Family relationships and mental illness
Impacts and service responses

Elly Robinson, Bryan Rodgers & Peter Butterworth

It is now well recognised that mental illness is a significant issue in Australia, and the impact of such problems is increasingly recognised. Approximately one in five people will experience a mental health disorder every year, with the most common disorders being anxiety and depression. The effects on families can be significant, and the quality of support and service delivery to families and affected family members is crucial.

This paper will give a brief overview of mental health problems, including types and prevalence, causes of mental illness, and family-related risk and protective factors. The impact of mental health problems on family relationships and family dynamics will be explored, including the role of carers and relationship issues resulting from, or contributing to, the presence of a mental health problem.

Approaches to helping families deal with mental health problems in the context of family relationship services will be suggested.

Section 1: Overview of mental health problems in the general population

The scale of mental health problems in Australia

Recent years have seen a growing public awareness of the nature and scale of mental health problems as they impact on the general population. One contributory influence in this country has been the information gathered by the first Australian National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics (ABS) in 1997. The published results of this survey remain the primary source of quantitative data on Australia's mental health.[1] The 1997 study found that around one in five adults in the population had experienced a depressive, anxiety or substance use disorder in the past 12 months meeting the conventional diagnostic criteria used in psychiatry (Andrews, Hall, Teeson, & Henderson, 1999). The prevalence of affective (i.e. depressive) disorders was 7.2%, anxiety disorders 9.5%, and substance use disorders 7.7%, and the more specific diagnoses within these broader categories are shown in Table 1.

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1. Findings from the second National Survey of Mental Health and Wellbeing are due for release in late-2008.

Australian Government

Australian Institute of Family Studies
Australian Family Relationships Clearinghouse

The Australian Family Relationships Clearinghouse (AFRC) is an information and advisory unit funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. The Clearinghouse aims to enhance family relationships across the lifespan by offering a resource and a point of contact for providers of family relationship and support services, policy makers and members of the research and broader communities. The Clearinghouse collects, synthesises and disseminates information on family relationships and facilitates networking and information exchange.

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Table 1: Prevalence of psychiatric disorders in the past 12 months by ICD-10 diagnostic criteria

Diagnosis	%
Any affective disorder	7.2
Major depression	6.7
Dysthymia	1.3
Any anxiety disorder	9.5
Panic disorder	1.1
Agoraphobia without panic disorder	1.1
Social phobia	2.7
Generalised anxiety disorder	3.0
Obsessive-compulsive disorder	0.3
Post-traumatic stress disorder	3.3
Any substance use disorder	7.7
Alcohol harmful use or abuse	3.0
Alcohol dependence	3.5
Drug harmful use or abuse	0.2
Drug dependence	2.0
Any of the above disorders	18.6

Source: 1997 National Survey of Mental Health and Wellbeing as reported by Andrews, Henderson and Hall (2001)

In addition to these common mental disorders, we know that around two to three percent of adults will experience more serious disorders during their lifetime, such as schizophrenia and bipolar disorder (i.e. manic depression). Although these overall figures of the prevalence of mental disorders appear very high (and are sometimes referred to as being of "epidemic proportions") they could well be underestimates. Some other disorders, including personality disorders, eating disorders and pathological gambling are not included in the national survey figures. Furthermore, many individuals experience mental health problems that impact on the quality of their lives or on the lives of other family members, even though these do not meet the criteria for psychiatric diagnoses.

It is notable that the sum of the prevalence figures for specific disorders in Table 1 exceeds the percentage for having any disorder (18.6%) by a considerable margin. This reflects the fact that many people meet criteria for more than one diagnosis, and further, that having any one disorder increases the likelihood of receiving an additional diagnosis. Over a third of individuals with any diagnosis met the criteria for two or more disorders (Andrews et al., 2001).

One reaction to the high prevalence estimates of mental disorders has been to suggest that diagnostic criteria identify problems of a trivial and self-limiting nature. However, additional information on the burden of mental disorders (covering economic costs and disability) serves to emphasise their seriousness. From the same national survey it has been estimated that, in Australia, around 680,000 work days per month are lost due to sickness absence for mental health reasons (Lim, Sanderson, & Andrews, 2000). Of these, about 351,000 were attributed

to depressive disorders. An additional 1.9 million "work cutback days"[2] per month were attributed to mental disorders, 900,000 of these to depression. These figures focus exclusively on temporary absences from work and do not include lost productivity from unemployment due to mental disorders.

