CYP
the children and youth programme

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Maternal Mental Health and Poverty: The Impact on Children's Educational Outcomes

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Preface

This thematic Report is the sixth in a Special Report Series addressing the rights and well-being of children and youth in Ireland and Northern Ireland. The Report corresponds with three key UNESCO aims: to strengthen awareness of human rights; to act as a catalyst for regional and national action in human rights; and to foster co-operation with a range of stakeholders and networks working with, or on behalf of, children and youth.

The terms 'children' and 'young people', as used in this Report, refer to those under the age of 18. The focus on children and young people in the Report reflects the age range corresponding to the definition of a child in the United Nations Convention on the Rights of the Child (UNCRC).

The Children and Youth Programme adopts a rights-based approach to policy development and implementation, with the intention: to have an all-island focus; to retain academic independence; and to ensure the voice of children and youth is present. The Special Report Series of the Children and Youth Programme will be the primary output of this approach. The objectives of the series are to:

1. focus on a topical issue considered to affect the well-being of children and youth;
2. examine the impact of selected policy and practice interventions on human rights and well-being;
3. gain an understanding of the processes of implementation;
4. share learning that will enable duty holders to better meet their commitments to children's rights and improved well-being;
5. share learning that will enable rights holders to claim their rights.

A common theme which permeates the special thematic reports is education. The right to education is firmly established in international law and is crucial for the exercise of other rights. Education reinforces, integrates and complements a variety of other Convention rights and cannot be properly understood in isolation from them. In doing so, the Report reflects the UNESCO position that education is a universal inalienable human right which plays a critical role in the development and empowerment of every child, regardless of their gender, age, race and mental and physical abilities.

The authors are responsible for the choice and presentation of views contained in this Report and for opinions expressed therein, which are not necessarily those of UNESCO and do not commit the Organisation.

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Executive Summary

The purpose of this Report is to explore educational outcomes for children of parents, particularly mothers, with poor mental health using a rights-based approach. The Report summarises current policy interventions in this area in Ireland and Northern Ireland, highlighting examples of good practice and identifying areas in which gaps in monitoring and delivery should be addressed.

Mental Health

The World Health Organisation (WHO) identified that various psychological and biological factors can determine the level of mental health of a person at any point of time. The prevalence rate of poor mental health in the adult population is difficult to quantify but estimates generally identify a figure between 20%-30%. In one survey in Ireland, 14% of respondents reported experiencing mental health problems in the previous 12 months, whilst survey statistics in Northern Ireland have indicated a possible mental health problem amongst one in five respondents, with a growing body of evidence linking higher rates of poor mental health to the period of conflict.

Parental Mental Health

The prevalence rate of parental mental health can be difficult to establish, with challenges that include under identification of conditions, poor patient uptake of services and incomplete data. Research in the United Kingdom suggested that over one third of all adults with mental health problems are parents and that an estimated two million children live in United Kingdom households where at least one parent has a mental health problem. There is no systematic data collection in Ireland or Northern Ireland to indicate how many adults using mental health services are parents of dependent children although some data is available. The Growing Up in Ireland study found that 9.3% of mothers and 4.1% of fathers were classified as being depressed, whilst 14% of mothers and 6.2% of fathers had previously been treated for depression.

Using the United Kingdom average as an estimate of prevalence levels in Northern Ireland, it is possible that between 60,000 and 75,000 children are living with a parent with mental ill-health. This means that some children will assume a caring role within the family which can impede their educational experience and affect their own general well-being.

Maternal Mental Health

The World Health Organisation identified the mental health of mothers as meriting special consideration. Mothers with poor mental health are likely to face more difficulties than their mentally well counterparts, with evidence suggesting this often manifests in the early years. Research in the United Kingdom suggested that approximately a quarter of pupils in an average primary school classroom were living with a mother with a mental health problem, whilst a range of survey data indicated that more mothers reported being treated for depression in Northern Ireland than elsewhere in the United Kingdom.

Poverty and Mental Health

Poor mental health tends to co-exist with low income, social disadvantage and low social support, as well as, less effective means of coping with psychological distress and the social and economic supports available to families. Research has highlighted the significant relationship between adult mental health, unemployment and poverty; more specifically, links between poverty and poorer maternal mental health, have been identified, with single mothers one of the most economically and socially disadvantaged groups. Although it is difficult to unravel whether poverty or mental health problems come first, it is generally agreed that poverty can be both a cause and result of poor mental health. In both Ireland and Northern Ireland, a range of policy documents in relation to children have highlighted the collective impact of early childhood experiences, poverty, poor physical and mental health and multiple disadvantage. These have advocated a holistic, child-centred approach based on early intervention and inter-agency co-operation, although it is noted that limited sharing and cross-referencing data across children's social care services and adult mental health services can impede effective collaboration.

Education, Disadvantage and Mental Health

Education has a pivotal role to empower children and young people to overcome adversity. Children who grow up in poorer families and who live with parents who have mental health problems are more likely to struggle in terms of educational attainment and participation in education. The impact of poverty and disadvantage on educational achievement has been identified in Ireland and Northern Ireland, and government in both jurisdictions have introduced a range of policies to address this, including greater involvement of parents and corresponding initiatives to support pupils' general health and well-being.

Supporting Education

School can be an important protective factor in the lives of children and young people and can provide a useful setting for intervention and support. Positive interactions between school and home can have a buffering effect on vulnerable families and research has identified preventative and/or effective interventions that can ameliorate children's experience of poor parental mental health and support their education. These encompass both community-based and school-based services, the former providing a gateway towards identifying a possible maternal mental health problem and the latter providing more tailored interventions. Community-based initiatives such as Springboard in Ireland, and Sure Start and Family Support Hubs in Northern Ireland have aimed to improve the social, emotional, physical and educational development of children and their families, with early intervention services matched to individual family needs. School-based programmes, such as Big Brother Big Sister and Mindout in Ireland and the Extended Schools and Full Service programmes in Northern Ireland have provided valuable support for pupils who are affected by parental mental health issues, providing a range of mentoring, counselling and skills-based services.

Beyond the two jurisdictions there is a range of evidence-based programmes for children and their parents. These include Building Bridges, developed by Family Action in the United Kingdom, with an

emphasis on early intervention among families where one or both parents have severe and/or enduring mental health problems, and the Strengthening Families Programme in the United States designed to increase parental involvement in their child's education, as well as, providing and training and support for parents and children to work together.

Whilst these programmes focus on a whole family intervention, others are more child-centred. For example, the Family Association for Mental health Everywhere (FAME) programme in Canada helps children to better understand their parents' mental health problems, and encourages the development of coping skills. In Australia, the Simplifying Mental Illness Life Enhancement Skills (SMILES) programme actively works with children of parents with mental health problems to build self-confidence and resilience, gain better understanding of their parents' mental health problems and reduce feelings of isolation. Also in Australia, Children And Mentally ill ParentS (CHAMPS) is a peer support programme which aims to build resilience skills among children with parents with poor mental health in settings such as after school clubs and holiday programmes. Evaluations of these programmes have identified positive outcomes for children and parents alike, with improvements in self-esteem and coping strategies and stronger family relationships.

Although these are parental rather than maternal interventions, the core objectives of the programmes suggest transferability to specific groups, an approach endorsed in research evidence. The Strengthening Families Project has been adapted both in the United Kingdom and in Ireland and Family Smiles has been adapted in the United Kingdom.

Key Conclusions

Drawing on evidence, the following key messages have been identified.

1. There is a need for better prevalence data on the number of children who have a parent with a mental health problem.

This Report has highlighted the difficulty in accurately gauging the extent of parental mental health issues in Ireland and Northern Ireland and the absence of a comprehensive data source in both jurisdictions has been noted. As a result, the adult and his/her role as a parent is neither adequately recognised nor fully addressed in policy and service provision, with implications for the outcomes for children. The collation of a comprehensive data set would provide a more detailed representation of the numbers of individuals with a mental health problem, but also their characteristics, including parental status, socio-economic status, the nature and duration of their condition.

2. There is a need for further child-centred research to better understand the relationship between maternal mental health, poverty and children's educational outcomes.

The mental health of mothers has been identified internationally as meriting particular consideration and the impact of a mother's poor mental health on children's social, emotional and educational well-being is identified in policy and research. Further research from a child-centred perspective would illuminate some of the complexities of this relationship and provide insight to inform policy and practice.

3. Joint protocols between health and education can improve educational outcomes for children and young people.

Research has highlighted the limited nature of integrated support for children of parents with poor mental health and a general lack of collaboration between children's social care services and adult mental health services. The evidence has suggested that joint protocols and stronger collaboration would effectively utilise specialist expertise, including education, to better inform assessment and planning.

4. Staff training and appropriate educational interventions within schools are crucial to enable children to enjoy access to a full educational experience.

Educational staff should be trained and supported to identify a possible parental mental health problem and to understand the impact of this on the educational, social and emotional development of children and young people. Improved understanding of the issues for families experiencing parental (maternal) mental health problems could facilitate appropriate interventions and support in the form of care, protection, and participation at school. Such an approach can help safeguard a continuity of education, empower children to achieve their full potential and enhance their long-term life chances.

5. Targeted interventions for families experiencing mental health problems should be slotted into existing parental programmes.

The research evidence suggests that parental support programmes have a positive impact on children and their families. Although not all directly address the issues of maternal (parental) mental health, there is scope for these programmes to incorporate targeted support in the form of self-help and coping skills, as well as, options for seeking additional support and help. In addition, the successful adaptation of some international targeted programmes has provided a useful template from which further community-based and school-based interventions could be developed for children and young people in Ireland and Northern Ireland.

1 Introduction

A range of factors, social, contextual and environmental, can undermine mental health[1], with short and long-term consequences for individual and family well-being. The relationship between poor parental mental health and children's well-being is increasingly documented, with the evidence suggesting adverse developmental outcomes across the domains of a child's life (Cleaver, *et al.*, 2011; Gould, 2006). More specifically, maternal mental health has been recognised as a pivotal influence on children's well-being, particularly when combined with socio-economic disadvantage (World Health Organisation (WHO), 2008; Beresford *et al.*, 2008).

