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## **Families affected by parental mental illness: Australian programs, strategies and issues. The (missing) role of schools.**

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**It has been estimated that between 21 and 23 percent of families are affected by parental mental illness. While the impact of parental mental illness affects individuals differently, such families are more likely to be socially isolated and experience financial and marital discord with increased risks for children, genetically, psychologically, socially and environmentally. An overview of the support programs available to such families in Australia is shown here, including those targeting children, parents, the family as a unit, the workforce, and the general community with a particular reference to the place of schools and school personnel. Common elements across all support programs are highlighted as well as service issues and gaps. Few of these programs consider the role of the school in the lives of these families, nor the contribution that school-based interventions and counselling could potentially make. Recommendations for best practice, with implications for school communities, to support this particular group of at risk families, concludes the paper.**

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## **Introduction**

Epidemiological studies have shown that one in five adults will experience a mental health issue at some stage during their life (Kendler, Gallagher, Abelson & Kessler, 1996), with one study showing that 21-23% of all families have, or have had, at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2009). The term mental illness encompasses a wide range of psychiatric symptoms that persist over time and are functionally disabling to individuals in living skills, social interactions, family relationships, employment and/or education. The widespread nature of parental mental illness means that the needs of such families are a significant public health issue. An analysis of Australian support programs for families affected by parental mental illness (FAPMI) is presented here, with implications for how such families are best supported, with a particular focus on school communities and their relationship with families.

Having a parent with a mental illness can affect a family in a variety of ways, resulting in a need for multifaceted intervention points that focus on the child, the parent with a mental illness, the family as a unit, the workforce, the child's school, and finally society (for a detailed overview, see Reupert & Maybery, 2007b). Each of these stakeholders requires a different focus, for example, some children from FAPMI require general education about mental illness, transport and accommodation when their parent is ill or hospitalised, functional adult role models, opportunities to learn adaptive problem solving strategies and respite for care-giving of the ill parent and/or younger siblings (Reupert & Maybery, 2007a). The parent with the mental illness requires appropriate and timely mental health assessment and intervention, strong social networks and individualised parenting skill training (Thomas & Kalucy, 2003), as well as rehabilitation plans that acknowledge their parenting responsibilities (Reupert, Green & Maybery, 2008). For the family, crisis planning is important, given the likelihood of hospitalisation or a mental health episode (Reupert, Green & Maybery, 2008). The workforce, including school based personnel, requires training and knowledge to be able to work within strength-based family models (Maybery & Reupert, 2006, 2009). Finally, society as a whole needs to change. In teasing out impacting variables for at risk children, Rutter (1981) found that the direct effects of parental illness were less influential than the social adversity usually associated with mental illness, such as poverty, unemployment and isolation. The problems and subsequent points of possible intervention for FAPMI are multidimensional and will vary according to the unique needs of families. At the same time, one opportunistic point of identification and intervention is a child's school.

Most young people spend a large proportion of their time at school; indeed Mattox (1991) argues that today's youth spend more waking hours in school than they do in the company of their parents. Schools have an important role in socializing children and preparing them for the adult world. Furthermore, schools are well placed to identify and support children experiencing difficulties, both academic and psychological. Many children with behavioural difficulties never attend mental health specialists (Offord et al., 1987), and children with emotional and behavioral disorders tend to be managed in non-psychiatric settings such as schools (Gwendolyn, Zahner & Daskalakis, 1997). Thus, schools have the potential to provide identification and early intervention with at risk children and their families, such as FAPMI. Additionally, schools are typically considered to be less stigmatizing than many other social agencies. Identifying the general supports available to FAPMI and in

particular, the role schools and school-based personnel have in identifying and supporting COPMI in Australia today is the aim of the current study.