At the population level, mental disorders are the leading cause of non-fatal disease burden in Australia (Mathers, Vos, & Stevenson, 1999) and depression is estimated to become the second leading cause of disease burden and the major cause of disability worldwide by 2020 (Murray & Lopez, 1997). Although rare, the fatal consequences of mental illness are also significant in Australia. Suicide accounts for only about two percent of all adult deaths in recent years, but was responsible for 10.6 percent of years of life lost through premature death when estimated for 1998. This estimate was based on a notional "full" life of 75 years (ABS, 2003) and the figure of 10.6 percent is therefore a reflection of the comparatively young age of many people who died from suicide. Fortunately, youth suicide rates have fallen in recent years, especially for young men where the rate is now about half of the peak reached in 1997 (Australian Insitute of Health and Welfare [AIHW], 2007). However, suicide is still the second highest contributor to deaths in the 12–24 year old age group, accounting for 19% of deaths in 2004.

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The youth suicide rate in particular highlights the need to consider mental health problems in childhood and adolescence, as does the evidence that adolescence is the period in which many mental disorders begin (Patel, Flisher, Hetrick, & McGorry, 2007). According to the child and adolescent component of the 1997 National Survey of Mental Health and Wellbeing, about 14% of children aged 4–17 years had mental health problems (Sawyer et al., 2000; Rey, 2001). Internalising disorders (where psychological distress is expressed or directed internally, e.g., depression) and externalising disorders (where the distress is directed outwards, e.g., ADHD, conduct disorder) were equally common (AIHW, 2005). For young people aged 18–24 years, the 1997 National Survey of Mental Health and Wellbeing showed that around 27% had experienced a mental disorder in the past year, a higher proportion than for adults generally. The most common category of disorder in this age group was substance use problems, affecting 21% of young men and 11% of young women. This raises the question of the use of substances either as a precursor to mental illness or for the purposes of self-medication to deal with mental illness. Whilst a discussion of dual diagnosis of mental illness and substance abuse is outside the scope of this paper, its frequency is worthy of note.

These figures highlight the importance of early identification in order to increase the chances of early diagnosis and treatment. Barriers to help-seeking at this age, however, include stigma and negative attitudes towards help-seeking from professionals, believing that services won't be useful and a tendency to think that problems should be handled personally. Young men and young people from an Aboriginal or Torres Strait Islander or other culturally and linguistically diverse (CALD) minority groups may be particularly reluctant to seek help (Rickwood, Dean, & Wilson, 2007). If help is sought by young people it is more likely to be from friends or family, or in the case of professionals, family doctors or school counsellors (Rickwood et al., 2007). The Internet may also be a source of information and support, particularly for more stigmatised or extremely personal problems (Nicholas, Oliver, Lee, & O'Brien, 2004). As a result, many young people who are dealing with mental health problems may not come to the attention of professionals who can assist with appropriate early interventions or treatments.

Mental illness and families

The extremely high population burden of mental disorders assumes special significance for family relationship services for several reasons. These include:

1. Mental disorders impact not just on the individuals affected but also on those around them—including immediate family and other relatives—and may be both a cause and a consequence of family/relationship difficulties.

2. Although most common mental disorders are amenable to treatment, the majority go undiagnosed and untreated.

3. Many disorders are chronic or recurrent and they often call for long-term management, not just acute care.

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2. Work cutback days are defined here as days where people worked but reported that their productivity was reduced, in quantity or quality, by their problems.

4. Much of the care provided for people with mental disorders (even very serious disorders) is informal care provided by family members.

5. Many of the "vulnerable" family groups that represent the clientele of family relationships services have a greater risk of mental health problems than the population average.

1. The interpersonal nature of mental health problems

Mental health problems are often of a deeply personal nature in that:

- they are often not visible to others;
- most are characterised and identified by emotional and other subjective symptoms; and
- many individuals experiencing problems attempt to conceal or downplay their difficulties.