This Thematic Report from the Children and Youth Programme (CYP) focuses on the relationship between poverty and maternal mental health in Ireland and Northern Ireland, and the impact of these on educational outcomes for children and young people. The Report will adopt a child rights-based approach, using the General Measures of Implementation and General Principles as elementary tools for good policy (CYP, 2011). The objectives of the Report are to:

1. explore the relationship between poverty and mental health, particularly maternal mental health;
2. consider the dual impact of poverty and maternal mental health on children and young people's educational experience;
3. identify existing community and school-based provisions for affected children and young people in Ireland and Northern Ireland;
4. identify exemplars of interventions, nationally and internationally, that support access to, and enjoyment of, education for affected children and young people;
5. make recommendations for policy development and implementation.

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1   In the context of this Report, mental health is defined according to the World Health Organisation (WHO): a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. See http://www.who.int/features/factfiles/mental_health/en/

Education is inseparable from the fabric of social life (Share *et al*., 2012) and plays a critical role in nurturing the development of children and young people. Crucially, this requires a whole child approach that extends beyond intellectual development (OFMDFM, 2006; Walsh and Murphy, 2003). Whilst government policy in Ireland and Northern Ireland has sought to introduce measures to address and alleviate social disadvantage and exclusion to ensure that all children and young people can enjoy access, participation and achievement in education (Department of Education and Skills, (DES) 2011; Northern Ireland Department of Education (DE) 2011; DES, 2005), criticisms of the education system in both jurisdictions continue to be directed towards the perceived reproduction of inequalities, particularly in relation to broader structural issues of poverty and socio-economic division which have implications for vulnerable groups of children (Macinnes *et al*., 2012; Barnardos, 2009; Horgan, 2009).

The Report comprises five further sections. Section 2 contextualises the focus of the Report within a rights framework; Section 3 outlines the relevant legislative and policy context for Ireland and Northern Ireland; Section 4 explores the concepts of poverty and mental health, with a particular focus on maternal mental health; Section 5 provides an overview of the role of education and considers the contribution of universal and targeted programmes; and Section 6 draws concluding messages for policy in relation to education support.

2 Access to Education

The United Nations Convention on the Rights of the Child (1989) (the Convention) addresses the many domains of a child's life through substantive articles that include educational, social and welfare rights. As a universal, normative framework the Convention establishes child rights as '*… holistic and places emphasis on supporting the strengths and resources of the child him/herself and all social systems of which the child is a part'* (United Nations Committee on the Rights of the Child, (CRC) 2011, p. 23). The Convention also identifies the responsibilities of parents[2], and the role of State Parties in the provision of facilities and services to enable parents to fulfil their role. Article 27 states that children have a right to a standard of living adequate for their development. Whilst the child's parents (or other guardians) have primary responsibility for providing this, the Article (para 3) also requires state parties to assist parents to implement this right, particularly in cases of need where the parent requires material assistance and/or access to support programmes.

The CRC, in their Concluding Observations for both jurisdictions (CRC, 2008, 2006) highlighted the difficulties of economic disadvantage stating that '... *many families lack appropriate assistance in the performance of their child rearing responsibilities and notably those families in a crisis situation due to poverty'* (CRC, 2008). Identifying the vulnerable position of these children and young people the CRC advocated that children's best interests should be visibly addressed in policies and services that impact on them alongside investment in core services including education and health (CRC, 2008, 2006). In addition, this also applied to greater co-ordination between health policies and those aimed at reducing income inequality and poverty (CRC, 2008). It was also noted that early intervention programmes improve services and programmes related to the mental health of children and their families (CRC, 2006).

2 Article 5: parental guidance; Article 18: parental responsibilities and state assistance; Article 27: adequate standard of living.

The CRC has described the purpose of education to '… *maximise the child's ability and opportunity to participate fully and responsibly in a free society'* (CRC, 2001, p. 5). In educational terms, the Convention encompasses not just the right to education but also the familial, environmental and structural influences that may impact on access to, and participation in, school. Article 28 outlines the obligations of State Parties to make education available and accessible to every child, including implementing measures to encourage attendance and reduce drop-out rates; Article 29 identifies education as integral to the holistic development of children, enabling them to reach their full potential with a sense of identity forged through socialisation and interaction with others. Although most children and young people in Ireland and Northern Ireland enjoy their right to education, the CRC Concluding Observations have noted that problems including economic hardship, family obligations and poor health care exist for some and have recommended investment in resources to support this disadvantaged group (CRC, 2008).

The General Principles[3] and General Measures of Implementation[4] which underpin the Convention contextualise state obligations to implement and monitor children's rights. Their cross-cutting nature means that they have significant relevance to the educational experience of children and young people. For example, General Comment No. 1[5] notes that in acting in the best interests of the child, education systems and curricula should recognise the unique characteristics and learning needs of the child within his/her social and environmental context, and that discrimination of any form undermines the capacity of the child to benefit from educational opportunities. This is reiterated in the CRC Concluding Observations for Ireland and Northern Ireland, with recurrent emphasis on strengthening the voice of the child, ensuring that children have a right to express their views including in families, schools and the health sector (CRC, 2008, 2006, 2002).

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3 Article 2: the principle of non-discrimination; Article 3: the best interests of the child as a primary consideration; Article 6: the right of the child to life, survival and development; Article 12: due weight to be given to the voice of the child.
4 Article 4: to undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the Convention; Article 42: to make the Convention known to adults and children; Article 44.6: to make reports under the Convention widely available.
5 The Aims of Education (CRC, 2001).

3 Policy Context

Families in which a parent experiences poor mental health have often struggled to have the needs of both parents and children recognised (Cleaver *et al.*, 2011; SCIE 2011; Tunnard, 2004). In general terms, this has been attributed to an identified service gap based on limited and/or differing understandings, protocols and practices amongst health, education and other professionals (SANE, 2012; CRC, 2008, 2006; Darlington *et al.*, 2005). More specifically, the limited nature of specific integrated support for children of mothers with poor mental health has underlined a lack of collaboration between adult mental health services and education services which can impede effective decision making (Cleaver *et al.*, 2011; Mensah and Kiernan, 2010). Research has recommended the development of joint protocols that span both domains (Cleaver *et al.*, 2011), citing the particular benefit to schools of cross-sectoral partnerships that support children and young people in a network that is inclusive of family and the wider community (International Union for Health Promotion and Education (IUHPE), 2010; Reupert and Maybery, 2007; Browne *et al.*, 2004). In this regard, there has been some progress in both jurisdictions.

3.1 Ireland

In Ireland, government policy[6] is shaped by a social perspective based on a life cycle approach with childhood identified as a distinct stage[7]. The National Children's Strategy (2000) outlined the commitment of government to improving the lives of children and young people.

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6   Department of An Taoiseach (2006) Towards 2016 Ten-Year Framework Social Partnership Agreement 2006-2015 Department of An Taoiseach. Government Publications Office. Dublin, Ireland. www.taoiseach.gov.ie.

7   Based on Bronfenbrenner's (1979) ecological model.

Recognising the multi-dimensional nature of children's lives, it advocated an integrated delivery of core services in partnership with children, their families and the wider community. This was emphasised in the Agenda for Children's Services (2007, p. 12) which described such partnership as a *'… shared responsibility reflecting the complex, overlapping task of achieving good outcomes for children'* and reiterated in the stated commitment of Department of Children and Youth Affairs' (DCYA, 2012, p. vi) to *'… develop, strengthen and align policies, legislation and resources in order to achieve better outcomes for children and young people and provide support for parents and families'*. More recently, a Task Force established to inform the development of the new Child and Family Support Agency (CFA), proposed a framework of inter-agency collaboration with a spectrum of universal and specialist services and a focus on early intervention that included accessible mental health services (DCYA, 2012) reflecting the views made by the Committee on the Rights of the Child in their Concluding Observations (CRC, 2006). A new approach to providing an integrated response to the needs of children has been developed through the Identification of Need (ION) process, which is a multi-agency, early intervention initiative that enables parents and children, assisted by practitioners, to identify their own needs. The intention is that the ION would be adopted by all agencies, thereby providing a continuum of support to children and families. An evaluation[8] of the ION found that it provided a supportive structure that enhanced inter-agency working and added to the continuum of care offered to families, who in turn welcomed the key features of the ION, such as parental control over the process, its informal approach, multi-agency intervention and the emphasis on trusting relationships and practical support. It is hoped that the CFA will introduce the ION (or an adapted version) as a national model of service delivery.

Developments in Ireland have sought to promote the message that *'… society as a whole has a part to play in the well-being of children, and that services of varied agencies and departments that are core to child and family supports must operate in a*

> **In Ireland, government policy is shaped by a social perspective based on a life cycle approach with childhood identified as a distinct stage.**

8   See Forkan and Landy (2011)
    http://www.childandfamilyresearch.ie/sites/www.childandfamilyresearch.ie/files/ion-exec_summary-d1-1_final_23.11.2011.pdf.

singular unified fashion' (DCYA, 2012. p. iv).[9]
At the same time, wider government policy has
continued to prioritise education, notably in
relation to diverse pupil needs, equal access
and equality of opportunity, and greater
integration of services, particularly for pupils
from disadvantaged communities (Department
of the Taoiseach 2006; National Childrens Strategy, 2000).
The recent joint initiative[10] published by the Department of Education
and Skills, the Department of Health and the National Educational
Psychological Service (2013) highlighted the importance of co-ordinated
inter-agency collaboration within the education system as a means of
promoting the well-being and mental health of young people within the
education system and in life in general.

3.2 Northern Ireland

In Northern Ireland, legislation[11] relating to children and young people
establishes the primacy of their welfare with particular regard to the
importance of effective early interventions, the nature of parental
responsibility and the involvement of young people in decisions
affecting them. The ten-year strategy[12] of the Northern Ireland Executive
(Office of the First Minister and Deputy First Minister (OFMDFM), 2006)
for children and young people has set out a policy framework shaped
around six high level outcomes that include enjoying learning and
achieving and living in safety and with stability. It has similarly adopted
a whole-child approach, recognising that not all children have an equal
start in life and advocating targeted support to particular groups of
children and young people to ensure they have the opportunity to fulfil
their potential.

