults (1998), a national household survey, identified that eighteen percent of Australian adults had suffered from a mental illness during the past 12 months. Of these, almost 8 percent had experienced a substance use disorder during that time (McKey, 1998). In the US, 28.8 percent of the general population qualify for an alcohol, drug or mental disorder diagnosis, with 3.5 percent having both problems (US National Comorbidity Survey, cited in Whiteford, 1998).

In clinical populations, MISA rates are much higher (McKey, 1998). Prevalence rates of substance abuse issues in mental health settings have been consistently reported at between 30 and 80 percent, and are even higher when nicotine is included (Todd, Sellman & Robertson, 2002). Also, more than half of the people who use or abuse substances have experienced psychiatric symptoms significant enough to fulfil diagnostic criteria for a mental illness (Regier et al., 1990). In Australia, the National Council on Drugs (ANCD) stated that "although it is difficult to accurately measure the prevalence of this problem, figures suggest that as many as three quarters of all clients with drug and alcohol problems have a dual diagnosis" (MISA). Similarly, it is asserted that an equally high percentage of people with mental illness also abuse substances (ANCD, 2002, cited in NSW Parliament Legislative Council: Select Committee on Mental Health, 2002).

In people with substance use problems, the most commonly encountered mental health disorders are anxiety or affective disorders (such as depression), reflecting their high incidence in the general population (Regier et al., 1990, cited in Kavanagh et al., 2000). The National Longitudinal Alcohol Epidemiologic Survey (NLAES) is the largest U.S. survey on dual diagnosis (MISA) to date. Results suggest that patients with an alcohol abuse or dependence diagnosis are 3.7 times more likely to present major depression and 7.2 times when it is related to drug abuse or dependence, particularly cannabis dependence (de Lima et al., 2002). In the Epidemiological Catchment Area Study, more than half of those who “abuse drugs” other than alcohol had at least one comorbid mental illness (de Lima et al., 2002). Drug use was found to be most common in people with antisocial personality disorders (83.6%), bipolar disorder (60%) and schizophrenia (47%) (Phillips, n.d.).

Among people with a mental illness, abuse of certain types of substances, particularly alcohol and cannabis, appears to be most common, and where drug abuse occurs, it often co-exists with alcohol abuse (Rassool, 2002). Studies have shown that moderate to heavy alcohol use has been associated with exacerbation of depressive symptoms in major depression; increased frequency of admissions and more rapid cycling in those with bipolar disorder, and increased readmissions in those with psychotic disorders. Cannabis use has been associated with increased positive symptoms (hallucinations, delusions and thought disorder), increased rates of rehospitalisation and shorter relapse time in people with schizophrenia (Todd, Sellman & Robertson, 2002).

The association between personality disorders and substance abuse have been identified by numerous studies. Among injecting drug users, the most common psychiatric disorder is anti-social personality disorder, with Australian opiate addicts demonstrating a 61 percent lifetime prevalence of personality disorder (Drake & Noorday, 1994, cited in Gafoor & Rassool, 1998).

A highly significant issue in MISA, though rarely addressed in the literature, is nicotine addiction and mental illness. In the US, 40-50 percent of patients with depression and anxiety disorders, and 70-90 percent of patients with chronic schizophrenia are addicted to nicotine, compared with 25-30 percent of the general population (Ziedonis & George, 1997, cited in Lindsay & McDermott, 2000). Little attention is paid to the interactions between nicotine dependence and mental illness, and its treatment, despite having serious impacts on the person’s physical health, symptomatology and daily functioning.

Women who abuse substances are more likely to have or develop a mental illness (Penn et al., 2002), and have less social support, which is often associated with the use of dysfunctional coping strategies (Rhoads, 1983; Tucker, 1982, cited in Dawe et al., 2000). Women are also less likely to attend group treatment programs (Comtois & Ries, 1995, cited in Lindsay & McDermott, 2000), and as many as 50 per cent of women exit programs before completing treatment (Moore & Finkelstein, 2001, cited in Patton, 2003), which is thought to be largely associated with care responsibilities for dependent children and a lack of accessible programs for women.

Impact of MISA

People with a mental illness, who may be socially isolated, may be drawn into the drug-using culture, which is less stigmatised for social interactions (Gafoor & Rassool, 1998). Social factors may also contribute to continued drug use. For example, people with mental illness are known to experience “downward drift”, whereby as a consequence of their illness they may find themselves living in marginal neighbourhoods, where drug use may be more prevalent (Hatfield, 1993).

In the mental health field, self-medication theories and self-report studies suggest the use of substances to relieve symptoms (Siegfried, 1998). For example, stimulants such as amphetamines and cocaine have been used to counteract extrapyramidal side-effects of prescribed medications, and to enhance mood (Schneier & Siris, 1987, cited in Rassol, 2002). It is often difficult however, to distinguish between symptoms related to substance abuse and those related to mental illness. Substance abuse may produce symptoms of mania, psychosis, depression, anxiety and personality disorder, depending on the type of drug and the route of transmission (Rassool, 2002). The symptoms of acute withdrawal may also mimic those of psychosis and affective disorders (Phillips, n.d.).

Dual diagnosis (MISA) is associated with a host of social, behavioural, psychological and physical problems, including:

- increased symptom severity and suicidal behaviour¹
- greater non-compliance with treatment²
- more hostile and aggressive behaviours³
- increased risk of violence to others⁴
- higher rates of offending, imprisonment and homelessness⁵, and
- longer duration of admission to psychiatric inpatient units⁶.

People with MISA often experience high levels of vulnerability and burden on family/carers, and are at greater risk of stigmatisation and exclusion from existing service provision (Rassool, 2002). In fact, people with MISA have been found to be more difficult to engage and treat in view of their higher levels of physical, social and psychological impairment (Gafoor & Rassool, 1998).

MISA Service Delivery

Since the issue of dual diagnosis first began to emerge, treatment providers have “bounced” MISA clients from service to service in what became known as “ping, pong therapy” (McKey, 1998). At a service level, treatment for individuals with MISA has traditionally been provided in separate mental health and alcohol and other drug programs in serial or “parallel” fashion (Judd et al., 2003). Individuals must negotiate

¹ Drake & Wallach, 1989; Hall & Solowij, 1997, cited in Wright et al., 2000

² Bebbinton, 1995, cited in Wright et al., 2000

³ Wilen et al., 1993, in Gafoor & Rassool, 1998

⁴ Swanson et al. 1990; Cuffel et al., 1994, cited in Wright et al., 2000

⁵ Tessler & Dennis, 1989, cited in Wright et al., 2000

⁶ Menezes et al., 1996; in Holland, 1998

between the two systems, and are often excluded from both. Philosophical conflicts exist between the two systems, regarding: use of medication; the quasi-religious nature of twelve-step rehabilitation programs; mandated versus voluntary programs, and the issue of primary diagnosis (Ridgely, Goldman & Willenberg, 1990, cited in Minkoff, 2001). Each system has different thresholds for intervention and definitions for significant harm, and variations in eligibility criteria (Tye & Precey, 1999).