Oyserman, Mowbray and Zemencuk (1994) reviewed ten intervention programs in the USA for severely mentally ill mothers and their children and found three types of programs for FAPMI including hospital mother-baby units, mother-baby units with in-home care, and home-care programs. However, these programs did not address those beyond the mother-child dyad, the broader socioeconomic context of mental illness (for example, housing or schooling). Fraser and colleagues (2006), focusing on child targeted interventions only, reviewed 26 programs from around the world. Their empirically based critique highlighted that most interventions were randomised with no comparison or control groups; subsequently Fraser et al. (2006) stress the need for more rigorous evaluation and long term follow up of participants. More recently, and again in the US, Hinden, Biebel, Nicholson, Henry and Katz-Leary (2006) interviewed 25 directors of programs for families affected by parental mental illness. Most programs had a family-centered, strengths-based focus, including in-patient programs, family interventions (such as case management) and community-based programs (such as parent education and support groups).

In Australia, the *Children of Parents Affected by a Mental Illness Scoping Project* (AICAFMHA, 2001) surveyed numerous services around Australia to provide a comprehensive listing of programs targeting FAPMI. One of the many objectives of the scoping report was to ascertain the extent to which programs promoted child and family participation in school and community activities. It was found, in 2001, that there were 34 different programs, directed towards workers, children and/or parents (with an additional ten programs focused on research or community education). While it is difficult to ascertain how the 34 were specifically broken down, the main strategies employed by agencies appear to be directed at children, such as providing education about mental illness. Furthermore, while 41% of programs were reported as encouraging family participation in schools, it is unclear as to how this was accomplished. Since that time there have been several national and state Australian government initiatives including *Pathways to Resilience: Children of Parents with a Mental Illness Project, 2002* (Smith & Nicholls, 2002), *Principles and actions for services and people working with children of parents with a mental illness, 2004* (AICAFMHA, 2004) and *Families Where a Parent has a Mental Illness, 2007* (Mental Health Branch, 2007), all stressing the importance of embedding family-focused practices in the core service delivery of human and health agencies. How these policy documents have translated into programs and service development is as yet unclear.

Identifying current practice models has the potential to highlight exemplary practice developed for specific localities, clients and circumstances. Comparing current practice models with current research also provides an opportunity to identify service gaps, areas of duplication and other issues regarding services directed to these at risk families. Consequently, the aim of this paper is to describe the types of programs in Australia targeting FAPMI, either directly, for example, children, parents, and/or families or indirectly, such as workforce responses and/or community changes, and to provide an analysis and critique regarding the current focus of intervention. Most importantly, the current role of school communities will also be examined.

## Methodology

Whilst there are numerous support services in Australia for those with a mental illness, the current study only reviewed those programs specifically targeting families and family members affected by parental mental illness. Two methods were employed to identify and to collect information on Australian programs. First, three publicly listed major websites were reviewed between April and June, 2007, including:

1. The Australian Infant, Child, Adolescent and Family Mental Health Association programs website of programs:  
<http://www.aicafmha.net.au/copmi/national/programs/index.htm>
2. The Australian Network for Promotion, Prevention and Early Intervention for Mental Health website: <http://auseinet.flinders.edu.au/links/index.php?a=54#list>
3. The COPMI (Children of Parents with a Mental Illness) Resource Centre:  
[http://www.copmi.net.au/jsp/resources/resource\\_view\\_community.jsp](http://www.copmi.net.au/jsp/resources/resource_view_community.jsp)

Second, data base reviews were conducted across PsychInfo, Google, Medline, EBSCO and ERIC (using the search terms; parental mental health, families affected by parental mental illness, children of parents with a mental illness, programs, services, interventions). Searches were limited to Australian interventions between 2001 (the last year of the Australian scoping report) and 2007. At times searches identified the same program, and this was accounted for in the final report.