9   In November 2012 the Government approved the general scheme of the Child and Family
     Support Agency Bill, and drafting of the legislation necessary to establish the agency is
     currently underway.
10 Department of Education and Skills/Health Service Executive/Department of Health Ireland
     (2013) Well-being in Post-primary Schools: Guidelines for Mental Health Promotion and
     Suicide Prevention.
11 The Children (Northern Ireland) Order (1995).
12 Office of the First Minister Deputy First Minister (OFMDFM) (2006) Our Children and Young
     People - Our Pledge http://www.ofmdfmni.gov.uk/ten-year-strategy.pdf.

More recently, policy on Delivering Social Change[13] intends to tackle disadvantage and social exclusion through co-ordinated actions between government departments in order to *'… deliver a sustained reduction in poverty and associated issues across all ages; improve children and young people's health, well-being and life opportunities; break the long-term cycle of multigenerational problems'* (OFMDFM, 2012, p. 3). Crucially, the impact of parental influence on children's well-being and life chances is recognised alongside the contribution of parental support and early intervention programmes (*ibid*). Prevention and early intervention are emphasised in associated policy documents, including the Lifetime Opportunities: Anti-Poverty and Social Inclusion Strategy for Northern Ireland (OFMDFM, 2006), Improving Children's Life Chances, the Child Poverty Strategy (OFMDFM, 2011), Families Matter: Supporting Families in Northern Ireland (Department for Health Social Services and Public Safety (DHSSPS), 2009) and Regional Hidden Harm Action Plan (2008).[14] Collectively, these documents recognise the value a mainstream approach to improving outcomes for children and young people, with greater collaboration between agencies and sectors in the commissioning and planning of services, can have in improving outcomes for children and young people. This position is reflected elsewhere, notably in the Action Plan (2011-2014) of the Children and Young People's Strategic Partnership[15] (CYPSP) which highlighted the integrated relationship between early intervention and family support (CYPSP, 2011).

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13 OFMDFM (2012) Delivering Social Change: Children and Young Persons Early Action Document.

14 OFMDFM (2006) Lifetime Opportunities: Anti-Poverty and Social Inclusion Strategy for Northern Ireland; OFMDFM (2006) Improving Children's Life Chances. The Child Poverty Strategy; Department of Health, Social Services and Public Safety (DHSSPS) (2009) Families Matter. Supporting Families in Northern Ireland; DHSSPS (2008) Hidden Harm Strategy Action Plan.

15 The Children and Young People's Strategic Partnership (CYPSP) is a cross-sectoral, strategic partnership, consisting of the leadership of all key agencies who have responsibility for improving outcomes for all children and young people in Northern Ireland. See http://www.cypsp.org/

4. Mental Health

The WHO defines health as *'… a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'* and describes good mental health as *'… a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'* (WHO, 2010)[16]. Broadly, there is consensus that variable *'… social, psychological and biological factors determine the level of mental health of a person at any point of time'* more specifically, *'… persistent socio-economic pressures are recognized risks to mental health for individuals and communities'. The clearest evidence is associated with indicators of poverty, including low levels of education'*[17].

There have been many attempts nationally and internationally to estimate the percentage of the population who have mental health issues, mainly using census or epidemiological data. Generally, the figure is between 20%-30% (Parrott *et al*., 2008; Gould, 2006; Tunnard, 2004; Nicholson *et al*., 2004; Andrews *et al*., 1999; Falkov, 1998) although the prevalence rate in the adult population is difficult to quantify, with factors such as under-diagnosis, social stigma and reluctance to reveal mental health problems resulting in an estimate that is acknowledged to be on the conservative side (Huntsman, 2008).

In Ireland, a survey[18] carried out by the Health Research Board (HRB) (Tedstone, *et al*., 2008) sought to establish the extent of psychological distress, mental health problems and the use of mental health services. It found that 12% of the sample was currently experiencing symptoms of psychological distress and 14% of the sample reported experiencing mental health problems in the previous 12 months.

16 http://www.who.int/features/factfiles/mental_health/en/.
17 *Ibid.*
18 The Health Research Board National Psychological Wellbeing and Distress Survey (HRB NPWDS), is a telephone survey of a nationally representative random sample of 2,711 adults aged 18 years and over and living in private households.

Additionally, in the largest national survey[19] on the extent of mental health and social well-being in Ireland, it was found that major depression was prevalent in 6% of the sample, with women more likely to experience depression (8%) than men (5%). Women were also more likely to report generalised anxiety disorder (3%) than men (2%) (Morgan *et al*., 2008).[20]

> **There is growing evidence that higher rates of mental ill-health are linked to the period of conflict in Northern Ireland.**

In Northern Ireland, research has shown that mental health problems are highly prevalent, with elevated rates of post-traumatic stress disorder in comparison to other countries (Bunting *et al*., 2012).[21] Recent survey statistics indicated a possible mental health problem amongst one in five respondents (DHSSPS, 2012) whilst research has established a strong link between unemployment and adult mental health (Centre for Social Justice, 2010). These findings reiterated previous studies (for example, Horgan and Monteith, 2009; Kenway *et al*., 2006) which established that the number of people in Northern Ireland receiving Disability Living Allowance (DLA) for mental health reasons was 2.9% of the total adult population. This was three times the comparable figure for Great Britain (0.9%) and has more than doubled since 1998 when 1.2% of the total adult population received DLA for mental health reasons (Kenway *et al*., 2006). Gallagher *et al*., (2012) have also suggested prevalence rates that are around a quarter higher than in England and Scotland and there is growing evidence that higher rates of mental ill-health are linked to the period of conflict in Northern Ireland (Horgan and Monteith, 2009; Cairns, 2005; O'Reilly and Stephenson, 2003).

19 The Slan survey included face-to-face interviews with a sample of over 10,000 adults in the Republic. The survey measured three distinct components of mental health and well-being: positive mental health; non-specific psychological distress and diagnosed mental health problems including depression and generalized anxiety disorder.

20 It should be noted that both these studies occurred as Ireland was on the cusp of an economic recession. Thus data collected would have been done so during the Celtic Tiger era. As research indicates that economic recessions can lead to increased mental health difficulties alongside a range of other factors findings from these studies should be considered within the economic context of the time.

21 Part of the World Mental Health (WMH) Survey Initiative that involved 28 countries throughout the world. The following disorders were examined: anxiety disorders [panic disorder, generalized anxiety disorder (GAD), social phobia, specific phobia, agoraphobia without panic, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD) and separation anxiety disorder/adult separation anxiety (SAD/ASA)]; mood disorders [major depressive disorder (MDD), dysthymia and bipolar disorder]; impulse control disorders [oppositional-defiant disorder (ODD), conduct disorder, attention-deficit/hyperactivity disorder (ADHD) and intermittent explosive disorder (IED)]; substance use disorders (alcohol abuse, drug abuse, alcohol dependence, drug dependence).

4.1   Parental Mental Health

The prevalence rate of parental mental health issues can be difficult to establish due to compounding factors that include, under identification of conditions, poor patient uptake of services and incomplete systemic recording of patients as parents (SCIE, 2011; Huntsman, 2008), leading to calls for mandatory data collection and also sharing of information (Ofsted, 2013). This has meant that frequently *'... the identity of the patient as parent does not receive sufficient recognition'* (Göpfert, 2004, p. 8). Research in the United Kingdom reported that parental mental health was a significant factor in about 25% of new referrals to social services departments (Tunnard, 2004); that over one third of all adults with mental health problems are parents; and that an estimated two million children live in households where at least one parent has a mental health problem (Parrott *et al*., 2008). Although the figures are not broken down by region, we can use the United Kingdom average as an estimate of prevalence levels in Northern Ireland, indicating that at least 60,000 children are living with a parent with mental ill-health, and if prevalence rates for mental health problems are 25% higher in Northern Ireland, then the estimate could be between 60,000 and 75,000 children.

There is no systematic data collection in Ireland or Northern Ireland to indicate how many adults using mental health services are parents of dependent children; this in turn means that the voice and the needs of these children and young people are unexplored (Department of Health and Children (DOHC), 2006). A significant stumbling block in both jurisdictions has been a reported reticence on the part of mental health professionals to approach parenting issues because of the possible impact on their relationship with the patient and the stigma attached to mental health and seeking support (Macdonald *et al*., 2011). In Ireland, little is known about the prevalence of mental health problems amongst parents although some data is available. The Growing up in Ireland study[22] measured the psychological well-being of parents and found that

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22 The study based on data collected from 8,568 nine year-old children, their parents and teachers collected at the end of 2007 and the beginning of 2008. A nationally representative sample of 1,105 schools was selected from all primary schools in Ireland and, of these, 910 schools agreed to participate in the study (82%). A sample of children and their families was randomly generated within those schools.

9.3% of mothers and 4.1% of fathers were classified as being depressed[23] whilst 14% of mothers and 6.2% of fathers had previously been treated for depression (Nixon, 2012). Research by Somers (2006) found that children whose parents had schizophrenia were found to experience more psychiatric difficulties and more problems at school compared with children whose parents had no mental health difficulties. They were also found to spend increased periods of time in the family home and were at risk of becoming socially isolated. This research gap has highlighted that the '... *experiences and needs of children of (mental health) service users must be addressed'* (DOHC, 2006, p. 29). In Northern Ireland, there have been similar consistent calls for a prevalence study to establish a baseline of parental mental health, as well as, measuring service impact and outcomes locally (Lees, 2012; Macdonald *et al*., 2011). This gap in data has been described as *'… an indication of the minimal consideration given to the specific needs of families where parental mental health difficulties exist'* (Monds-Watson *et al*., 2010, p. 36).