The complexity of the parallel system is further compounded when child protection issues are identified. The literature recognises that the interface between child protection and health is a complex matrix of services, thresholds, differing knowledge bases, and diverse ethical and legal considerations (Tye & Precey, 1999).

Though much of the research is U.S. and U.K. based, Australian services have demonstrated similar experiences. In a survey of mental health and alcohol and drug services, staff indicated a problem in the co-ordination of client care across services, including disputes over duty of care (Kavanagh et al., 2000). Another Australian survey of service providers, identified barriers to effective treatment of MISA including: lack of liaison between services, lack of community resources, high workloads, and lack of knowledge and expertise (Byrne et al., 2000b).

There is a general lack of knowledge and expertise in treatment of MISA (Gafoor & Rassool, 1998). There is a lack of empirical evidence regarding effective treatments (Judd, et al., 2003), and traditional substance abuse treatment has high attrition and relapse rates, making assessing treatment outcomes difficult (Killeen & Brady, 2000). At a clinical level, mental health workers report lack of knowledge about the nature and interactions of MISA issues (Todd, Sellman & Robertson, 2002). In addition, many child protection and non-government organisations who support children of parents with a mental illness often lack vital knowledge about mental illness (Tomison, 1996b).

Gafoor and Rassool (1998) found that workers may be reluctant to intervene due to feelings of frustration, inadequacy, or lack of confidence in their ability to effect change; often hold negative views about treatment outcomes, and may demonstrate opposition to what they perceive as overtly self-abusive behaviour. Drug abuse is often viewed as a moral deficit rather than a disease (Coyer, 2001), and rigid, judgemental and punitive attitudes among health and social service providers, and the community, are seen as major barriers to help-seeking (Judd, et al., 2003).

People with a dual diagnosis (MISA) are generally more difficult to engage and maintain in treatment (Whiteford, 1998) and often, high caseloads can contribute to “penalising” healthy behaviour. That is, clients who are functioning well with minimal support needs are often overlooked, as attention is focused on clients in crisis. This can impact on a person’s compliance with treatment and maintenance in a program, therefore it is suggested that regular meetings and support would assist this problem (Penn et al., 2002).

Most mental health and substance abuse treatment settings have been designed for the individual, and in the limited MISA literature, support programs for families generally target the parents of adolescents, and not children or families affected by parental mental illness and substance abuse issues. According to Luntz (1995, cited in Handley et al., 2001), in the mental health field, no specialist service takes formal responsibility for primarily addressing the children's needs, despite being at high risk of developing psychopathology and adjustment problems.

Parent-child or family facilities are rarely available in mental health or drug and alcohol settings (Dawe et al., 2000). There is an overall shortage of residential drug treatment services that will accommodate women and their children, and in NSW this shortage has been noted by service providers (NADA, 2004). This may delay women seeking help from fear of removal or separation of their children (Parity, 1998, cited in Lindsay & McDermott, 2000). In fact, a study of women in substance abuse treatment programs, demonstrated most had a history of treatment failures. A common reason for not completing substance abuse treatment was child-care issues (Killeen & Brady, 2000).

Mental Illness, Substance Abuse and Parenting

There is a clear gap in the literature and service provision in relation to children whose parents have coexisting mental illness and substance abuse issues. The small body of research in dual diagnosis (MISA) overlooks the impact on children, and the observations in this review are drawn from the separate literature surrounding either substance abuse or mental illness.

There is greater literature on children of parents who abuse alcohol, than of any other substance-abusing group, though of this, most research relates to fetal exposure to maternal alcohol use (Johnson & Leff, 1999). There are fewer studies of child outcome in families affected specifically by parental drug abuse, however it appears that there are many commonalities.

Prenatal effects of alcohol and drug use have been well documented, and can include spontaneous abortion, premature birth, foetal distress, physical and/or mental disability, birth defects and withdrawal symptoms upon birth (Russell, 1995, cited in Tomison, 1996a). Child abuse or neglect is a significant concern for these infants, given their vulnerability, increased distress, and need for support (Dore, Doris & Wright, 1995, cited in Tomison, 1996a; Johnson & Leff, 1999).

Children exposed prenatally to drugs demonstrate more disorganised, destructive, aggressive, and externalising behaviours when compared with controls (Griffith et al., 1994; Hawley et al., 1995, cited in Killeen & Brady, 2000). Much of the research however, suggests that postnatal substance abuse by the mother and the environment that this behaviour creates, may be more, or equally as harmful to child development (Killeen & Brady, 2000).

The peak life stage for substance abuse is 18-35 years, the child-bearing years (Lex, 1995, cited in Campbell, 1997), and the literature reveals that illicit drug-using women:

- are less likely to access pre- and postnatal care¹
- may avoid seeking help for parent-child problems²
- fear that their use will be exposed, which may lead to intervention by child protection authorities³
- perceive that nothing is wrong, or lack interest in parenting⁴
- may be isolated or marginalised from traditional health services⁵
- experience a lack of relevant services in rural regions and urban areas of poverty⁶.

Drop out from treatment is a common problem in parent-child interventions and in the drug and alcohol field, due to factors including: poverty, poor family or social support, low expectations of treatment acceptability or effectiveness, therapist skill and sensitivity, and continued drug use (Miller & Prinz, 1990; Marlett & Gordon, 1985; Prinz and Miller, 1991; Gainey et al., 1995, cited in Dawe et al., 2000).

In addition, the impoverished, non-supportive environment of substance abuse often makes treatment attempts futile (Killeen & Brady, 2000). Substance abusing women often present with complex needs around persistent physical and sexual abuse, limited availability of sober living arrangements and have a high prevalence of personality disorders (Jerrell & Ridgely, 1995, cited in Penn et al., 2002). The connection with substance abusing partners may also impede treatment advice or compliance (Robbins, 1995; Waldby, 1988, cited in Campbell, 1997).