Programs were grouped according to the points of intervention outlined earlier, i.e. those targeting the child, the parent with the mental illness, the family unit, the workforce, the school community and the general community. The place of schools was considered in two ways; first in a separate section regarding programs directly offered *from schools* and two, *across settings*, in terms of other agencies involving schools and school based personnel. As well, various *practice questions* were sought for each program including: What are the types of interventions employed? Where does funding come from? Is there any degree of interagency collaboration in these programs? If so, explain who and why. What have been the numbers of participants so far? Is the program short term (if so, for how long?) or ongoing? *Research questions* were also used, including: Why are specific interventions employed? That is, what is the rationale or evidence base for these specific interventions? Is there a theoretical basis for these interventions? If so, what is it? What evaluation measures are used, if any?

Whilst every effort was made to identify programs currently offered in Australia, the final analysis does not claim to be exhaustive, but instead provides a representative sample of programs in Australia today.

## Results

Identified programs are presented according to the child, the parent with the mental illness, the family as a unit, the workforce and the general community. Other data, pertaining to the research and practice questions, is then shown. Data was coded independently by the researchers for concepts, according to the different client groups as well as the research and practice questions highlighted above; they then met to reach a consensus regarding final groupings.

Table 1 presents 63 FAPMI programs identified in Australia. Thirty-two target children and adolescents, ten focus on the parent with a mental illness, six on families, 11 on the workforce (including two for school personnel), and four on the general community.

<b>Target group</b>	<b>Number of programs</b>
Child and adolescent	32
Parent with a mental illness	10
Family	6
Workforce	9
Schools	2
Community	4
<b>Total</b>	<b>63</b>

Table 1: The number of FAPMI programs in Australia, according to different client groupings.

#### *Child and adolescent programs*

There were 32 child and adolescent programs, 25 of which were peer support programs, five were for carers, one for children who had been abused or neglected, and another (a telephone service) which provided one to one counseling and referral. The aims of the 25 peer support programs were to develop peer support networks, teach new skills such as communication skills and adaptive coping behaviors, and increase self esteem and young people's understanding of mental health and illness, all within a group setting. A mixture of holiday programs, camps and during school term programs were offered. These programs were commonly divided in terms of age groups (e.g. children aged 6-9, 9-12, and 13-18 years). The five carer programs also utilised a peer support framework via camps and after school group activities.

Four of these programs describe running concurrent programs; that is, programs for parents and another, separate, program for their children; for example, a school holiday program for children and then a parenting group of mothers who have a mental illness. One service also provided a website, presenting the diaries of four fictional teenagers whose parent had a mental illness, as well as fact sheets specifically developed for young people. None of the programs, as far as can be ascertained from the database, were located at school sites; additionally, practising teachers or other school based personnel were not involved. Programs tended to be run by government and non government community and mental health agencies.

#### *Parent with the mental illness*

Ten programs for parents with a mental illness were identified. One was specifically for indigenous parents with children less than five years of age, and consisted of group as well as one to one work. Four programs provided an outreach service in the parent's home. The focus for many of these programs was on the parent, with the explicit aim that this would then provide better outcomes for the family.

Parent support consisted of accessing and maintaining independent housing, daily living skills, enhancing community links, personal support to maintain health

and well being. Three of the identified programs provided support and psycho-educational groups for parents affected by mental illness, with two specifically focusing on parenting skills. Again, none of the programs identified had a focus on schools and how school communities might support parents and their children.

#### *Family focused programs*

Six programs were identified for families, of which three types were found:

1. At home or residential treatment where both parent and infant (under the age of 3) are the focus of intervention;
2. Two playgroups for parents and their children under the age of 5;
3. Two services describe working directly with the family as a whole. One of these outlined the use of a Family Safety Plan, which involved an action plan for parent being hospitalised or experiencing a psychotic episode.

Once again, none of the identified family programs had a link to schools or children's education.

#### *Workforce*

There are nine programs targeting the capacity of the workforce to better address and respond to the needs of FAPMI. Most targeted adult mental health practitioners as an important referral source, though other workers were also involved (for example Getting There Together; Cowling, Edan, Cuff, Armitage & Herszberg, 2006). Four specifically highlighted developing cross-agency linkages for agencies working with these families. Two projects involved a post audit of inpatient files to ascertain whether the needs of the children of their clients were being met. Other interventions involved convening network meetings, and providing advice to workers in the field.