At the same time, mental health problems have features that are fundamentally interpersonal. The clinical diagnosis of almost all mental disorders includes the criterion that "symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning." Although the onset of disorders may not be identified as such by family members, it is still usually the case that relatives and close friends recognise that "something is wrong" with the person affected and they can be influential in decisions to seek professional help. Impaired functioning in occupational roles has already been described, but similar impairment is also likely in an individual's parenting role or their engagement in a couple relationship. Postnatal depression is an obvious example where a mental health problem is seen to affect functioning in a parental role, including development of attachment and other parent–child interaction. Other common mental disorders are also found to be linked with a range of adverse social outcomes, including marital dissatisfaction (Whisman, 1999) and the likelihood of marital breakdown (Mendlowicz & Stein, 2000; World Health Organization, 2001; Kessler, Walters, & Forthofer, 1998).

> Mental disorders are also found to be linked with a range of adverse social outcomes, including marital dissatisfaction and the likelihood of marital breakdown.

An additional interpersonal feature of mental health problems is the importance of perceived stigma (when public endorsement of prejudice related to a stigmatised group occurs), and self-stigma (what stigmatised people may do to themselves, if the public stigma is internalised) (Corrigan, 2004). Both types of stigma are associated with help-seeking for mental health issues, and both impact on the likelihood of receiving help. Individuals may be particularly sensitive to the views or presumed views of relatives and friends about mental health problems and this can be a factor in their willingness to disclose their own problems or to seek professional help.
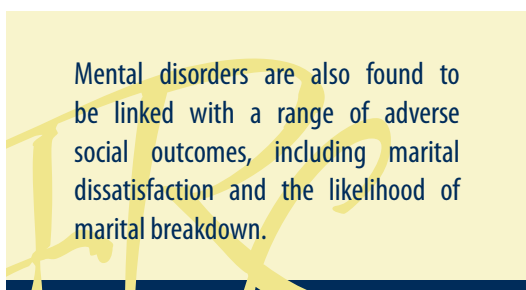
2. Untreated disorders

Most people in Australia who experience common mental disorders do not receive adequate services. In the 1997 national survey, 28% of people with an anxiety disorder, 14% of those with a substance use disorder, and 55% of those with a depressive disorder in the past year had received some form of professional help (Andrews et al., 1999). Although professional help for depression was comparatively high, only 32% of the people receiving help were provided with treatments that are known to be efficacious (Andrews, Sanderson, Corry, & Lapsley, 2000), so the proportion obtaining effective help was only about one in six. It will be interesting to see if these figures improve for the second survey (due for release in late-2008), as a result of a possible increase in public knowledge and greater willingness to seek care since 1997 and the recent availability of time-limited treatment by psychologists under Medicare arrangements, on referral by a medical practitioner.

The lack of professional care for mental health problems has implications for family relationship service providers for the following combination of reasons:

- Untreated problems are likely to last longer and may worsen in terms of severity.
- Inappropriate forms of self-help, such as substance use, can lead to secondary problems (i.e. comorbidity).
- Clients with untreated disorders will be less likely to benefit from interventions provided by family relationship services, either because their problems (e.g., depression) reduce engagement with the intervention or because problems work directly against the intervention (e.g., substance use or gambling problems could undermine financial counselling).

3. Managing chronic and recurrent disorders

Whilst treatment can often be effective for common mental disorders, particularly if help is received before difficulties become too entrenched, there will be many instances where problems continue to be chronic

or recurrent. The management of diabetes has been suggested as analogous to management of chronic depressive and anxiety disorders (Andrews, 2001). Such management should cover not just personal care but also ways of dealing with the broader context of interpersonal relationships and family responsibilities. For some therapies (e.g., behaviour marital therapy or family therapy) the importance of family relationships is an integral part of treatment, but this is not always so for other therapies, such as individual cognitive behaviour therapy. This presents a challenge for both mental health services and for family relationship services to accommodate issues arising from mental health problems that can impact on families (just as chronic physical disease or disability affect families as a whole). Services will often have expertise in one or other area, mental health or family relationships, but typically not in both.