Alcohol

Johnson and Leff (1999) describe the environment of children of parents who abuse alcohol as being characterised by:

- a lack of parenting
- poor home management
- lack of family communication, and therefore poor modelling of parenting skills and family effectiveness
- family conflict, including emotional or physical violence,
- poor organisation and disrupted family rituals
- family stress including work problems, illness, marital strain and financial problems
- isolation, and lack of extended family to provide support, balance and encouragement to the child
- frequent relocation, and
- lower academic functioning, frequently absence or lateness for school, poor clothing and nutrition, and less help from parents with school work (Kumpfer & de-Marsh, 1986, cited in Johnson & Leff, 1999).

¹ Finnegan & Kandall, 1992; Glover Reed, 1987, cited in Byrne et al., 2000a

² Dawe, et al., 2000

³ Finnegan & Kandall, 1992; Waldby, 1988, cited in Byrne et al., 2000a

⁴⁻⁶ Dawe, et al., 2000

Children of parents who abuse alcohol are diagnosed more frequently with behavioural and attention disorders, oppositional disorders or conduct disorders (Earls et al., 1988, cited in Johnson & Leff, 1999). When a parent is abusing other substances, the risks for developing a mental disorder or behavioural and emotional problems are similar, in particular oppositional, defiant and non-compliant behaviour and juvenile delinquency (Smith, 1993; Willens et al., 1995; Loeber, 1990; Ferguson & Lynskey, 1998, cited in Dawe et al., 2000), and they are at greater risk of substance abuse themselves (Johnson & Leff, 1999).

In fact, Goodwin (1976; 1985, cited in Johnson & Leff, 1999) reports that as many as 25 percent of male relatives and up to 10 percent of female relatives of those who abuse alcohol, are at risk of developing alcohol abuse problems. Other factors may combine with genetic predisposition to increase risk for alcoholism, including environmental influences, temperament and personality traits (Johnson & Leff, 1999).

Drug Abuse

Parental abuse of drugs places children at biologic, psychologic and environmental risk, and is associated with significant medical and psychosocial problems in children. Lack of prenatal care, poor nutrition, poverty, and other environmental factors are all confounding issues in the outcomes for children whose parents abuse substances (Killeen & Brady, 2000).

While current Australian figures are not available, it is recognised that a high proportion of children raised in substance abusing families are at high risk of child abuse and neglect¹. Factors include:

- substance abusing women being more likely to have difficult or abusive relationships with male partners²
- chaotic lifestyles centred around procuring drugs, intoxication and withdrawal, all of which impact on the caregiver's capacity for parenting³
- effects of intoxication on parental cognitive functions such as memory and consciousness, leaving children in the care of different adults⁴
- and impact on the capacity of parents to provide safety, consistency and familiar routines⁵

Substance abusing mothers have been described as using more negative reinforcement in their parenting behaviour, and demonstrate less positive affect and greater detachment from their infants (Bauman & Dougherty, 1983, cited in Killeen & Brady, 2000; Fitzgerald et al., 1990, cited in Dawe et al., 2000).

Mothers on methadone maintenance demonstrate difficulty communicating with their children, with significantly more directive and aversive behaviours, and significantly

¹ Cohen & Brook, 1987; Famularo et al., 1989; Tracy, 1994; Chaffin et al., 1996, cited in Dawe et al., 2000

² Hien & Scheier, 1996; Miller, Downs & Gondoli, 1989, cited in Hans, Bernstein & Henson, 1999

³ Dawe et al., 2000

⁴⁻⁵ Schuler, Nair & Black, 2002

fewer pro-social behaviours (Bernstein & Hans, 1994; Bauman & Dougherty, 1983, cited in Dawe et al., 2000). They typically display a more authoritarian attitude to child rearing, which has been clearly linked to the development of oppositional behaviours in non-substance abusing families (Dadds, 1987, cited in Dawe et al., 2000).

In addition to problems of interaction quality, a disproportionately high number of substance abusing mothers have difficulties sustaining continuous care of their children over time (Hans et al., 1999). In a study of 400 participants of drug treatment programs, nearly half (48%) reported that they had children under 18 years, though only 16 percent of those with dependent children were living with them (Grella, 2003).

An additional issue in families affected by parental substance abuse, is the growing number of children of HIV-positive injecting drug users. These children may be at significant risk, as they suffer from the emotional distress of also having a parent with a life-threatening illness, who may also have periods of unavailability due to ill health (Boyd-Franklin et al., 1995, cited in Pilowsky et al., 2003).

Mental Illness

In the mental health literature, there are no reliable national figures on the numbers of children affected by parental mental illness, in any country (Cowling, 2001). There is difficulty in obtaining exact data, as many parents are reluctant to identify themselves as having mental health or behavioural problems due to concerns about potential system responses, such as removal of their children (NSW Parenting Program for Mental Health, 2003).

In 1995, a crude measure estimated that 27,000 Australian children are affected by maternal psychotic illness alone (Cowling, McGorry & Hay, 1995), and despite recommendations to change data collection and service delivery, only small, localised initiatives have been undertaken. More recently, the report: *Australian Social Trends 2000* indicates that 11 percent of Australian children have parents who have mental health problems or a behavioural problem (ABS, 2000, cited in NSW Parenting Program for Mental Health, 2003).

The 1996 National Mental Health Report indicated that 29 percent of mental health service consumers have dependent children (Lindsay & McDermott, 2000). Similarly, the AICAFMHA Scoping Report (2001) cites Australian studies, which indicate that anywhere between 29 and 35 percent of mental health services consumers are female parents of dependent children under the age of 18. International studies have shown similar rates, with 28 per cent of adults admitted to inpatient mental health care having children (Oppenheimer, 1979, cited in Ostman & Hansson, 2002). In the UK, various small scale surveys and audits suggest that at least 20 percent, probably one-third and in some cases up to 50 percent of adults known to mental health services have children (Royal College of Psychiatrists, 2002).

It is important to note that only 45 percent of people with a mental illness in Australia use public health services (National Mental Health Working Group, 1994, cited in Gaining

Ground, 2000), therefore, the figures are likely to be an under-estimation of the numbers of children affected by parental mental illness. It has also been noted that fathers are clearly missing from the literature (Dawe et al., 2000), with many studies focusing on mothers.

There is a growing body of literature exploring the issues of mental illness and parenting. However, given the recent recognition of this group, and the stigma associated with mental illness, much of the research is based on small, local programs, the literature is descriptive and samples are relatively small. What is emerging however, is consistent at both a national and international level.