While child protection research has shown an association between parental mental health and child welfare referrals, other research has indicated that the mental ill-health of parents alone presents little risk of significant harm to children (Cleaver *et al*, 1999); rather the co-existence of other factors such as domestic violence and/or parental alcohol or drug misuse, that can place the child at increased risk (Cleaver *et al*., 2007; Humphreys and Stanley, 2006; Cleaver *et al*., 1999). Current approaches to the treatment of poor mental health through community-based interventions mean that most parents will continue to care for their children (Mordoch and Hall, 2008; Cummins *et al*., 2007; Gladstone, Boydell and McKeever, 2006). Although this can be interpreted as a positive step in preserving family continuity, it has also generated an expectation that parents with mental health issues could continue or resume their family roles earlier while still attempting to address their own needs (Thomas and Kalucy, 2003). Similarly, Maybery and Reupert (2009; 2006) found parents were sometimes reluctant to involve their children and other family members in their treatment, making intervention and/or support more difficult. Alternatively, some children and young people have assumed a caring role within the family where the pressure

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23 Based on the Centre for Epidemiological Studies Depression Scale which assesses depression on a 20-item scale in which individuals are asked to report how they have been feeling for the past week on a four-point scale ranging from 'rarely or none of the time' (score of 0) to 'most or all of the time' (score of 3).

of such responsibility can impede their educational experience, affecting attainment, attendance and participation in school activities, as well as, their own general well-being (The Children's Society, 2013; Cleaver *et al.*, 2011; Roberts *et al.*, 2008; Dearden and Becker, 2003; Aldridge and Becker, 2003). Conversely, other research has found that some young carers saw school as a place of refuge (Cree, 2003).

The impact of caring on children and young people has been identified in Ireland and Northern Ireland[24], in particular, the restrictions it can place on educational and recreational opportunities. In the first study of its kind in Ireland[25], a small proportion of young people reported caring for a parent with a mental health problem (Fives, *et al.*, 2010) and a similar finding (12%) has been reported in a subsequent survey[26] (Dooley and Fitzgerald, 2012). In Northern Ireland, an estimated 8,500 young people provide care for a family member, although only a minority are known to social services or voluntary organisations and it is unknown how many are caring for a parent/s with mental health problems (Patient and Client Council, 2011). The needs of young carers have been identified as deserving particular attention *'… in order to ensure that their caring duties do not limit their opportunities to acquire the education and skills they need to inform their choices as adults'* (The Patient and Client Council (2011, p. 1) and it is recommended that the Department of Education should *'… remind schools and teachers of their role in supporting young carers'* (DHSSPS, 2006, p. 29).

A recent study by the Mental Health Foundation (2010) found that while some young carers may receive social support to provide respite or to enable them to participate in social activities, further intervention is required to address the problems they may experience regarding school. This includes regular lateness or absence and difficulty completing assignments on time: *"Schools don't want to learn about needing to give extensions or be more flexible."* (Young carer, Lincoln, p. 19); disruptive behaviour, being bullied and difficulty developing friendships *"I used to lie to friends if they asked why I was upset ... I would make up this*

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24 For example, Belfast Health and Social Care Trust (2011); Patient and Client Council (2011); Northern Ireland Commissioner for Children and Young People (2010); DHSSPS (2006) Caring for Carers: Recognising, Valuing and Supporting the Caring Role.

25 A study of 26 children, aged 5-17. See Fives, A., *et al.*, (2010).

26 Sample consisted of 14,036 young people, ranging in age from 12-25 years from all across the Republic of Ireland. See Dooley, B. and Fitzgerald, A. (2012).

fantasy world where I would pretend my life is perfect ... It was my way of being normal, my way of coping." (Young carer, Liverpool, p. 20); and leaving without any formal qualifications. In addition, young people indicated a need for further information about mental illness and mental health and help coping with their own feelings: *"Getting information will make it easier to come to terms with"* (Young carer, Lincoln, p. 16).

4.2 Maternal Mental Health

> **The World Health Organisation has identified the mental health of mothers as meriting special consideration.**

The World Health Organisation (WHO, 2008) has identified the mental health of mothers as meriting special consideration. Broadly, research indicates that women are more likely to experience depression and anxiety than men (Beresford *et al*., 2008; Park *et al*., 2006); in particular, mothers with poor mental health are likely to face more difficulties than their mentally well counterparts (Reupert and Mayberry, 2011; Ackerson, 2003) and in some instances poor interpersonal functioning and low self-esteem can exacerbate the condition (Sidebotham *et al*., 2006; Bifulco *et al*., 2002), resulting in intermittent parenting (Anthony and McGinnis, 1978). Research in the United Kingdom has indicated that approximately a quarter of pupils in an average primary school classroom were living with a mother with a mental health problem (Layard, 2005; Meltzer *et al*., 2000), and the evidence suggests that this often manifests in the early years. For example, analysis of the United Kingdom Millennium Cohort Study[27] (MCS) found that approximately a third of all mothers surveyed reported feeling sad or low for more than two weeks after giving birth and approximately a quarter of mothers suffered from depression or serious anxiety (Bunting and Galloway, 2012). In addition, more mothers reported being treated for depression in Northern Ireland than elsewhere in the United Kingdom.

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27 The Millennium Cohort Study (MCS) is a multi-disciplinary research project following the lives of around 19,000 children born in the United Kingdom in 2000/1. The sample was selected from a random sample of electoral wards, disproportionately stratified to ensure adequate representation of all four United Kingdom countries, deprived areas and areas with high concentrations of Black and Asian families. Four surveys of MCS cohort members have been carried out so far: at age nine months, three, five and seven years. The Centre for Longitudinal Studies (CLS) is responsible for running the cohort study. See www.cls.ioe.ac.uk/Default.aspx.

Similarly, the Growing Up in Scotland[28] (GUS) study suggested that approximately 12%-16% of women in the survey suffered from depression, anxiety or stress at any one point during the first four years following the birth of a child, accounting for a third of mothers overall, with 17% experiencing repeated spells of poor mental health (Marryat and Martin, 2010).

The impact of poor maternal health during pregnancy and the first year after childbirth has been noted (Hogg, 2012), with more than one in ten women affected. Depression, in particular, has been associated with maternal withdrawal, lack of involvement and negative emotional responses towards the child (Dix and Meunier, 2009). Children may experience a mother's mood fluctuations, withdrawal and unpredictable or inappropriate behaviours or responses (Leschied, *et al*., 2005; Falkov, 2004). Research has suggested that mothers with poor mental health may exhibit poor interpersonal functioning and low self-esteem (Sidebotham *et al*., 2006; Bifulco *et al*., 2002;) leading to intermittent parenting (Anthony and McGinnis, 1978), whilst other studies have indicated that children living with a mother with poor mental health are at increased risk of developing emotional, behavioural and mental health difficulties in later life (Giallo, *et al*., 2013; Mowbray and Mowbray, 2006; Hall, 2004;). Further studies have confirmed a relationship between poor maternal mental health and the well-being of children, with a range of evidence identifying the impact *inter alia* of diagnosis and duration, parental hospitalization, chaotic lifestyles, developmentally inappropriate roles and responsibilities and poor parent-child interaction on short and longer term outcomes (Social Research Unit, 2013; Marryat and Martin, 2010; Wachs *et al*., 2009; Fernbacher *et al*., 2009; Mowbray and Mowbray, 2006; Leschied *et al*., 2005; Falkov, 2004; Hall, 2004).

> " Studies have confirmed a relationship between poor mental health and the well-being of children. "

28 The Growing Up in Scotland study follows two groups of children. The first cohort follows 5000 children who were born between June 2004 and May 2005 and the second cohort follows 3000 children born between June 2002 and May 2003. The families were selected at random from Child Benefit records and are representative of Scotland as a whole. The research is carried out by the Scottish Centre for Social Research, in collaboration with the Centre for Research on Families and Relationships at the University of Edinburgh and the MRC Social and Public Health Sciences Unit at Glasgow University.

As highlighted above, poor maternal mental health rarely occurs in isolation, often combining with multiple other factors, the sources of which can be difficult to untangle. Some research has shown a strong association between maternal mental health, marital discord and/or separation, poverty and relative socio-economic disadvantage (Beresford *et al*., 2008). In the next section we focus on the relationship between maternal mental health and poverty.

> *Research has highlighted the relationship between adult mental health, unemployment and poverty.*

4.3 Poverty and Mental Health

As already stated, the frequent co-existence of psycho-social difficulties combined with a range of environmental and socio-economic factors makes it difficult to gauge the contribution of maternal mental health difficulties to specific outcomes for children and young people (Social Research Unit, 2013; Beeber and Miles, 2003). However, WHO highlights the role of poverty as a crucial factor in contributing to poorer health outcomes (WHO, 1995, p. 34):

> *Poverty and mental ill health form a vicious circle: poverty is both a major cause of poor mental health and a potential consequence of it. Widening disparities in society or economic changes in individuals' life courses seem to be of particular importance here. Whether defined by income, socio-economic status, living conditions or educational level, poverty is an important determinant of mental disability and is associated with lower life expectancy and increased prevalence of alcohol and drug abuse, depression, suicide, antisocial behaviour and violence.* (WHO, 1995)[29]

In Ireland, recent figures indicate that 19% of children are at risk of poverty (Central Statistics Office, 2011) whilst in Northern Ireland, 93,000 children are living in relative poverty, which equates to 21% of the child population (OFMDFM 2013).[30] Research has also highlighted the significant relationship between adult mental health, unemployment and

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29 WHO Regional Committee for Europe, Fifty-third session, Vienna, 8–11 September 2003
   http://www.euro.who.int/__data/assets/pdf_file/0007/87694/RC53_edoc07.pdf.
30 A child in Ireland 'at risk of poverty' lives in a household with an income less than 60%of national median income. A child in Northern Ireland living in relative poverty lives in a household where the income is below 60% of the median United Kingdom household income.