4. Informal caregiving

A significant part of the caregiving burden falls on family members, especially for more serious mental disorders. This role is often undertaken by parents when a young person or child is affected, by spouses, siblings or ageing parents when an adult is affected, and by adult children of the elderly. However, less typical instances represent important exceptions, for example, children and young people under 18 years caring for their parents. Notable issues for carers of people with severe mental disorders include access to specialist services, availability of ancillary services such as respite care, eligibility for financial assistance (e.g., carers' payments), and therapeutic support for themselves (Edwards, Higgins, Gray, Zmijewski, & Kingston 2008). Caregiving for family members is dealt with in more detail in a later section. However, it should be noted here that there is no clear-cut separation between caregiving (with a defined carer and receiver) and the more common circumstance of providing emotional and practical support for a relative with mental health problems. This is best viewed as a continuum of care, often involving reciprocal support, which merges into the issues mentioned in the previous section on managing chronic and recurrent disorders.

5. Vulnerable families

For some family relationship service providers, their whole target client group can be seen as potentially vulnerable to mental health problems. Domestic violence services need no reminding of the possible mental health consequences for victims, particularly if this has been a repeated event. The research literature on risk and protective factors for adult mental disorders provides the evidence base for the characteristics of individuals and families that increase the likelihood of being affected by mental health problems. Unlike the vast majority of physical disorders, mental disorders are more common in young and middle-aged adults, compared with older adults. Depression and anxiety disorders are more common in women than men, whereas substance use disorders are more prevalent in men. Family history of mental health problems, especially of parents or other first-degree relatives, is another important risk factor.

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The demographic and socio-economic factors that have the strongest association with depression and anxiety are lone parenthood and unemployment (especially when long term) (Butterworth, 2003; Crosier, Butterworth, & Rodgers, 2007). An underlying feature in both instances is financial hardship, which is indicated by lack of material resources and inability to afford essentials rather than by income alone. Adults with dependent children, especially mothers, are at increased risk for depression and anxiety, with the mothers of younger (pre-school) children having the highest risk. Past (own) relationship breakdown is also related to an increased risk of depression and anxiety (as seen in stepfamilies as well as lone parent families), as is parental separation in the family of origin even after many years (Rodgers, Power, & Hope, 1997).

Occupational skill level as such is not strongly related to risk of mental health problems. Rather, work characteristics such as insecurity, high demands and low control are more pertinent, and having a combination of these poor characteristics may be worse than having no job at all (Broom et al., 2006). Some occupations place people at particular risk of mental health problems, most notably, the possibility of post-traumatic stress disorder (PTSD) for those in the defence forces and for workers employed in emergency services. PTSD often occurs in conjunction with other anxiety disorders and/or depression.

The risk of mental health problems in children and young adults also varies substantially across groups in the population. The child and adolescent component of the national survey showed that problems were more common in children whose families had low incomes or whose parents were unemployed. Both internalising

and externalising childhood disorders were roughly twice as common in lone parent families and in step/blended families as in original parent families (AIHW, 2005). In young adults, those who had not completed a secondary education had higher rates of mental disorders; and, as in older adults, the unemployed and those not in the labour force, were also at greater risk (AIHW, 2007).

Stressful life events and transitions, whether expected or unexpected, or forms of longer-term disadvantage can influence the mental health status of one or more family members. Such life events and disadvantages include violence, death or serious illness of a family member, other relative or close friend, redundancy, financial crises, homelessness, incarceration, natural and other large-scale disasters, family breakdown, criminality in parents, and parental substance abuse (Department of Health and Aged Care, 2000). The impact on family and individual wellbeing and functioning will vary according to the intensity and duration of the issue, and the capacity of family members to react in adaptive ways. Some serious life events, such as family separation, may have a substantial impact on personal wellbeing for two years or longer (Hope, Rodgers, & Power, 1999).

The causal relationship between life events, long-term disadvantage and mental health is not always clear-cut. Studies of unexpected events (e.g., sudden bereavement) or of major disasters that affect large numbers of people show that acute stressors can have a direct impact on mental health, although not everyone exposed to such events does develop problems. It is also the case that experiencing mental health problems can place people at greater risk of future adversity, such as financial hardship or homelessness. A third connection is that past circumstances and events may place people at greater risk of both stressful circumstances and mental health problems. This indicates the complex and reciprocal processes underlying interactions between mental health and aspects of family functioning or family events. The significance of mental health problems as both a cause and a consequence of relationship difficulties and instability means that such problems are likely to be of high prevalence in the clients of family relationship services.