Parents with a mental illness tend to:

- have concerns regarding the impact of symptomatology on their roles, and on their family¹
- have poor self-esteem and self-confidence in relation to parenting²
- lack understanding of mental illness³
- experience higher rates of marital discord and marriage breakdown⁴
- experience a range of problems related to poverty, poor housing and unemployment⁵
- be more represented in lower socioeconomic environments⁶
- have poor access health and support services⁷
- fear that asking for help regarding their children will result in a loss of custody⁸
- avoid or delay hospitalisation to prevent separation from children or placement of children in care, thereby increasing the risk of exposing children to traumatic experiences and inadequate care when they are unwell.⁹

In addition, women with psychotic disorders are more likely to receive less than optimal antenatal care, have more obstetric complications than mothers without schizophrenia, and are at risk of reproductive losses such as termination and loss of custody of their children (Miller, 1990; Sacker et al., 1996; Thomas et al., 1996, cited in Barkla, et al., 2000). In fact, one study indicated that while there has been little change in the percentage of mental health service consumers with offspring, the proportion with custody of their children decreased over the years: 89 percent in 1986, 76 percent in 1991 and 64 percent in 1997. Eighty-six percent of those with custody were women (Ostman & Hansson, 2002).

¹⁻² Byrne et al., 2000b

³ Handley et al., 2001

⁴ Anthony, 1970; Cohen, 1993; 1984, cited in Byrne et al., 2000b

⁵ Anthony, 1970; Cohen, 1993; 1984, cited in Byrne et al., 2000b

⁶ Chenoweth, 1994

⁷⁻⁸ Hearle et al., 1999

⁹ Gaining Ground Project, 1998

While child behaviour problems and difficulties in parent-child interaction can be stressful for any parent, they may be more problematic for those with a mental illness (Byrne et al., 2000b).

For example, Weissman and colleagues (1972, cited in Tomison, 1996b) observed that the interactions between depressed parents and their children were marked by parental disinterest, hostility, less involvement and poor communication. These behaviours have also been described in the literature and observed in practice with parents diagnosed with schizophrenia and bipolar disorder.

In a study of post-natal depression, depressed mothers tended to respond significantly less to the cues and needs of their infant than control mothers at three and six months postpartum (Milgrom, 1992, cited in Tomison, 1996b).

Some researchers have suggested that maternal personality disorders may affect children's development even more than depression (Rutter & Quinton, 1984; Weiss et al., 1996, cited in Hans, Bernstein & Henson, 1999). Characteristics of 'cluster B' personality disorders, such as antisocial and borderline personality disorders, often involve inappropriate expressions of anger or violence and core difficulties relating to other people, including a preoccupation with self, lack of empathy, and a wide range of impulsive emotional reactions, which may create problems in the parenting role.

The relationship between parental mental illness and childhood risk is complex, multifaceted and changeable over time, with outcomes depending upon child characteristics, alterations in family functions and stressors and protective factors (Falkov, 1998). The degree, if any, of psychiatric disturbance in children of mentally ill parents can be seen as a function of the:

- intensity, frequency, duration, and severity of parental dysfunction;
- the degree of genetic loading for a specific illness;
- the availability of a healthy alternative caregiver;
- the intensity and duration of exposure to parental dysfunctional behaviour, and
- the degree of psychosocial stress experienced by the child (Garmezy & Rutter, 1983, cited in Silverman, 1989).

Many parents with a mental illness cope well with parenting and some children show few, if any, adverse effects (Anthony & Cohler, 1987; Cox et al., 1987; Rolf et al., 1990, cited in Royal College of Psychiatrists, 2002), however studies have shown that 25 – 50 percent of children with a mentally ill parent will also experience some psychological disorder during childhood, adolescence or adulthood, and 10 – 14 percent will be diagnosed with a psychotic illness at some point in their lives (Farrell et al., 1999). While there are many risk factors, the type of disorder, if any, that a child of a parent with a mental illness will develop over time, cannot be predicted with any accuracy (Silverman, 1989).

In a study of adolescents of depressed mothers, 74 percent reported difficulties such as school problems, parental conflicts, and involvement with the law, drugs and sex,

compared with 10 percent of controls (Weissman, 1984, in Chenoweth, 1994). Other studies have indicated a heightened risk of other forms of psychopathology particularly antisocial behaviour, and an increased overall prevalence of major depression, substance abuse, psychiatric treatment, and poor social functioning (Beardslee, 1983; Weissman & Gamman, 1987, cited in Chenoweth, 1994).

Of particular relevance to the MISA literature, however, is the report that about half of adolescents presenting with their first episodes of schizophrenia or bipolar disorder will develop a substance abuse disorder in their lifetime (Cuffel, 1996, cited in Lindsay & McDermott, 2000).

In addition to the psychological risks, the issues affecting children include:

- parentification¹
- isolation from peers and other adults²
- unmet developmental needs³
- feelings of grief, loss, anger and/or depression⁴
- concern about developing mental illness themselves⁵
- lack of understanding of the illness⁶
- the impact of their parent's hospitalisation⁷
- disruption to home and school⁸
- exposure to traumatic experiences⁹
- pressure to keep the illness hidden and fear of being removed from the family¹⁰
- lack of informal support and professional interventions do not address their needs¹¹.

Issues for Child Protection

It is generally acknowledged that child abuse and neglect is a multi-determined phenomenon that cannot be explained by any one factor (Ammerman, 1990; National Research Council, 1993, cited in Tomison, 1996a). Overall however, the two most prevalent disorders identified in child protection cases have been depression and substance abuse (Chaffin, Kelleher & Hollenberg, 1996, cited in Tomison, 1996b).

A history of mental illness or substance abuse has been identified as one of thirteen risk factors associated with physical abuse and neglect in infants (Browne & Stevenson, 1983, cited in Tomison, 1996b). Other factors include: parental indifference, intolerance or overanxiousness towards the child; a history of family violence; socio-economic

¹⁻⁵ Byrne et al., 2000b

⁶⁻⁷ Handley et al., 2001

⁸⁻¹⁰ Gaining Ground Project, 1998

¹¹ Webster, 1992

problems; a parental history of childhood abuse and/or neglect; the presence of a step-parent or co-habitee in the family; single or separated parent, or young mother; and infant mental or physical disability (Tomison, 1996b). In addition, research indicates an increased risk of abuse and neglect by mothers who are highly stressed (Ethier et al., 1995; Abidin & Bruner, 1995; Mash, Johnston & Kovitz, 1983, cited in Harmer, Sanderson & Mertin, 1999). As indicated in the literature, many of these factors are present in families where parents have mental illness and substance abuse issues.

Data dealing with the relationship between mental illness and child abuse and neglect in the Australian population is very limited (Tomison, 1996b). Studies show that the rate of custody loss for mothers with a mental illness is high (Miller & Finnerty, 1996, cited in Handley et al., 2001). Parents with a mental illness often have grave fears of losing their children and resist treatment, particularly hospitalisation, which often means that child protection services are called in to a crisis (Shipp, 1999). It is often at this time, that children of parents with a mental illness first come to the attention of mental health and child protection services (Gaining Ground, 1998).