poverty (Social Research Unit, 2013; Cleaver *et al*., 2011; Jenkins *et al*., 2008; Melzer *et al*., 2004). More specifically, links between the longevity of poverty and poorer maternal mental health has been highlighted. For example, Monteith *et al*., (2008) found that parents living in poverty had poorer mental health and that mothers living in persistent poverty (three out of four years) had the worst scores regarding poor mental health. It has also been established that for a substantial minority of mothers, poor mental health is experienced well beyond the postpartum period and through the early years of their child's life and can be exacerbated by social disadvantage (Marryat and Martin, 2010). Evidence has highlighted that single mothers are amongst the most economically and socially disadvantaged groups in many western countries and as such experience greater levels of financial hardship, poverty and social exclusion than other family and household types (Crosier, *et al*., 2007). While some studies have shown the correlation between poverty and maternal mental health, it is difficult to ascertain whether poverty or mental health problems come first but it is generally agreed that poverty can be both a cause and result of poor mental health (Social Research Unit, 2013; A Vision For Change, DOC, 2006; WHO, 2005; Langer and Michael, 1963).
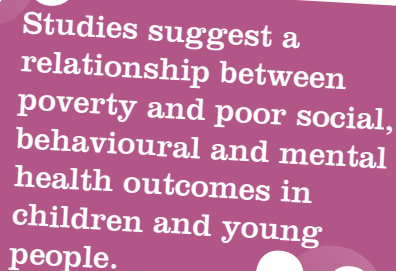
Mental health problems tend to coexist with low income, social disadvantage and low social support, as well as, less effective means of coping with psychological distress and the social and economic supports available to families. This means that individuals easily lose touch with the kind of supportive social networks that are essential for maintaining a sense of identity and well-being (Forkan, 2011; Ghate and Hazel, 2002; Seguin *et al*, 1995).[31] The financial value of employment has been established amongst parents with poor mental health, as has being able to participate in wider society as active citizens (Family Action, 2012; Parrot *et al*., 2008; Waddell and Burton, 2006). However, for some adults with poor mental health, challenges such as absence from work and inability to secure flexible hours/employment can affect income and career prospects (Gould, 2006).[32] Research has found that people

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31 Ghate and Hazel (2002) refers to three forms of support: informal support networks (such as family); semi-formal support (community or neighbourhood-based services) and finally formal support (statutory/state agencies).
32 Gould (2006) highlighted that in the United Kingdom less than one quarter of adults with long-term mental health problems were in work. Burchardt (2003) also found that the onset of mental health problems significantly increases the risk of employment loss, compared to other health conditions or impairments.

with pre-existing mental health problems were less likely to be in paid work (Gould, 2006) and were more likely to lose paid work as a result of poor mental health (Payne, 1999). In addition women tend to be over represented in low income and low status jobs, often part-time, and are also more likely to live in poverty than men (Horgan, 2009).[33] Conversely, financial hardship as a result of losing a job, being able to find employment or negotiating access to benefits has been identified as a potential stressor, which could lead to parental mental health problems or exacerbate an already problematic situation (Family Action, 2012; Parrot *et al*., 2008; Gould, 2006).

It is in this context that the interplay between the mental well-being of parents and the general well-being of children should be considered. Research has established a strong correlation between deprivation and poor educational attainment (Goodman and Gregg, 2010; Horgan, 2009; Redmond, 2008; Ridge, 2006). Research has also established that children growing up in poorer families tend to have lower levels of educational attainment and participation in post-compulsory education than their more privileged peers. Similarly, other studies suggested a relationship between poverty and poor social, behavioural and mental health outcomes in children and young people (Roscoe *et al*., 2012; Gladstone *et al*., 2011) with children growing up in poverty four times more likely to be diagnosed with a mental health disorder (Mensah and Kiernan, 2010; Howell, 2004) and further disadvantaged due to difficulties accessing services (Gamm, *et al*., 2010). Research has also highlighted the possibility of behavioural, emotional and social outcomes for children of parents with mental health problems (see Roscoe *et al*., 2012; Gladstone *et al*., 2011). Further, parents' mental health issues also impact on development and educational attainment (Marryat and Martin, 2010). This will be further discussed in the section on Education, Disadvantage and Mental Health.

> “Studies suggest a relationship between poverty and poor social, behavioural and mental health outcomes in children and young people.”

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33 However, Katz, *et al.,* (2007: page 26) state that 'The issue of whether and how poverty differentially affects mothers and fathers is a significant gap in the research.'

In both jurisdictions, a range of policy documents in relation to children have highlighted the collective impact of early childhood experiences, poverty, poor physical and mental health and multiple disadvantage[34]. While health policy documents outline an overall mental health strategy, the area of maternal mental health tends to focus primarily on the period prior to the birth of the child and immediately after.

Policies in Ireland have advocated a more child centred approach. For example, A Vision for Change (DOHC, 2006) has emphasised that the experiences of children must be addressed. Children First (DCYA, 2011) stated that the welfare of children is of 'paramount importance', emphasising early intervention along with consideration for the welfare and safety of children of a person who is being treated for a mental health or addiction problem. In Northern Ireland, a series of policies have advocated a more holistic approach to parental mental health, where early intervention and inter-agency collaboration are emphasised as ways to tackle disadvantage, safeguard children and improve short and long term outcomes for young people most at risk. For example, the Children and Young People's ten-year Strategy (OFMDFM, 2006) has advocated integrated service provision, whilst Improving Children's Life Chances: The Child Poverty Strategy (OFMDFM, 2011) has sought to ensure all children achieve their full potential regardless of background. Elsewhere, policy documents such as Healthy Child, Healthy Future (DHSSPS, 2010) have highlighted the overall relationship between improvements in child health and better outcomes for families.

With regard to mental health and its impact on children, the Bamford Review (DHSSPS, 2005) identified increased adverse outcomes for children living in households where parental mental health problems

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34 Department of Health and Children (DOHC) The National Children's Strategy, Our Children their lives (2000-2010); Department of Children and Youth Affairs (DCYA) (2011) The Children and Young People's Policy Framework (Currently in consultation phase); DCYA (2007) The Agenda for Children's Services : A Policy Handbook; DCYA (2001) Youth homelessness Strategy. In the case of Northern Ireland, see for example, OFMDFM (2012) Delivering Social Change Children and Young People's Early Action Document; DHSSPS (2010) Healthy Child, Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland; DHSSPS (2008) Regional Hidden Harm Action Plan; DHSSPS (2005) The Review of Mental Health and Learning Disability (NI): A Strategic Framework for Adult Mental Health Services (The Bamford Review).

co-exist alongside financial hardship and marital discord, which could lead to extended periods of separation, disrupted schooling, neglect and a higher risk of psychological disturbance. The Review recommended that *'… the assessment process for parents with a diagnosis of severe mental illness includes an assessment of the needs of children within the household. Written child protection protocols and policies, agreed between child care and mental health services, are an essential element of good practice and it will be vital to ensure that such protocols remain in place and are reviewed as organisational structures change and evolve'* (DHSSPS, 2005, p. 103).[35] This link is not made as explicit in further documents (DHSSPS, 2009; Northern Ireland Executive, 2008). Supporting children of parents with mental health problems through a collaborative approach between services is not without challenges; limited sharing and cross-referencing electronic databases across children's social care services and adult mental health services can impede effective interface collaboration (DHSSPS, 2010). Similar challenges have been found in the United Kingdom where children living with parents/guardians who have mental health problems are not receiving the help they need and the extent to which adult and children's services worked effectively together varied considerably, with stronger collaborations in drugs and alcohol services than in adult mental health services (Ofsted, 2013). There are, however, examples where the collection of data on children who have parents or carers with mental health problems has been introduced. Recently, Haringey Council in England has introduced a joint working protocol where mental health workers routinely record if a client is a parent so that the child's school can be contacted and involved in developing the wider care plan (Haringey Council, 2011).

> There are examples where the collection of data on children who have parents or carers with mental health problems has been introduced.

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35 Monds-Watson *et al* (2010) refers in particular to the tragic case of Madeleine O'Neill, who was in receipt of mental health services, took the life of her nine-year-old daughter Lauren, and then took her own life. This case and others have identified deficits in communication and joint working between agencies as contributing factors. Similarly, a 2008 report into another major child protection case again brought into focus deficits in working relationships between mental health services and children's services, suggesting that the way in which these services work together needed to improve (WHSSB & EHSSB 2007).

5 Education

Education plays a pivotal role in empowering children and young people to overcome adversity, enhance social, emotional and cognitive well-being and acquire lifelong skills (Cooper and Jacobs, 2011; Terrion, 2006). The role of parents in contributing to the educational outcomes of their children is widely acknowledged in policy and research (DES, 2011; Cleaver *et al.*, 2011; DE 2010; DES, 2007; Hill and Taylor, 2004), with evidence suggesting a correlation between parental involvement, academic achievement and socio-emotional development (Rhee *et al.*, 2003; Jeynes, 2003; Fan, 2001). Such resilience can also manifest in the child's own personality or through the development of other secure relationships (Aldridge, 2012; Parrot *et al.*, 2008) and can determine how well they cope with poor parental mental health (Aldridge, 2012; SCIE, 2011). For those children affected by poverty and poor maternal mental health, the support offered directly and indirectly by education services is crucial. This is further explored in the following section.

5.1 Education, Disadvantage and Mental Health

Children who grow up in poorer families and who live with parents who have mental health problems are more likely to struggle in terms of educational attainment and participation in education.

In Ireland, research evidence has indicated that children and young people from low socio-economic communities are at greater risk of experiencing literacy and numeracy difficulties for reasons associated with poverty and poor health (Smyth and McCoy, 2009; Combat Poverty Agency, 2003: Kellaghan, *et al.*, 1995).

There have been consistent calls for Government to improve
children's rights to access and participate in education, particularly
as a means of breaking the cycle of poverty and disadvantage
(CRA, 2013, 2012, 2011, 2010). There has been some progress
in this regard and a series of priority actions[36] have been identified
for primary and post-primary education to develop an inclusive
environment for all learners, address educational disadvantage and
raise attainment (DES, 2011). For example, Government has recently
introduced a strategy to improve levels of literacy and numeracy[37]
and the Delivering Equality of Opportunity in Schools (DEIS) initiative
continues to support schools in which disadvantage is most
concentrated. More widely, it is recognised that parental involvement
can mitigate the potential negative effects of low socio-economic
status and that efforts to improve the educational achievement of
children and young people should take place alongside corresponding
initiatives that improve their general health and well-being (DES,
2011). In Northern Ireland, the impact of poverty and disadvantage
on educational achievement has been similarly identified (Nolan,
2013; National Society for the Prevention of Cruelty to Children
(NSPCC) and Barnardos, 2010) and Government has sought to
address this through a range of policy for schools that includes the
contribution of parents[38]. For example, Every School a Good School:
A Policy for School Improvement (DE 2009) is an over-arching policy
strategy for raising standards, where the link between
underachievement and socio-economic disadvantage is
acknowledged, whilst the revised Literacy and Numeracy Strategy
(DE 2011) is intended to raise standards and to close the gap
between the highest and lowest achievers. Research has identified
disparities in academic achievement across socio-economic
boundaries (Horgan, 2009), for example, amongst pupils in receipt of
free school meals (MacInnes *et al*., 2012; Purvis, 2011).