#### *Schools*

Two school projects were identified, one a training package for school based personnel. The other package, *Supporting Kids in Primary Schools (SKIPS)*, to date has been conducted with six schools, involving in two interactive workshops with teachers and three classroom sessions with Grade 5 and 6 children (Joyce, Allchin, Malmborg, Candy & Cowling, 2003). SKIPS Evaluation, consisting of pre and post surveys with 58 teachers showed teachers knew more about mental health issues and held less negative stereotypes about mental illness after attendance (Joyce, Allchin, Malmborg, Candy & Cowling, 2003). Evaluations with just over 400 children showed reduced prejudice towards people with schizophrenia after involvement in the program.

#### *Community approaches*

Four projects specifically targeted community attitudes towards mental illness, through tip sheets, a website and booklets on parenting and mental illness. One service provider described supporting consumer empowerment and encouraging consumers to provide informal education and advocacy. There was no specific consideration, as far as can be ascertained from the data bases reviewed, for schools, children's education or the involvement of school based personnel. Data were also analysed according to various practice and research questions.

### *Practice questions*

Funding for FAPMI projects most often came from state governments, though many were run within existing services. Most projects were short term, lasting around three years. Interagency collaboration on programs was often not described, though there were some exceptions.

### *Research questions*

The clinical experience of facilitators and the success of other programs (particularly those targeting children) as well as consumers' views provided the basis for existing interventions. Professional development sessions, policy documents and the resilience/vulnerability literature were also referred to when demonstrating an evidence base.

Forty-one of the 63 identified programs, or 65%, employed evaluation tools, though this figure includes those whose evaluation was still in development. Most evaluation strategies were anecdotal or formative in nature, including participant satisfaction reports. Standardised evaluation tests were rarely used so that comparisons between groups and over time were difficult to make. When standardised tools were employed, these did not always link to program objectives. For example, one program used the Edinburgh Postnatal Depression Scale pre and post intervention but rather than target depression, this particular program aimed to enhance confidence in parenting. On the whole, participant drop out rates were not recorded, and control groups were not used.

### **Discussion**

This study shows that, while there are many different approaches to FAPMI, most programs target children and adolescents. It also needs to be noted that there was no direct involvement of schools or school-based personnel in these interventions, highlighting an important but missing sub-system of children's lives. This is directly relevant to the concept of school-based family counseling. Generally, these programs provide peer support and psycho-education, usually in the form of after school activities, or holiday camps. Some of these programs focus on children's caring responsibilities, though the majority do not mention this. While it is difficult to directly compare the results of this study with that of the Scoping Report (AICAFMHA, 2001), there do appear to be more programs overall currently available for FAPMI (total of 63) than in 2001 (total of 44), and children and adolescents are still the main focus of intervention.

The second most predominant focus is on enhancing workforce capacity to better address the needs of FAPMI, particularly workers from adult mental health. This is an important finding as epidemiological data suggests that families at highest risk (i.e. single parents with severe disability) commonly attend adult mental health services for treatment (Maybery, Reupert & Goodyear, 2005). At the same time, it has been shown that many adult mental health workers do not have the skills and knowledge to identify, refer and/or intervene appropriately with family members (Maybery & Reupert, 2006); consequently targeting adult mental health workers is vital. Teachers and other school based personnel are another component of training programs with two packages specifically designed for education audiences.