While the number of cases of fatal abuse and neglect is small, there is an important link identified with parental mental illness (Royal College of Psychiatrists, 2002). The children most at risk of significant harm are those who feature within parental delusions, and children who become targets for parental aggression or rejection (DH, HO and DfEE, 1999, cited in Aldridge & Becker, 2003). There are also high rates of undiagnosed mental illness and low referral rates to mental health services among families known to child protection services (Zuravin, 1988, cited in Royal College of Psychiatrists, 2002), suggesting that many parents remain untreated for their mental illness.

While the impacts of mental illness on parenting may cross diagnostic boundaries, various studies have observed families with specific parental mental health diagnoses. For example, depressed parents were found to be almost three and a half times more likely to initiate physical abuse than non-depressed counterparts, and in obsessive-compulsive disorder, obsessional rituals may interfere with child-rearing responsibilities. In fact, a significant association was found between obsessive-compulsive disorder and neglect (Chaffin, Kelleher & Hollenberg, 1996, cited in Tomison, 1996b).

In personality disorders, poor compliance with treatment has been observed to be common, and various abnormal behaviours including overt violence, self-mutilation or sexual disinhibition may be present (Westen et al., 1990; Schaffer, Carroll & Abromowitz, 1982, cited in Aldridge & Becker, 2003). While not common, Munchausen Syndrome by Proxy, is perhaps the mental disorder where the relationship between parental psychopathology and child abuse is most obvious. In this syndrome, the parent fabricates or induces illness in the child, or exaggerates symptoms, and may even smother or poison the child to produce physical signs of an illness (Tomison, 1996b).

Children of substance abusers make up the largest group of children entering the child protection system (Barth, 1994, cited in Besinger et al., 1999). It has been estimated that at least half, and even up to 80 percent of all parents whose children are known to the

'welfare' system in the US, have substance abuse issues (Dore, Doris & Wright, 1995; Besinger et al., 1999; Barth, 1994, cited in Tomison, 1996a).

In NSW, the 1994-95 National Child Maltreatment Statistics indicated that 22 percent of all substantiated emotional abuse cases were reported to result from a parent's substance abuse problem (Angus & Hall, 1996, cited in Tomison, 1996a). In Victorian protective services, 41.5 percent of families sampled had substance abuse concerns recorded as contributing to child protection concerns. In cases of neglect, 57 percent of cases had a substance abuse concern recorded (Tomison, 1996a). Chaffin and colleagues (1996, cited in Tomison, 1996b) reported that substance abuse appeared to be the most common factor associated with both physical abuse and neglect, approximately tripling the risk when other factors were controlled.

Campbell (1997) proposes the rationale of "competing demands of substance abuse and child rearing". Substances may have a sedating effect on the user, resulting in their inability to respond to their child's needs appropriately (Hindman, 1977, cited in Besinger et al., 1999). Alcohol and drugs also have disinhibiting effects leading to poor impulse control, low frustration tolerance or tendencies towards violence, including physical or sexual violence (Flanzer, 1993; Gelles, 1993; Curtis, 1986; Cicchetti & Olsen, 1990; Araji & Finkelhor, 1986, cited in Tomison, 1996a), and domestic violence. In fact, one US study found that 64.9 percent of substance abusing women reported being physically or sexually abused or had their life threatened by a spouse or boyfriend, which is 2 - 3 times higher than the rate in national surveys of the general population (Gilbert et al., 1997, cited in Kettinger et al., 2000). Other factors such as poverty, stress, or child abuse experienced by the parents themselves, increase risks for both substance abuse and abusive behaviour (Orme & Rimmer, 1981, cited in Besinger et al., 1999).

Children who have been subject to abuse or neglect, in addition to having a caregiver who is a substance abuser, are likely to be in need of mental health services (Dore et al., 1995, cited in Besinger et al., 1999). The effects of child abuse and neglect include low self-esteem, more negative affect, impulsivity, and avoidant or anxious attachment (Cicchetti & Olsen, 1990; Gelardo & Sanford, 1987, cited in Henderson, 1994). This is further compounded by the genetic and environmental risk factors associated with parental mental illness and substance abuse.

In addition, it should be noted that young people in the care system are one of the most vulnerable in terms of psychological disturbance. Their risk for mental health problems and disorders, and behavioural problems is higher than that of any other easily identified group in our society (Bamford & Wolkind, 1988; Wolkind & Rushton, 1994, cited in Kufeldt et al., 1995). A study in the UK explored the mental health of adolescents aged 13-17 years living in residential care and foster care. The total weighted prevalence rate of mental disorders in adolescents in the care system was 67 percent compared with 15 percent in the comparison group, with 96 percent of adolescents in residential units and 57 percent in foster care having mental disorders. Similarly, a Scottish study estimated the prevalence of clinically significant psychopathology in 57 percent of children in the foster care system (Minnis et al., 2001).

Cultural Diversity, MISA and Parenting

There is little acknowledgement in the literature of culturally diverse or Aboriginal or Torres Strait Islander (ATSI) populations affected by parental mental illness and substance abuse issues. Significant needs assessment studies, research and services for people from culturally and linguistically diverse backgrounds with MISA remain to be undertaken (Lindsay & McDermott, 2000). And despite the recognition of multiple social issues, including substance abuse, mental illness and violence affecting Aboriginal society, research remains limited in relation to parental comorbidity issues (Tomison, 1996a).

New South Wales (NSW) has the most culturally diverse population in Australia, with 40.2 percent of the non-English speaking population living in the state (ABS, 1996, cited in NSW Parenting Program for Mental Health, 2003), and yet members of culturally diverse groups have difficulties in accessing mental health care, and are underrepresented among those receiving mental health (Ziguras et al., 2003) and drug treatment services (Reid et al., 2001). Under-representation at treatment services is believed to indicate under-utilisation of services rather than a lower need (Reid et al., 2001), with substantial mental health issues being associated with migration, flight, torture and trauma, and resettlement. There is a lack of information about related symptoms, service utilisation, and treatment effectiveness for culturally diverse individuals with substance abuse disorders, and very limited data concerning service utilisation and treatment effectiveness among culturally diverse consumers of mental health services (Jerrell & Wilson, 1996).