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36 Department of An Taoiseach (2006) Towards 2016 Ten-Year Framework Social Partnership
    Agreement 2006-2015; Department of Education and Skills (DES) (2011) Statement of Strategy
    2011-2014.
37 The National Literacy and Numeracy Strategy Literacy and Numeracy for Learning and Life
    (2011-2020); Programme for Government.
38 OFMDFM (2006) Lifetime Opportunities. Government's Anti-Poverty and Social Inclusion
    Strategy for Northern Ireland and OFMDFM (2012) Delivering Social Change. Children and
    Young People's Early Action Document also deal with the challenges of deprivation and social
    disadvantage. See also OFMDFM (2011) Improving Children's Life Chances. The Child
    Poverty Strategy and Department of Education (2009) Every School a Good School. Policy for
    School Improvement.

A child's education can also be compromised if the parent has poor mental health, resulting in lower attainment academically, emotionally and socially (Marryat and Martin, 2010; Smith, 2004). In general terms, extraneous factors such as interrupted schooling, difficulties concentrating on school work and worry about a parent all impact on children's educational experiences (Oskouie *et al*., 2011), whilst the stigma attached to having a parent with poor mental health can lead to social withdrawal, with some children reluctant to engage with their peers (Fjone *et al*., 2009). More specifically, children's exposure to a mother with poor mental health has been shown to adversely affect their social, cognitive, emotional and behavioural outcomes in the short and long term (Wachs *et al*., 2009; Covell and Howe, 2009; Chang *et al*., 2007). Amongst children in the early years, this can mean that, *'at the point when they are about to start formal education, these early deficits may affect their transition to school and their subsequent development and attainment'* (Marryat and Martin, 2010, p. vii) whilst amongst older children, it has been shown to lead to lower academic achievement and higher rates of school drop-out (Bohon *et al*., 2007). In addition, the capacity for mothers with poor mental health to be actively involved in their child's education may be compromised (Sharp *et al*., 1995: Atkin, 1992) if they are less available to help with homework, participate in shared activities, or discuss school issues (Stein *et al*., 2007).

5.2 Supporting Education

School can be an important protective factor in the lives of children and young people. The centrality of school in their lives and, by association, their families, means that it can provide a useful setting for intervention and support. By focusing on educational concerns in the first instance, the direct needs of children can be addressed alongside opportunities to forge stronger relationships with parents. In this regard, positive interactions between school and home can have a buffering effect on vulnerable families where *'... sympathetic, empathic and vigilant teachers … recognise and identify parents' problems and the impact that these issues may have on various aspects of children's and young people's lives'* (Cleaver *et al*., 2011, p. 194).

> 66 A child's education can be compromised if the parent has poor mental health … 99

Research has helped to identify preventative and/or effective interventions that can ameliorate children's experience of poor maternal mental health and support their education (Reuters, 2001). These include alternative support from within or outside the family (Cleaver *et al*., 2011; Lee *et al*., 2001); educational or recreational success outside the home (Mensah and Kiernan, 2010; Falkov, 1998; Jennings and Kennedy, 1996; Kendall-Tackett, 1996); and peer friendships (Maybery *et al*., 2005). Whilst the evidence has illustrated the benefits of educational support programmes specifically for children living with a mother with mental health difficulties, they have been slow to develop (Orel *et al*., 2003, Stormont *et al*., 1997).

> **Progress has been made to support children and their families in both jurisdictions ...**

Progress has been made to support children and their families in both jurisdictions and a range of policy[39] has outlined the duty of care held by schools to safeguard and support the welfare of all pupils, as well as, their responsibility to identify, intervene and monitor those children and young people who require extra support. In Ireland, broad education policy[40] sets out legal obligations for schools and parents to enable children and young people to develop personally, intellectually, socially, emotionally and morally whilst acknowledging that, for some pupils, their educational experience can be impeded due to circumstances arising from social or economic disadvantage (DES, 2000,1998). Other, more specific, education policy has provided guidance[41] that underlines the unique position of schools to recognise and address wider child welfare issues that may negatively impact on educational progress. As a continuum of support, the guidance is based on early intervention and individual need for all children experiencing difficulties, although the particular circumstances of maternal mental health are highlighted (Department of Education and Skills/Health Service Executive/Department of Health Ireland Guidelines for mental health promotion and suicide prevention,

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39 See Department of Education and Skills/Health Service Executive/Department of Health Ireland (2013) Well-being in Post-primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention. See, for example: DE (2012) Learning to Learn - A Framework for Early Years Education and Learning; DE (2009) Every School a Good School. Policy for School Improvement; DE (2006) Extended Schools: schools, families, communities - Working Together; Education and Libraries (NI) Order 1986 - Articles 58 and 59 and Education (NI) Order 2003.
40 The Education Act, 1998; The Education Welfare Act, 2000.
41 For example, DES (2011) Child Protection Procedures for Primary and Post-primary Schools; DFES (2013) Well-being in Post-primary Schools: Guidelines for Mental Health Promotion and Suicide Prevention.

2013). This approach has also shaped the nature of welfare support in schools, ranging from individual support to children and their families through to whole school approaches integrated within the local community (NEPs/DES/DoH/HSE, 2013). Government bodies[42] established to implement aspects of educational policy have a range of remits to protect and promote the education and welfare needs of children and young people that includes *'… a service to the most disadvantaged areas and most at risk groups'* (DES, 2011, p. 29). Corresponding strategies[43] have been developed to secure best outcomes for children's school attendance and educational welfare that includes a unified support service in partnership with parents and other agencies (National Educational Welfare Board Strategic 2009). Elsewhere, other initiatives such as the School Completion Programme (SCP), The Home School Liaison Programme (HSCL), the Visiting Teachers Service for Travellers Service (VTST) and the Educational Welfare Service have been developed to address issues relating to attendance, participation, engagement, early school leaving and attainment (DCYA, 2012; DES, 2011).

In Northern Ireland, wider education policies have set out to ensure that all children can achieve their potential at each stage of their development (DE, 2012; 2010)[44]. Stressed in wider education documents is the duty on schools to safeguard and promote the welfare of pupils and to address issues that might impact negatively on educational progress. Measures to support pupil's welfare range from counselling services in schools, to extended/full-service programmes aimed at fostering greater collaboration between home and school (DE, 2010; DE, 2006).[45] Associated policy documents[46] have sought to de-stigmatise mental health issues inside and outside school through mental health promotion and prevention, an approach that is endorsed elsewhere (Davidson *et al*., 2012; Connolly *et al*., 2011; DHSSPS, 2006).

42 For example, The National Education Psychology Service (1999); The National Education Welfare Board (2003).
43 For example, NEWB (2009) Every Child Counts.
44 DE (2009) Every School a Good School. Policy for School Improvement; DE (2012) Learning to Learn - A Framework for Early Years Education and Learning.
45 DE (2006) Extended Schools. Schools, families, communities - working together (DE 2006); DE (2012) Extended Schools - Building on Good Practice. Circular Number: 2010/2.
46 For example, DHSSPS (2012) Safeguarding Social Well-being: A Strategy for Social Work in Northern Ireland 2012-2022; DHSSPS (2006) Suicide Prevention Strategy and Action Plan 2006-2011.

Corresponding strategies[47] and policies[48] have also promoted early intervention, and addressed issues relating to attendance, educational welfare, child protection, child behaviour in schools, as well as, suspensions and expulsions.[49] Integral to these documents is the role of teachers to identify and support pupils who are at particular risk of educational underachievement, particularly where family circumstances might act as barriers to learning.

A range of ameliorating interventions can influence the extent to which children and young people are supported in their education. These encompass both universal (community-based) and targeted (school-based) services, the former providing a gateway towards identifying a possible maternal mental health problem and the latter providing more tailored interventions. These are explored in the following sections.

5.2.1 Community Based Interventions

In Ireland, initiatives such as Springboard[50] were developed to promote the well-being of parents and children utilizing the strengths of families themselves, as well as, through the provision of a range of family support services, within their own local communities (McKeown, 2001). The purpose of the initiative was to provide a direct service through a structured package of care, intervention, support and counselling to targeted families and children, as well as, to families within the wider community (DOHC, 1998). Through Springboard, services such as, individual and group work, homework clubs and after-school activities, including art, crafts and swimming have been offered. The Springboard programme was found to have a small but statistically significant effect on the psychological well-being of children

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47 DHSSPS (2012) Safeguarding Social Well-being: A Strategy for Social Work in Northern Ireland 2012 - 2022.
48 DE (2006) Extended Schools. Schools, families, communities - working together; DE (2010) Extended Schools – Building on Good Practice. Circular Number: 2010/2.
49 See DE (2013) Attendance Guidance and Absence Recording By Schools Circular Number: 2013/13. The documents refers to the Education Welfare Service, which is a specialist education support service, which seeks mainly to assist families and young people where school attendance is an issue but also with issues such as child protection, child behaviour in schools, as well as, suspensions and expulsions. See, for example, www.neelb.org.uk/parents/ews/.
50 Springboard was established in 1998 by the Department of Health and Children.

and on the parent-child relationship and amongst parents a decrease in stress, an increase in support networks and an improvement in parenting capacity (McKeown *et al*., 2006).[51]

In Northern Ireland, social support interventions, for example, Sure Start and Family Support Hubs, as well as, other community and voluntary befriending schemes, provide valuable support. The Sure Start Programme[52] is targeted at parents and children under the age of four living in the 20% most disadvantaged wards in Northern Ireland. By providing services, such as parenting support, the programme seeks to improve the social, emotional, physical and educational development of children and their families. Evaluations of Sure Start in the United Kingdom have highlighted its positive impact on parents, including the creation of a cognitively stimulating home learning environment (DfE, 2010; Hutchings *et al*., 2007). In Northern Ireland, an evaluation of the Sure Start Programme for two-year olds[53] found similar advantages and also identified areas for improvement, including more effective strategic planning, greater professional development and stronger collaborative working practices among education and health professionals (ETI, 2010).