Working with families as a whole, targeting community attitudes towards mental illness, and school based programs are the least commonly employed approaches in Australia today. In comparison, Hinden, Biebel, Nicholson, Henry and Katz-Leavy (2006) in the USA found that the majority of the 26 programs reviewed were family based. In addition, an emphasis on children as opposed to families is at odds with the current Australian policy emphasis which is predominately family focused. Furthermore, the few family interventions identified in this study tend to be for families with children under five years of age. This may well result from a growing awareness about the importance of attachment in the early years of a child's life and corresponding models of resilience, which some program descriptions include. Why program support moves from a focus on families onto children/adolescents alone, as children get older, is unclear. One possibility is the inability of workers to 'see double', that is, an ability for workers to simultaneously recognise and work with the needs of adult clients and of their child/ren, particularly as children get older (Fleck-Henderson, 2000).

At the same time, schools are in an optimal position to work with families, and by starting with the educational concerns of their children, can potentially encourage families, teachers and other school-based personnel to work on other related issues that provide a supportive and collaborative environment for the whole family. Ball (1998, p.6) extends this argument when she writes: "If schools are to work with partnership with parents, both will be required to address problems rather than to pass them on."

Given their locality and the place that education has in the lives of young people, schools and those working in schools have the potential to "see double"; that is, work with both children and their parents. Thus, the omission of schools and school-based personnel as sources of FAPMI support and intervention is problematic and needs to be rectified.

Collectively, thirty-two child and adolescent programs is still not a substantial focus, given the numbers of children who have at least one parent with a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2009). At the same time, however, this constitutes the primary focus of intervention work for FAPMI in Australia today. Where once they were described as the *hidden children* who were invisible to adult mental health professionals, increasingly such children are being targeted for preventative peer support programs - though, we would hasten to add, not on a major scale, nor one which is considered important by schools or school-based helping professionals in any systematic, formal manner.

Community approaches are usually in the form of educational materials, disseminated across a variety of groups and agencies of which schools is one, though it is difficult to ascertain what happens to such materials after they are disseminated. The efficacy of such an approach remains dubious. Freemantle, Harvey, Wolf, Grimshaw, Grilli, and Bero (1999) reviewed eleven studies evaluating the effectiveness of disseminating educational materials, such as educational pamphlets and audio-visual material, and found no statistically significant improvements in targeted outcomes.

Overall, the child and adolescent programs identified here tend to focus on *outcomes* as opposed to *sources* or causes of the problems that young people might endure. For example, the child and adolescent programs usually aim to enhance young people's self esteem and encourage adaptive coping styles. This does not necessarily address why the child might suffer from low self esteem and utilise maladaptive coping strategies, or how such attributes were first acquired. An ecological perspective that considers the child within his or her family as well as broader environment (including the school, the child's education competencies and school relationships) is not commonly incorporated in such approaches. Such a narrow view of the child has direct implications for program outcomes. For example, whilst one program evaluation found that children's self esteem increased as a result of the program, at the same time parents reported an increase in conduct problems and reduced pro-social behaviour (Maybery, Reupert & Goodyear, 2006; Goodyear, Cuff, Maybery & Reupert, 2009). The evaluators tentatively suggest that whilst the program improved children's self-esteem, this in turn might also have made the children more confident and hence critical of others within their families. The importance of working with children within the context of their families and the broader community, including school, is underscored by such program results. Similarly, Gerrard (2008) highlights the dangers of school intervention programs that focus exclusively on the individual student and ignore students' subsystems such as family, peer and community. An identification and intervention system that is broad, though sufficiently specialized to incorporate the child, his and her own needs, and that of his or her family within the school and beyond, is particularly important for FAPMI and other at-risk families.

Most support services for FAPMI are provided via a group setting, i.e. groups of young people or groups of parents. Implicit in a group approach is little or no differentiation for individual needs and perspectives. For example, children are grouped according to age, not according to their own mental health needs or family backgrounds. This means that they are provided with general education about mental health, which may or may not be relevant to their own parents' mental illness diagnosis. Problems with a generic approach to education have been highlighted elsewhere (Reupert & Maybery, in press). Schools again might provide ideal locations in which counselors or other mental health staff might respond flexibly, either to individual children, or to groups of children facing similar issues.