There can be particular issues for children and families from culturally and linguistically diverse backgrounds, including: marginalisation, educational disadvantage and trans-generational stress (NSW Health, 1998). Families and individuals may experience loss and grief, a lack of support networks and cultural challenges including language, values and beliefs that may create intergenerational conflicts. Families may face socioeconomic problems such as unemployment, low income and inadequate housing, and may have difficulty accessing suitable health and support services (NSW Parenting Program for Mental Health, 2003). These, and many other factors place people from culturally diverse backgrounds at high risk of experiencing mental ill health (Sozomenou et al., 2000).

Dealing with the effects of parental disability often presents stresses additional to those considered normative during childhood and adolescence, and adding issues of ethnicity and 'difference' is likely to have significant consequences for these children's development. In fact, children and young people from culturally diverse backgrounds whose parents' have a mental illness, find themselves having two sources of being 'different' to integrate, which may impact on the formation of their self-identity (Andriotis, 2001).

Culturally appropriate strategies to engage and support culturally diverse families have been identified in previous studies, and include: establishing trust around cultural values and practices; sensitivity to confidentiality within and outside the family; the preference

of practical assistance rather than ‘counselling’, and greater involvement of the family in work with youth. It is also acknowledged that positive dimensions of the child’s cultural background may contribute to his/her resilience (Andriotis, 2001).

Indigenous Populations

Aboriginals and Torres Strait Islanders are seriously disadvantaged in comparison with the general Australian population, experiencing markedly poorer health, poorer nutrition, greater poverty, poorer housing and facilities, lower levels of education, and higher levels of unemployment, imprisonment, racism and discrimination (ABS & AIHW, 1997; Raphael & Swan, 1997, cited in Commonwealth Department of Health and Aged Care, 2000). Although data is limited, it is clear that people from both Aboriginal and Torres Strait Islander communities experience high rates of mental illness and disorder.

It is fundamental to recognise the impact on mental health of historical events related to invasion and colonisation, including grief and loss, premature death, racism, social disadvantage, family breakdown and separation of children from their families. The ongoing consequences of colonisation are evident in the high levels of stress, grief, depression, suicide and substance abuse in many ATSI communities (Raphael & Swan, 1997, cited in Commonwealth Department of Health and Aged Care, 2000).

The use of both licit and illicit drugs is a major health issue for Australian Aborigines. While a large proportion of Aboriginal Australians do not consume alcohol, those who do frequently show severe alcohol problems, which are associated with family conflict and violence (Kowalyszyn & Kelly, 2003).

The risks Aboriginal children face are therefore high, including high rates of abuse and neglect, higher rates of foster care placements and higher numbers of children in corrective facilities than for non-Aboriginal children (NSW Parenting Program for Mental Health, 2003).

The literature around ATSI communities and the impacts of mental illness and substance abuse is quite dated, and appears to focus mostly on that of young people in rural and outback communities. Little evidence of parental mental illness, substance abuse, and in particular, ‘MISA’ in indigenous communities exists in the literature. These limitations, clearly indicate the need to work with culturally diverse and Aboriginal and Torres Strait Islander communities in identifying needs and establishing approaches to supporting families affected by parental MISA.

Resilience and Protective Factors

Despite the risks, not all mentally ill parents are inconsistent or ineffective at parenting, and in many cases, parental mental illness will not directly increase the risk that the child will express psychopathology (Silverman, 1989). Similarly, there are subgroups of children of substance abusers, who despite all odds, enjoy good health from birth; experience a positive environment at home; and develop into socialised, competent and self-confident individuals (Johnson & Leff, 1999).

Certain individuals may be more competent in adapting to stressful living environments than others. This is what is referred to as 'resilience'. In the Developmental Psychopathology Model (Cicchetti & Toth, 1998, cited in Dawe et al., 2000), an individual's development is determined by an interaction of influences, including the presence or absence of specific risk or protective factors, previous levels of functioning, and the developmental level during which adversity is experienced (Dawe et al., 2000).

Protective factors include:

- a responsive and safe home environment¹
- supportive and highly organised family, and positive family qualities the child's temperament²
- the child's age at time of parental ill health, and
- the extent and quality of the external support system, including the availability of one or more adults with whom the child can develop a supportive relationship.³

Efforts to enhance the resilience of at risk populations have been noted (Chenoweth, 1994) and many risk factors may be modified by preventive interventions. Such interventions can improve family stability, foster the parent's ability to meet the child's needs and minimise the pathology to which the child is exposed (Silverman, 1989).

In addition, early detection and intervention of parent-child problems is a major factor in the prevention and treatment of poor child outcomes (Dawe et al., 2000). Emerging evidence reveals that parent-child interventions are most effective at an early age, reducing as children move into adolescence (Dishion & Patterson, 1992, cited in Dawe et al., 2000).

Improvement in parenting can have a major impact in changing dysfunctional behaviour in children. Research is now indicating that maladaptive childhood behaviour may be reversed with appropriate interventions focused toward mother and child (Killeen & Brady, 2000). Assisting substance abusing people in their role as parents can be an effective drug prevention strategy, breaking the intergenerational cycle of substance abuse, improving parenting practices and reducing the risk of children's and young people's involvement in harmful substance use (Vimpani & Spooner, 2003).

It has become increasingly clear that many child development problems associated with maternal substance abuse can be reversed if the affected children have stability in their lives (Chasnoff, 1992, cited in Killeen & Brady, 2000). Special programs for children include therapeutic child-care, counselling for psychological problems, substance abuse education, medical services, and appropriate referrals to other services in the community (Killeen & Brady, 2000).

¹ Johnson et al., 1990, cited in Dawe et al., 2000; Richter & Bammer, 2001

² Johnson et al., 1990, cited in Dawe et al., 2000; Richter & Bammer, 2001

³ Garnezy et al., 1984; Feldman et al., 1987, cited in Cowling, 1996

Promotion, Prevention and Early Intervention

While there are a range of policy frameworks at various stages of development, the Commonwealth Departments correspond strongly in relation to the emphasis on primary prevention to develop positive parenting skills and optimal family functioning, and early intervention targeting families at high risk, including parental mental illness and substance abuse (National Health and Medical Research Council, 2001). It is recognised that many of the influences on mental health outcomes lie across a range of service sectors and it is critical to apply mental health promotion and prevention strategies to each of these (Commonwealth Department of Health and Aged Care, 2000).

There is considerable potential to reduce the risk, or prevent the onset of mental health problems and disorders through prevention and early intervention programs for children and young people. Early intervention can prevent problems from becoming entrenched and thereby minimise the impact of these problems or disorders on the lives of young people (Raphael, 2000).