Family Support Hubs[54] were launched by the CYPSP in 2011. Adopting a whole-family approach and operating as a multi-agency network consisting of statutory, voluntary and community organisations, they facilitate early intervention support services for families in need providing training and resources that match family needs. The Hubs, which currently number 15, have been described as a signature project within the Delivering Social Change Framework and there are plans to establish ten more by 2014 (OFMDFM, 2011). Additionally, a series of programmes and initiatives have been introduced to

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51 The evaluation was carried out based on the three year pilot phase of the initiative and was based on a non-experimental design involving a pre-post comparison of programme participants on two main outcomes: Children's psychological well-being and the parent child relationship. The evaluation itself was limited as a result of the design of the Springboard programme as there is great variance in programme approach and content making it difficult to elucidate which aspects of the programme are linked to outcomes found.

52 Sure Start has operated in Northern Ireland since 2000. There are currently 35 Sure Start Programmes across Northern Ireland. See www.nidirect.gov.uk/sure-start-services.

53 The DE (2012; page 3) also makes the point that there is as of yet no overall evaluation of how Sure Start operates in Northern Ireland, and '… how it is strategically and operationally aligned with key objectives for DE or the wider Executive priorities.

54 Family Support Hubs were introduced in 2011. At the time of writing there were 15 support hubs in Northern Ireland which are identified as a 'signature project' within the Delivering Social Change Framework. The DHSSPS intend to establish a further ten Family Support Hubs by 2014.

encourage greater parental involvement in education. For example, the Education Works[55] campaign provided practical guidance to promote parents' involvement in their child's education. Other agency-led programmes such as Families and Schools Together (FAST)[56] and Ready to Learn[57], delivered by Save the Children and Barnado's respectively, have sought to foster stronger relationships between home and school to create a home environment that is conducive to learning. Elsewhere, Family Connections[58] is a partnership involving local families, schools and services which provides extended learning opportunities, integrated health and mental health services, parent support and community capacity building.

5.2.2 School Based Interventions

School-based programmes can provide valuable support for children who are affected by parental mental health issues (Barrett *et al*., 2006; Horowitz and Garber, 2006; Joyce *et al*., 2003; Spence *et al*., 2003). Research with children and young people who have a parent with a mental illness identified the most useful school supports as being: people (counsellors, teachers, friends) to talk to; practical support such as transport, breakfast programmes; flexibility and empathy on the part of teachers; coping mechanisms; greater awareness on mental illness; and after-school study programmes (Reupert and Mayberry, 2007; Fudge and Mason, 2004). Other effective interventions have included: negotiating and supporting arrangements for school work and homework; creating opportunities for academic success; encouraging supportive peer networks; and facilitating class discussions on general coping and mental health (Reupert and Mayberry, 2011).

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55 The Department of Education launched a series of adverts but also a web-site containing tips and information, see www.nidirect.gov.uk/education-works.

56 The FAST Programme involves weekly coaching sessions with parents to lead activities in which children take turns, listen to rules, answer questions and to do as their parents ask, and also to play with their children and share a family meal together.www.savethechildren.org.uk/about-us/where-we-work/united-kingdom/fast.

57 Ready to Learn is delivered as an after school programme for Primary One children with a parallel programme for parents and carers. wwww.barnardos.org.uk/what_we_do/who_we_are/northernireland/northern_ireland_history/readytolearn.htm

58 The Programme is run by Barnardo's in one Primary School (Rathcoole) in Newtownabbey and involves coaching sessions with parents, coaching sessions on activities, such as helping with homework. See http://www.rathcooleprimaryschool.com/keyinfoBarnardos.html.

In Ireland, for example, The Big Brother Big Sister schools mentoring programme was developed in 2003 by Foroige[59] in response to difficulties experienced by first year students in their transition to second level education. The programme theory contends that the presence of a non-familial caring adult can make a difference to the social and emotional development of the young person (Canavan, 2005). Currently, the programme runs in 64 schools and almost 1500 first year students were matched in the 2010/2011 academic year. An initial evaluation of the programme highlighted that key stakeholders perceived it to be of benefit and that it met a need for a structured transition support programme in schools (Brady *et al*., 2012). Elsewhere, the Mindout[60] programme aimed to develop, implement and evaluate a curriculum based programme in the form of a module promoting positive mental health directed at 15 to 18 year olds within the school setting. An evaluation of the programme found that it had positive short-term effects on a range of outcomes in a variety of school settings. However, crucial to the success of the programme was the support and dedication of individual teachers to its delivery. The programme has since been endorsed as a suitable resource for the Social Personal and Health Education curriculum in secondary schools in Ireland (Barry *et al*., 2007).[61]

In Northern Ireland, government funded initiatives such as the Extended Schools Programme[62] (DE, 2010, 2006), and Full Service Programmes in Schools[63] (DE, 2012) have targeted pupils living in disadvantaged communities who risk being marginalised. The programmes are often delivered in partnership with statutory agencies and other local voluntary and community groups. Both programmes have focused on improving educational achievement amongst pupils by introducing initiatives, such as, homework clubs, breakfast clubs, reading groups, healthy eating, and counselling services but have also sought to engage parents in skills-based courses to help them support their child's learning.

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59 http://www.foroige.ie/our-work/big-brother-big-sister.
60 http://www.youthhealth.ie/content/mindout-mental-health-promotion-programme-out-school-settings.
61 The programme underwent an evaluation through a randomized controlled experimental design, and a 12 month follow-up evaluation.
62 The Extended Schools Programme has operated since 2006. See http:// www.niesis.org/site/.
63 The Full Service Programme is currently being piloted in two communities experiencing high levels of deprivation. See www.deni.gov.uk/index/curriculum-and-learningt-new/standards-and-school-improvements/full_service_programmes.htm.

The Extended Schools Programme provides access to counselling, individually for pupils and for joint parent and child counselling.[64] Evaluations of the Extended Schools Programme and the Full Service Programme have been positive and it has been recommended that they should be developed elsewhere (Webb *et al*., 2012). Evaluation findings of both programmes highlighted the range of support provided, including their capacity to reduce the perceived stigma of receiving assistance individually or as a family, although parental engagement has been difficult to maintain in a sustained way (ETI 2013; DE 2010; ETI, 2010; Pricewaterhouse Coopers, 2008). Additionally, Nurture Rooms[65] have been established within early years provision to address barriers to learning in recognition that a range of influences such as maternal depression and other factors might impact on pupils behaviour (Grant, 2012). Evaluations of Nurture Room initiatives elsewhere have found that best results were achieved when parents and carers were actively involved in the practice of intensive support which helped children to flourish and grow (Education Scotland, 2009; Glasgow City Council, 2007). In addition, the Pupils' Emotional Health and Well-being Programme[66] was developed to raise pupils' understanding of mental health issues for themselves and others (DE 2010). In an evaluation of the programme pupils identified social-family problems, including parental illness, as having impacted on their education (Connolly *et al*., 2011). The evaluation also found greater reported success when a whole school approach to pupil well-being was adopted although barriers identified included limited planning time, limited staff expertise and lack of resources.

Beyond the two jurisdictions there is a range of evidence-based programmes for children and their parents. For example, Building Bridges[67],

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64 The Extended Schools Programme referred to one example of joint parent and child counselling sessions (ETI, 2010). There were also counselling Drop-In Sessions to be provided for parents through day-time, lunch-time and evening sessions:

65 Nurture Rooms are a relatively new phenomenon in Northern Ireland but have been operational elsewhere in the United Kingdom since the 1980s. See http://www.nurturegroups.org/pages/our-impact.html. They are currently funded through collective sources, including the Department for Social Development (DSD), the Neighbourhood Renewal Fund and the Big Lottery. Funding for 20 new units has been announced by the OFMDFM, as part of the Delivering Social Change strategy.

66 The 'Pupils' Emotional Health and Well-being Programme' was renamed the 'Matter Programme', ranging from smoking, alcohol and drugs to relationships and sex but also issues such as coping with stress, family problems and bullying.

67 See www.family-action.org.uk/section.aspx?id=14435. The Building Bridges Programme is currently running in the Colin area of Belfast, see NCB (2012) http://www.ncb.org.uk/media/875558/ncb_final_report_-_product_1.pdf.

developed by Family Action in the United Kingdom, emphasises early intervention among families where one or both parents have severe and/or enduring mental health problems. The programme supports the adult as parent or carer whilst responding to the needs of the child, providing accessible information about their parents' condition. Evaluations of the programme highlighted the co-ordinating function of the programme across professional domains, including primary care teams, health visitors and education welfare and also found evidence of impact, including fewer instances of family breakdowns, increased take up of mainstream services and improved school attendance (MacLeod 2011; Morris, 2007). The Strengthening Families Programme[68] developed in the USA was originally designed to increase resilience and reduce risk factors for alcohol and substance misuse, depression, violence and aggression, delinquency and school failure in high risk children and their substance misusing parents (Kumpfer *et al*., 1996). It has since evolved to provide a universal tool that can be used with non-substance abusing parents, with an emphasis on parental involvement in children's education and training and support for parents and children to work together (Ashton, 2004). Evaluations of the programme have identified a positive impact, noting improvements in parents, children, family environment and family resilience (Kumpfer *et al*., 2012; Coombes, *et al*., 2006)[69].