Protective factors

Social support and particularly the emotional support from a close relationship is one important protective factor for mental health problems. Often, but not always, this close relationship is with a spouse/partner or parent. People lacking such a close supportive relationship are at greater risk of anxiety and depression, and whilst this demonstrates one of the special strengths of family support it also identifies a possible weakness. When life events or other disadvantages affect several family members simultaneously, this can sometimes undermine the capacity of individuals to support one another. Some families may "pull together" in the face of mutual difficulties while others lose their collective strength. Family separation is a special example where support systems that have been in place for a long time may no longer be sustained or cease to be effective for a family. In these circumstances, family members (including children) may need to seek support from elsewhere.

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Additional protective factors are self-help strategies that aid recovery from mental health problems and may prevent difficulties progressing to diagnosable disorders. These include psychological strategies (e.g. increasing coping skills and cognitive approaches), behavioural strategies (e.g., exercise and relaxation techniques) and use of complementary therapies (e.g., St John's Wort) (Jorm, Christensen, Griffiths, & Rodgers, 2002; Jorm et al., 2004).

This section has addressed a number of ways in which mental health problems are particularly relevant for families. Clients of family relationship services may present with issues linked to mental health in many ways. One key feature that may impact on family functioning is a changed or changing relationship arising from a family member's mental health problems. The issues for those who live with or care for a person with mental health problems are examined further in the following section.
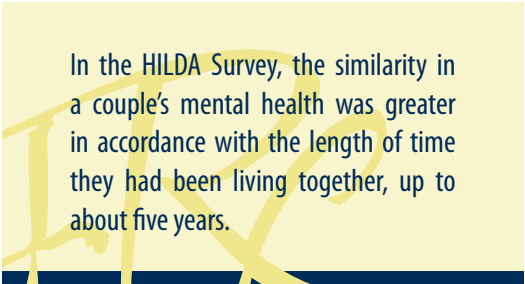
Section 2: Living with or caring for someone with a mental health problem

Living with someone who has a mental health problem

Research in many countries has shown that mental illness in married couples co-occurs at a level far greater than expected by chance, i.e. that mental illness in one spouse is associated with mental illness in their partner. This association is seen in samples from the general population, as well as in clinical samples, so the connection is not just because some couples are more likely to seek professional help or to come into contact with services for

other reasons. A large study in Edmonton, Canada used standardised interviews to assess lifetime psychiatric history in 519 pairs of spouses and reported significant associations between diagnosed disorder in one spouse and diagnoses in the other (du Fort, Bland, Newman, & Boothroyd, 1998). The associations were found for different types of disorders as well as for the same diagnoses in couples. For example, major depression was about twice as common in spouses whose partner had major depression compared with those whose partner did not have this diagnosis; and alcohol abuse or dependence was about three times as likely when a spouse had this problem. Instances where associations were found for different diagnoses included higher rates of major depression, phobia, PTSD, and alcohol and drug use disorders in wives if their husband had antisocial personality disorder. Husbands showed similar increased likelihood of disorders (except for major depression) if their wives had antisocial personality disorder. These findings were broadly similar to an earlier study conducted in Detroit that used a more limited range of diagnostic categories (McLeod, 1995).

There are no data from Australian research comparable to the Edmonton data, as most population samples, such as the National Survey of Mental Health and Wellbeing, only interview one person from each household and therefore do not include pairs of spouses. However, we do know that there are associations between partners in their reporting of recent psychological distress, i.e. symptoms of depression and anxiety. In the Household, Income and Labour Dynamics in Australia (HILDA) Survey, the similarity in a couple's mental health was greater in accordance with the length of time they had been living together, up to about five years (Butterworth & Rodgers, 2006). For relationships of five years or longer, the similarity in psychological distress between couples was at its maximum (reaching a correlation of 0.3).