Many children who are at increased risk of developing mental health problems and disorders can be identified by the services to which either they or their parents are connected, including mental health, drug and alcohol, child protection, criminal justice and education systems (Commonwealth Department of Health and Aged Care, 2000). Early intervention relies on early identification of signs and symptoms and immediate access to support. Service providers across a range of sectors therefore require training and support to be able to recognise early signs and symptoms, and know when, how and where to refer (Commonwealth Department of Health and Aged Care, 2000).

Recommendations for Service Delivery

Family Intervention

The present data showing the interconnections between mental illness, substance abuse, and parenting problems, clearly suggest that parents affected by MISA issues are in need of integrated treatment models that link substance abuse treatment to mental health and parenting interventions (Zweben, 1996, in Hans, Bernstein & Henson, 1999).

Programs such as the U.S.-based *Starting Early, Starting Smart* have demonstrated the effectiveness of integrated, cross-system programs. The program is a family-centred case management model which facilitates access to required services in order to improve the home environment, improve caregiver awareness and behaviour regarding parenting and child development, and improve attachment and caregiver-child interaction. The program does this by integrating substance abuse and mental health services into primary health care and early childhood settings. The multi-site evaluation has indicated effectiveness in: recruiting families, increasing access and continued utilisation of interventions services. Impacts for families include: decreased caregiver drug use, reduced verbal aggression, decreased indicators of parental stress, and increased positive interactions between parents and children (Springer et al., 2003).

Services must recognise that recovery from substance abuse is a process that occurs over time and involves psychological, physical, cognitive, emotional, and spiritual changes (Brown, 1985, in Brudenell, 2000), including adjusting between an established alcoholic/addict identity and the mother identity and adapting and shifting of strategies that maintains both identities. It is suggested that mothers need a support person for both recovery and parenting (Brudenell, 2000).

In mental health care, services must recognise that “most mental illnesses fluctuate and are modifiable, improving for most in the long term. Services should be comprehensive but flexible, to meet the individual needs of families when parents are unwell, while giving them the opportunity to be effective parents at other times” (Cowling, McGorry & Hay, 1995). Various programs have described the importance of families affected by parental mental illness planning for the care of their children, when parents are unable to cope with this task (Wang & Goldschmidt, 1996), and strategies such as Family Safety Plans can be utilised (KOPING, 2003; COMIC, 2002).

Family Education

While detailed in the mental illness literature, education of family members, is equally applicable to the substance abusing population. Family education, including the affected parent, about the nature of the parent’s illness or disorder, is essential to ensure early detection and management of the two interacting illnesses and impacts. Family members’ awareness of their own vulnerabilities also allows for the development of specific, individualised coping skills and resistances to the effects of parental psychopathology (Silverman, 1989).

Family awareness also facilitates early identification of psychopathological signs, behaviours and symptoms in children at risk (Silverman, 1989). In fact, in a study to identify their needs, carers requested easy access to appropriate information and education regarding services available and methods of access (Mellor, 1998). For carers in regional or under-resourced areas, innovative approaches to education and support may include carer support groups connected via internet or teleconference (Kavanagh et al., 2000).

The use of bibliotherapy, that is, literature to assist an individual’s understanding and treatment of their problems, generally through the aid of a therapist, has been recommended for children and adolescents with a parent with a mental illness (Tussing & Valentine, 2001) and may also be applied to those affected by parental substance abuse.

In an Australian survey of service providers, seventy four percent recognised the need for appropriate information and resource materials (Kavanagh et al., 2000), as well as hands-on resources such as workbooks or games that explain mental illness (40%) (Byrne et al., 2000b). In fact, several authors support the availability of age appropriate information about the nature of parental disorder and the prospects of recovery, in order to facilitate understanding of the issues (Wang & Goldschmidt, 1996).

Foster Carers

The literature surrounding the education and support needs of foster carers is mostly dated and very limited, particularly in relation to specific issues of family mental illness and substance abuse. As indicated previously, children in foster care and out of home care are a vulnerable group, with high rates of psychopathology and often special care needs. These caregiving needs place additional demands on the foster family, the foster care agency, and the professional support community, and require a co-ordinated response in terms of heightened awareness, training, access to services, continuity of care, follow-up, and applications of appropriate treatments or interventions (Blatt et al., 1997, cited in McNichol, 1999).

Training within mainstream foster care is an under-researched area, however the few studies conducted have suggested benefits from training foster carers in areas targeting the prevention of psychopathology, including communication and attachment between children and carers (Minnis et al., 2001).

Training programs such as *Communicating with Children: Helping Children in Distress*, from the UK organisation, Save the Children, have been perceived by carers as beneficial. Foster carers have reported improved perceptions of performance in the carer role, improved child behaviour and improved carer-child relationship. Minnis and colleagues found training had measurable and possibly even clinically significant effects, but no statistically significant impact on child psychopathology or on costs were demonstrated. In the United States, one study found that foster parent training lead to improved knowledge, and several other “by-products” of training, such as higher rates of sustained placements and continued involvement in fostering compared with non-trained parents (Boyd & Remy, 1978, cited in Hampson, et al., 1983).

Research has indicated that sustaining placements and reducing multiple placements for children, may reduce the risks for psychopathology directly associated with the number of moves made by the child while in foster care (Maas & Engler, 1959). It is useful to note that considerations for foster carer training outlined in the literature include: low recruitment rates, high attrition rates and low attendance, which the authors suggest may be intrinsic qualities of training foster carers (Minnis et al., 2001).

Service Providers

A core component of health promotion and early intervention strategies is education, for clinicians, consumers, carers, and the general community (NSW Department of Health, 2000). Several studies (cited in Gafoor & Rassool, 1998) have shown that education and training on substance abuse in the mental health workforce can enhance positive attitudes and increase confidence and skills in identifying and working with substance abusers.

Mental health clinicians, and others in human services, need to acquire knowledge and a core set of skills related to mental illness and substance abuse, including assessing substance abuse, motivational interventions and counselling for people with coexisting mental illness and substance use issues (Drake et al., 2001). Workers require access to knowledge about the effects and culture of substance abuse (Campbell, 1997), and need

realistic expectations about change and recovery to reduce staff burnout and frustration in working with the MISA population (Sciacca, 1991).

Specifically, Australian forums have provided recommendations for integrated, system-wide dual diagnosis (MISA) training for service providers, including general practitioners, and education for carers and family members (Tehan & Chong, 1998). Cross agency training needs to focus on sharing language and creating a common dialogue (Commonwealth Department of Health and Aged Care, 2000). In addition, in interagency child protection work, it is expected that practitioners and agencies share an understanding of the aims of intervention and of what is good practice; appreciate and respect the different roles and contributions of practitioners; understand the context and constraints within which agencies work, and commit to partnership and co-ordinated action across agencies (NSW Commission for Children and Young People, 2000).