Whilst these programmes have focused on a whole-family intervention, others are more child-centred, for example, in Canada the Family Association for Mental health Everywhere (FAME)[70] and in Australia the Family Simplifying Mental Illness Life Enhancement Skills (SMILES)[71] Programme, and the CHAMPS (Children And Mentally ill ParentS) Programme.[72] The FAME programme helps children to better understand their parents' mental health problems, and encourages the development of coping skills.[73] The Programme has found that children

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68 www.strengtheningfamiliesprogram.org/about.html.
69 Kumpfer *et al.,* (2012) refer to the evaluation of the Programme *Strengthening Families Program (SFP)* for families with high-risk children age 6 to 11 years olds in the Ballymun area in Dublin. The European Monitoring Centre for Drugs and Drugs Addiction (2013) found that the Strengthening Families programme had been successfully adopted within European countries.
70 See http://fameforfamilies.com/famekids/.
71 See www.copmi.net.au/smiles.
72 See www.easternhealth.org.au/services/directory/service,serviceid,13789.aspx.
73 The programme also provides children with a backpack containing items, such as, dental and personal toiletry kits, clothing, a journal, writing and art materials, a Crisis Contact Card and a Telephone Calling Card for emergencies.

participating had less worries about the impact of mental health and felt better informed.[74] CHAMPS, is a peer support programme which aims to build resilience skills among children with parents with poor mental health in settings such as after school clubs and holiday programmes. An evaluation of the programme found that it had contributed to improvements in self-esteem and coping, strengthened family connections and reduced relationship problems (Goodyear *et al*., 2009). Similarly, SMILES actively works with children of parents with mental health problems to build self-confidence and resilience, gain better understanding of their parents' mental health problems and reduce feelings of isolation. The programme also incorporates joint sessions with parents to develop their parenting skills and improve relationships with their children. Evaluations of the Australian SMILES Programme identified positive outcomes for children and parents alike. It provided children with a better understanding of their parents and improved their confidence and resilience and enabled parents to talk openly to their child about their mental health (Baldwin and Glogovic, 2010: Pitman and Matthey, 2004).

National and international evaluations generally suggest the positive impact of child-centred interventions (Maybery *et al*., 2005) and peer support programmes (Hargreaves *et al*., 2005), although the need for ongoing evaluation is emphasised to ensure children and young people receive information and support in a format appropriate and accessible to their age (Reupert *et al*., 2012)[75]. What these international examples highlight is that it is possible to develop programmes that actively engage children who have a parent with poor mental health.

> " National and international evaluations generally suggest the positive impact of child-centred interventions. "

74 E-mail correspondence with Programme Co-ordinator.

75 For example, Support in Mind Scotland (www.supportinmindscotland.org.uk) has also developed and designed an information leaflet for children (aged 11-14) with parents with mental health issues which includes advice and information, see *Need to Know: A guide for young people who have a parent with mental illness.* The Organisation also devised a guide for parents with mental illness *Making Time to Talk - Advice for parents with mental illness*, with among other things, tips for good parenting.

Evaluations of the programmes reiterate the principles of best practice that include the importance of links between school, home and community; consistency of approach; responsive approaches to teaching and learning; and opportunities for communication amongst young people themselves (IUHPE, 2010). Although these are parental rather than maternal interventions, their core objectives suggest transferability to specific groups, a finding endorsed in research, which found that programmes adapted to the specific culture and context can work well, and was preferred to the option of developing a programme from 'scratch' (European Monitoring Centre for Drugs and Drugs Addiction, 2013).[76] The programmes have already been adapted and delivered within the two jurisdictions.

For example, the Strengthening Families Project has been adapted both in the United Kingdom and in Ireland.[77] Similarly, Family Smiles has been adapted by the NSPCC in the United Kingdom[78].

76 The research involved surveys and interviews with 18 people involved in 12 countries, in the implementation of four American drug prevention programmes in Europe.
77 For the Strengthening Families Programme and the work in Ballymun (Dublin), See http://www.ballymunlocaldrugstaskforce.ie/userfiles/file/Ballymun%20SFP%206 11%20Years%202012%20Evaluation%20Report.pdf. For a United Kingdom context, see Coombes, *et al*., (2006).
78 NSPCC social workers lead groups of up to eight children over eight weeks to help them build confidence and self-esteem and gain better understanding of their parents' mental health problems, improve their self-esteem and reduce feelings of isolation. See www.nspcc.org.uk/what-we-do/the-work-we-do/priorities-and-programmes/physical-abuse/simplifying-mental-illness/smiles_wda87161.htm.

6 Key Messages and Next Steps

As highlighted in this Report, parents, particularly mothers, with poor mental health have particular needs to enable them to support and care for their children. The research evidence suggests that these children are an under-represented group: their needs are little understood and are only beginning to be afforded serious consideration in the legal, policy and practice context. The United Nations Convention on the Rights of the Child (1989) identifies children's rights to enjoy access to education, as well as, the responsibility of the State party to provide familial, administrative and service support to ensure this can happen. Drawing on evidence, the following key messages have been identified.

1. There is a need for better prevalence data on the number of children who have a parent with a mental health problem.

This Report has highlighted the difficulty in accurately gauging the extent of parental mental health issues in Ireland and Northern Ireland and the absence of a comprehensive data source in both jurisdictions has been noted. As a result, the adult and his/her role as a parent is neither adequately recognised nor fully addressed in policy and service provision, with implications for the outcomes for children. The collation of a comprehensive data set would provide a more detailed representation of the numbers of individuals with a mental health problem, but also their characteristics, including parental status, socio-economic status, the nature and duration of their condition. More effective and earlier identification of parents' problems would provide a better understanding of how children's needs and welfare are affected and assist in reducing the potential risk of harm.

2. There is a need for further child-centred research to better understand the relationship between maternal mental health, poverty and children's educational outcomes.

The mental health of mothers has been identified internationally as meriting particular consideration and the impact of a mother's poor mental health on children's social, emotional and educational well-being is identified in policy and research. Poor maternal mental health often occurs in combination with multiple other factors, with poverty a critical contributor to poorer outcomes for mother and child. Further research from a child-centred perspective would illuminate some of the complexities of this relationship and provide insight to inform policy and practice.

3. Joint protocols between health and education can improve educational outcomes for children and young people.

Research has highlighted the limited nature of integrated support for children of parents with poor mental health and a general lack of collaboration between children's social care services and adult mental health services. The evidence has suggested that joint protocols and stronger collaboration would effectively utilise specialist expertise, including education, to better inform assessment and planning. Examples of innovative practice, such as that introduced by Haringey Council, demonstrate how a collaborative approach in mental health services can routinely involve schools in the wider care plan when a client is identified as a parent, ensuring that the child's needs are identified and addressed in the school setting.

4. Staff training and appropriate educational interventions within schools are crucial to enable children to enjoy access to a full educational experience.

Educational staff should be trained and supported to identify a possible parental mental health problem and to understand the impact of this on the educational, social and emotional development of children and young people. Improved understanding of the issues for families experiencing parental (maternal) mental health problems could facilitate appropriate interventions and support in the form of care, protection, and participation at school. Such an approach can help safeguard a continuity of education, empower children to achieve their full potential and enhance their long-term life chances.

5. Targeted interventions for families experiencing mental health problems should be slotted into existing parental programmes.

The research evidence suggests that parental support programmes have a positive impact on children and their families. Although not all directly address the issues of maternal (parental) mental health, there is scope for these programmes to incorporate targeted support in the form of self-help and coping skills, as well as, options for seeking additional support and help. In addition, the successful adaptation of some international targeted programmes has provided a useful template from which further community-based and school-based interventions could be developed for children and young people in Ireland and Northern Ireland.

Next Steps

This Report has explored the particular relationship between maternal mental health, poverty and children's educational outcomes. It has highlighted the complex nature of this relationship specifically and within the broader framework of poor parental mental health, identifying limitations in data collection and integrated service provision. The impact of poor maternal mental health on children's educational outcomes has also been noted, and the value of community-based and school-based support programmes has been considered in terms of children's access to, and participation in, a full educational experience. Based on the research evidence it has been possible to establish five key conclusions, which provide a basis for policymakers to make better informed decisions surrounding support for young people whose parents suffer from mental health problems.

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UNESCO

UNESCO works to create the conditions for dialogue among civilisations, cultures and peoples, based upon respect for commonly shared values. It is through this dialogue that the world can achieve global visions of sustainable development encompassing observance of human rights, mutual respect and the alleviation of poverty, all of which are at the heart of UNESCO's mission and activities.

The broad goals and concrete objectives of the international community – as set out in the internationally agreed development goals, including the Millennium Development Goals (MDGs) – underpin all UNESCO's strategies and activities. Thus UNESCOs unique competencies in education, the sciences, culture and communication and information contribute towards the realisation of those goals.

UNESCO's mission is to contribute to the building of peace, the eradication of poverty, sustainable development and intercultural dialogue through education, the sciences, culture, communication and information.

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UNESCO Chairs and UNITWIN Network projects undertake training, research, information sharing and outreach activities in UNESCO major programmes areas (education, natural sciences, social and human sciences, culture, and communication and information). UNESCO Chairs and UNITWIN Networks provide an innovative modality for international academic cooperation and capacity building, acting as think tanks and as bridge builders between research and policy making, and between academia and civil society.

THE UNESCO CHAIRS

University of Ulster
The Chair, held by Professor Alan Smith, is located in the School of Education. Established formally in 1999, the Chair has a programme of work in Education for Pluralism, Human Rights and Democracy. Building on from the work of the Chair, the UNESCO Centre was founded in 2001 and has, for the past ten years, engaged in research, development and teaching in the areas of: Children and Youth; Education, Health and Well–being; and Conflict and International Development.

NUI Galway
The Chair, held by Professor Pat Dolan, is part of the Child and Family Research Centre (CFRC) located in the School of Political Science and Sociology. Established formally in 2008, the Chair has a core programme of work promoting civic engagement for children and youth. The Chair operates in the wider context of the CFRC, which has been engaged over the previous ten years in undertaking research, evaluation and training in the areas of Family Support and Youth Development.

BRIDGE BUILDING

As members of the UNESCO international education network, UNESCO Chair holders are encouraged to act as "bridge builders" by establishing and sustaining dynamic links between the academic world, civil society, local communities, research and policy-making. The Children and Youth Programme in Northern Ireland and Ireland presents an exciting opportunity to develop such links and to create a programme which is endorsed by UNESCO and which will be recognised nationally and internationally as a major component of the work of the two UNESCO Chairs.

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