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A number of different explanations have been suggested for this co-occurrence (often called "spousal concordance"), including that:

- people marry partners who are similar to themselves, and this could apply either to mental health problems or to other characteristics which put people at risk of mental health problems in the future;
- spouses have similar environments and experiences (e.g., life events) after marriage and these contribute to the similarity in their mental health; and
- mental health problems in one spouse impact on the mental health of their partner, due to difficulties in their relationship, through any consequences on their economic or living conditions, or as a direct consequence of one spouse having to care for the other (see section below on caregiving).

The increasing similarity of spouses with longer duration of marriage (Butterworth & Rodgers, 2006) supports the second or third explanations, provided that this does not come about because partners with dissimilar mental health are especially likely to separate early in their relationship. An example of how similar life events (or the same single event) can impact on a couple was shown in a Finnish study of major depression in spouses (Lindeman et al., 2002). Recent bereavement was very common (48%) in couples where both had experienced major depressive episode in the past year compared with couples where only one partner had been depressed (13%). Interestingly, researchers do not seem to have considered whether similarity in the mental health of partners could be because some couples are more likely to seek out effective treatments or have better self-management strategies and coping styles for their problems. In other words, there may be similarity in spouses' powers of recovery and not just in their initial likelihood of developing mental health problems.

Relationship satisfaction is related to a person's own mental health as well as the mental health of their partner. An early and often-quoted study reported that the odds of depression were 25 times greater for people in an unhappy marriage (Weissman, 1987). A more recent U.S. study analysed the marital satisfaction of wives and husbands together in relation to their own and their partners' depression and anxiety (Whisman, Uebelacker, & Weinstock, 2004). As expected, husbands' and wives' marital satisfaction was significantly linked to their own depression and anxiety; the greater their depression or anxiety, the lower their satisfaction, and the strength of these associations was very similar in men and women. Further, husbands' depression was associated with wives' marital dissatisfaction and vice versa. However, neither husbands' nor wives' anxiety was related to their spouses' marital satisfaction. Even the complexity of this picture is a simplification of the intrinsic connection between mental health and marital relationships, because these data were cross-sectional and did not consider expected reciprocal links where relationship satisfaction can feed back into the future depression and anxiety of husbands and wives (Fincham, Beach, Harold, & Osborne, 1997). Of course, additional specific aspects of a spouse's behaviour may have particularly strong effects on their

partner's mental health, including violence, and sexual and psychological abuse, and these shade into more common forms of negative marital interactions involving hostility, threats, overt and covert criticism, betrayal and disappointments (Beach, Fincham, & Katz, 1998).

Such inextricable associations between mental health and marital relationships are reflected in the application of marital therapy in the treatment of depression and other mental health problems. A recent Cochrane Review (Barbato & D'Avanzo, 2006) indicated that whilst there is currently no evidence to suggest that marital therapy is more or less effective than individual psychotherapy or drug therapy in addressing depression, there may be improvements in the relations of depressed couples. The review calls for further research to test whether marital therapy has better outcomes than other interventions for distressed people with a depressed partner.

Children of parents with a mental illness

There has been increasing recognition of the caring role that many children play in supporting a parent with a mental illness. It is estimated that between 21–24% of Australian children live in a household where at least one parent has a mental illness (Maybery, Reupert, Patrick, Goodyear & Crase, 2005). The caring role that these children undertake may vary from helping out to more extensive care (Sanders, 2004).

The effects of having a parent with a mental illness may impact on children in different ways. Children may be affected in terms of their own direct care, or indirectly through impacts on their social and emotional health and wellbeing. Core attachment needs such as love, physical and emotional nurturing, and security may be at risk. For example, depressed mothers may provide less stimulation, support and responsiveness to children, which can affect children's physical and psychological health, attachment and social problems (Burke, 2003). Children may be at an increased risk of developing mental health problems, either through genetic predisposition, parenting style or learned behaviour (Tunnard, 2004), with one study suggesting that approximately one-quarter of children living with a parent who has a mental illness are in situations of moderate, high or extreme risk of future mental health problems themselves (Maybery, Reupert et al., 2005). Poor relationships between parents and children may or may not result, but emotional safety and, particularly in cases of psychosis, physical safety may be compromised (Tunnard, 2004).