MISA Intervention

Despite the high prevalence of MISA there is scant evidence about the nature of ‘best practice’ services for this client group. No single method of treatment for any of the various dual diagnosis combinations have been proven (NSW Department of Health, 2000). Key findings from the National Institute for Social Work Seminar, London (2000, cited in Cowling, 2001) indicate that few services have protocols and procedures which address both mental illness and substance misuse.

As part of a Churchill Fellowship, Farrow (2002) explored international approaches to supporting individuals and families whose support needs cut across multiple service systems, in particular with those experiencing mental illness, substance abuse and family violence. What she found is that it is rare for any service to have an articulated approach. Like Australia, most services are generally organised along one area of expertise ie. mental health, drug treatment or family violence.

Often, the links between drug and alcohol services and mental health services are informal and developed via individual worker relationships rather than at an organisational level. The value of more formalised links and protocols has been recognised – in particular in relation to joint assessment, care planning and worker roles and responsibilities (Mellor, 1998).

In Australia, there have been policy recommendations at Federal and State level promoting a co-ordinated response from multiple service sectors and integration of service delivery for MISA (Australian Health Ministers, 2003; NSW, 2000). This is also supported by the National Standards for Mental Health Services (1996). In addition, reports to the *Select Committee on Mental Health Inquiry* recommend integrated care and links between specialist and mainstream services, and formal and informal collaborative partnerships across health and related care systems. Reports also state that: “understanding how and who to contact in other health and related organisations should be established as core, everyday business” (NSW Parliament Legislative Council: Select Committee on Mental Health, 2002).

It appears from the literature that US health programs have trialled the process of integrating mental health and drug and alcohol service delivery (Sciacca, 1996), and current trends indicate support for this approach for the MISA population. In the Australian literature, Tobin and colleagues (2001) recommend essential processes in developing an integrated approach including: clinician engagement in developing collaborative protocols; consumer and carer involvement; joint clinical case reviews; common orientation to both services and rotation of clinicians between the two services, and development of a risk assessment tool, to enable identification and communication of issues and enhance referral process.

Interagency Collaboration

In addition to recommendations linking the relevant health programs for people with mental illness and substance abuse issues, interdepartmental guidelines have been operating since the 1980s that require health workers to report suspected child maltreatment to the NSW Department of Community Services (Major, 1995, cited in Tomison, 1996a).

Interagency collaboration is vital because of the complex health and social needs of parents affected by MISA (Rassool, 2002) and their children. Any systematic approach to improving mental health for young people needs to be across many sectors and with a wide focus (Raphael, 2000).

No one agency can undertake all parts of the child protection – drug and alcohol - mental health interface, and a holistic approach must be adopted to address what are often multi-problem, disadvantaged families. This can only be achieved by a partnership between the various professions and agencies involved in child protection, child welfare, family support and community health (Tomison, 1996a), and current strategies involve all major stakeholders - consumers, family members, clinicians, program leaders and managers (Torrey et al., 2002).

At a service provision level, it is recommended that case discussions are utilised for both communication and case planning, and as group supervision or professional development procedures within, and between agencies (Cowling, 1997). At a network level, services need to establish protocols about the way they share information and address issues of confidentiality (McDonnell, cited in McKey, 1998). It is recommended that reliable pathways and agreements be established for communication and consultation between agencies (Cowling, 1997).

Given the complexities, it is recommended that services build on existing systems and programs wherever possible, and to minimise the extent to which additional specialised MISA programs must be developed (Minkoff, 2001). In Australia, a small range of community and government initiatives have been developed to respond to the need of people experiencing mental illness and substance abuse issues. Many of these projects involve the employment of a link person whose role is to connect mental health and drug and alcohol services to address the specific needs of individuals with MISA (McKey,

1998). To date however, these programs have not addressed the needs of children whose parents have co-existing mental illness and substance abuse issues.

Summary and Recommendations

It is well established that mental illness and substance abuse is highly prevalent, with rates of substance abuse disorders in mental health settings found to be as high as 80 percent (Todd, Sellman & Robertson, 2002) and more than half of substance users or abusers having experienced symptoms significant enough to fulfil diagnostic criteria for a mental illness (Regier et al., 1990). Awareness of the diversity of this population promotes recognition that many people with mental illness and substance abuse issues are parents. Often, their needs are complex and cross multiple service systems, which have typically not worked together to identify or address their needs.

The literature has been found to be repetitive, and is mostly derived from the U.K. and U.S., however themes and principles of service delivery emerge. Mental health and substance abuse programs tend to have an individual, adult focus, with little integration between the two. There is little empirical evidence regarding MISA treatment models efficacy and outcomes, a poor knowledge base amongst service providers, and poor co-ordination between the relevant service systems.

Additionally, there is little evidence available in relation to family intervention in mental health or substance abuse fields, and few research programs are evident to specifically address the needs of children whose parents have MISA issues. This is compounded by the high rate of children affected by parental MISA in the child protection system, with little co-ordination or communication between the health and child protection systems.

What is evident from the literature and the field, is the need for:

1. Integration across the interface of child protection, mental health and substance abuse programs, including improved communication, pathways to care, and co-ordination of care.
2. Participation of parents, children, carers and workers from the interface being involved in the service development process. This is particularly important as so little evidence exists regarding support and information needs, treatment and intervention strategies, and education needs, and the process will need to be informed by those key stakeholders.
3. Integrated education for service providers, to improve awareness of the issues, develop skills and knowledge specific to MISA and it's impact on parenting and children, and to facilitate collaboration across service systems.
4. Support and education for family carers and foster carers, surrounding the impact of parental MISA and strategies to assist the families.

The term “mind the gap” was cited in the UK child protection literature, as an expression used by senior managers to staff about interface working (Kearney, Levin & Rosen, 2003). It seems that this is most relevant in this area of practice. While there is no evidence surrounding the specific needs of children whose parents are affected by mental

illness and substance abuse issues, the literature from the mental health and drug and alcohol fields demonstrates a beginning awareness of issues, needs and service approaches.

The lack of empirical research makes it difficult to draw any conclusions. However, we can recognise the need to address these gaps. Programs and strategies, such as resource development and co-ordination of care across systems, must be developed in consultation with the stakeholders, including the families, carers and interface service providers, and be evaluated to determine efficacy and outcomes. Service development strategies and education can improve the capacity of service providers, and the systems they are part of, to address the families' needs, thereby reducing the risks and enhancing the family's capacity to cope.

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