This study found several support groups for mothers with mixed mental illness diagnoses; no programs for fathers with a mental illness were identified. While the issues for FAPMI can be generalised, some problems are specific to the parental diagnosis (Oyserman, Mowbray, Allen-Meares, & Firminger, 2000). Only one program was identified for indigenous families. As well, a flexible definition of caregivers (for example, grandparents or aunts) was mostly missing, as were issues of rurality and remoteness. Furthermore, while approximately half of adults with mental illness who attend specialist mental health settings also have a drug and/or alcohol problem (Mental Health Branch, 2007) the issue of dual diagnoses was not considered in any of the programs reviewed to date. Another major problem is that many of the programs identified here were short term, around three years. Steckler and Goodman (1989) argue that a grant period of three years or less is too short to achieve institutionalization of new health promotion programs, suggesting that agencies need

to invest in a plan of at least five years to better achieve long term, sustainable outcomes.

Similar to Fraser et al. (2006) the current findings show that programs in Australia do not employ rigorous evaluation tools and methods, and lack a strong empirical rationale. For example, whilst peer support was the most commonly used approach to support children whose parents have a mental illness, there is mixed evidence to indicate that peer support is the most effective prevention and/or treatment approach. For example, in two interview-based studies, Maybery, Ling, Szakacs and Reupert (2005) found that young people wanted peer support when dealing with their parent's mental illness, whilst Fudge and Mason (2004) found that young people identified a range of people that they might turn to for more information about mental illness, including their parents (not necessarily the parent with the mental illness).

### **Limitations of this paper**

An analysis of programs state by state was not undertaken, and this would have provided additional useful information in identifying areas of duplication. It has been difficult to obtain all the relevant information about programs; the data collection methods are not sensitive enough to provide an exhaustive identification of all programs, particularly individual interventions and to provide more specific information. Policy information from various countries might also account for some of the international differences but was considered too broad an undertaking for the present study. Finally, the geographic areas of programs (including populations served) were also not identified, so it is difficult to ascertain the scope or range of the programs presented. Further work might be enhanced by interviewing relevant service providers (see Reupert & Maybery, 2009; Reupert et al., 2009, for further work in this area). It also needs to be acknowledged that the present study provides an overview of programs at one specific time, and that services and programs are highly fluid and subject to ongoing changes.

### **Recommendations**

As outlined earlier, FAPMI are a particularly 'at risk' group of families and require effective and sensitive interventions, inclusive of children, the parent with the mental illness, the family, the workforce, the school, and society as a whole. Because of the prevalence of, and needs of such families, it is essential that support services and programs developed for family members are both valid and effective.

A greater integration between theory, research, practice and evaluation is required. The gap between research and practice has been highlighted elsewhere, with general findings showing that practitioners rarely engage in research and hold negative views about its importance (Watkins & Schneider, 1991) though, conversely, researchers rarely engage in clinical practice (Garfield & Kurtz, 1976, as cited in Kazdin, 1986). For FAPMI, a greater integration between research and practice is needed, with research becoming more accessible to practitioners and, at the same time, practice issues being used to inform and shape research. The place of evaluation to inform both practice and research also needs addressing. Long term funding to support the ongoing development of programs is central to this aim.

Whilst the importance of working directly with young people is acknowledged, service providers also need to work within the broader family unit and ecological sub-systems, including schools. Currently, few programs are offered for families, and instead tend to segregate family members into specific programs (e.g., peer support programs, or parent programs). Based on the multifaceted issues facing these families (Reupert & Maybery, 2007b) we believe that FAPMI need to be conceptualised ecologically, with a focus on the family, school and the general community, in order to better deal with the source of problems, and tailored to each family's specific strengths and difficulties.

### **The role of the school community**

While two training programs targeting school personnel were identified, it is difficult to ascertain from the present data the impact of such training on families. At the same time, however, the school, the one institution that virtually all children attend, can be an important environment in which families' needs can be identified and supported, via their children. Terrion (2006) highlights the importance of school communities for vulnerable families. Rather than parental involvement in a child's education per se, he stresses that it is the types of positive human interactions between schools and families that potentially mitigate the risk factors of vulnerable families, by reducing stress and isolation. Additionally, the inclusion of at-risk families within school communities often results in complex interactions with multiple participants, within and outside the school system (Evans & Carter, 1997). Given the isolation and stigma that FAPMI face, the school community is an excellent avenue to work with and to support different family members - not just the individual child, as many Australian programs currently do.

The School-Based Family Counseling (SBCF) model provides an exemplary framework from which child issues can be addressed through family counseling, provided as part of a school program. Often a child's school difficulties are manifestations of family insufficiencies or problems and hence the school context provides an avenue for both identification and intervention (Millard, 1990). However, traditional school counseling tends to focus primarily on the child as the client surfacing with a problem, even if the problems originate from his or her family life (Stinchfield, 2004). As Gerrard (2008) points out, though school counselors might refer families to outside agencies, many do not attend. Instead, SBFC provides the vehicle by which parents, teachers and students can work together. He continues by describing the unique position SBFC holds:

Going to a school or agency to consult with a counselor on how to help one's child succeed in school is something that many parents are willing to accept (especially if the counselor emphasizes that she/he needs the parents' help). This normalizes the counseling and reframes it in a way that de-stigmatizes coming for counseling. As the SBFC works with the parents and family to help the child, trust is built which permits the counselor to eventually work on other family issues affected the child (Gerrard, 2008).

Thus, school counselors who are appropriately trained are often the link between the family and the school, and can work ecologically with children, their families and teachers, as opposed to working with the child in isolation.

Instead of focusing primarily on the intellectual development of the child, education is increasingly regarding as needing to develop the whole child (Walsh & Murphy, 2003). Consequently, teachers also play a role in supporting a child's psycho-social needs. At the same time, schools and teachers are being confronted with an increasingly complex and demanding curriculum with some suggestion that "We don't expect teachers to be social workers, we expect teachers to teach" (Chaudhardy, 1998, as cited in Webb & Vulliamy, 2002). However, teachers are able to support at-risk children *through* their teaching. Reupert and Maybery (2007a) interviewed teachers, counselors and administrators, nominated by children whose parents have a mental illness, as those who were supportive of them and their families. These 'champion' school personnel were able to identify several creative school-based interventions, such as negotiating with and supporting children in their homework, explicitly departmentalising tasks thereby giving students control over their school work, creating opportunities for academic success, encouraging supportive peer networks, and facilitating class discussions on general coping and mental health issues. These school personnel were not providing a welfare role in addition to their teaching obligations, but instead finding ways of meeting the psycho-social needs of these at-risk children *through* their teaching approaches. Similarly, it has been found that school interventions which increase social and emotional competence result in higher academic achievement levels, although the reverse is not true (that is, academic enrichment does not increase social responsibility) (Coie & Krebhiel, 1984). Such research justifies the involvement of schools in students' psycho-social development.

The welfare role of schools exists at different levels, from individual support to children and their families through to whole school approaches integrated within the local community (Maybery & Reupert, 2007). Mindmatters, a resource and professional development program designed to promote and protect the emotional wellbeing of school communities, is an excellent resource in supporting schools to do this (see <http://cms.curriculum.edu.au/mindmatters/>). Alongside such material, cross-sectoral partnerships are required to support school personnel in this role (Maybery & Reupert, 2007), so that ultimately all children are supported by multiple positive networks, from their family, school and the broader community. Given that most programs for FAPMI in Australia today are directed primarily at the child, and less so at the family as a unit, school personnel can potentially bridge this service gap, by providing a service that provides ecological identification, prevention, support and intervention for these at risk families. SBFC is an exemplary model in which such collaborations can be realised.

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