> Children may be at an increased risk of developing mental health problems, either through genetic predisposition, parenting style or learned behaviour.

Children may have to deal with a range of feelings, emotions and reactions that come from having a mentally ill parent. One small study of family members from Polish, Croatian, Bosnian and Chinese backgrounds found children were affected by parental mental illness in a range of ways, with responses including confusion, fear, questions about normality, disruption of connections with sick family member, and worry that they will also become sick (Kokanovic, Petersen, & Klimidis, 2006). Children also felt awkward having friends over and grieved for the parent they once knew.

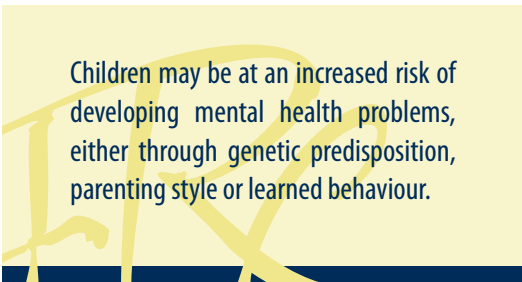### Siblings whose parents have a mental illness

Whilst the literature on young carers has increased in recent years, less has been written about sibling relationships, with most studies concentrating on how parental mental illness affects family functioning as a whole (Sanders, 2004). Maybery, Ling, Szakacs and Reupert (2005) found that parents with a mental illness and their children saw siblings as a great source of support, particularly during periods when the parent is unwell. Both siblings and peers were identified as crucial providers of support, and these relationships should be encouraged as an important part of service delivery to families dealing with mental illness.

Siblings may take on different caring roles for one or more family members. Older siblings may be looking after everyone, which may lead to poorer outcomes, but caring may also lend a sense of maturity and responsibility. Sanders (2004) stated that children may not want to give up caregiving, as long as they are supported and given information and recognition of the value of their role, and their parents are also professionally supported.

As stated previously, there can be a difference between living with and caring for a person with a mental illness, as living together does not always involve an active caring role. The following section explores the issues associated more specifically with caregiving.

Caring for someone with a mental health problem

According to Ohaeri (2003), fifty years has passed since the first study on the effects of caring for a person with a mental illness on a family, with the role of the family increasing substantially with the deinstitutionalisation
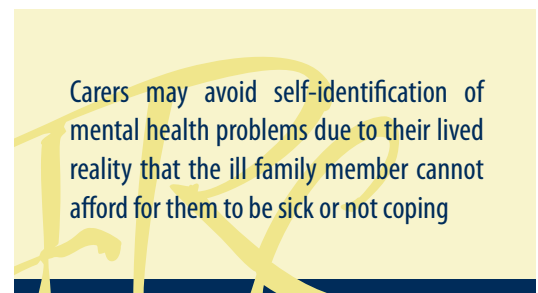
of mental health services. In fact, a shift to care in the community more generally has been reliant on informal care being offered by family and others, described by Bittman, Hill and Thomson (2007) as "the hinge of contemporary policy in the human services" (p. 256). Research interest has also increased, particularly around geriatric caregiving in families (Marks, Lambert, & Choi, 2002), with corresponding extensive literature on the impact of caring on caregivers' health. However, much of the research in the area of caregiving uses small, convenience samples of carers of a person with a specific disability, making it difficult to generalise to a wider population. As such, this review provides a snapshot of the available literature, concentrating specifically on caregiving for a person with a mental illness where research is available.

Numbers of carers

The ABS 2003 Survey of Disability, Ageing and Carers estimated that approximately 13% of people, or more than one in ten adults, were carers. One in five of these were primary carers,[3] and 71% of primary carers were women (ABS, 2004). Two aspects of caregiving relate specifically to mental health—the care involved in looking after a person with a mental illness and the impact of caring on the mental health of the caregiver. The second type may occur in the caring of a person with a range of physical and intellectual disabilities, as well as mental illness.

Caring may not always lead to mental health problems for the carer, but caring experiences are often talked about in terms that may relate to mental health (e.g., stress levels), without expressly being defined as such. It is therefore difficult to clearly distinguish from the literature under what circumstances a carer's mental health is or isn't affected. The mental health status and needs of carers may also go unidentified by families and professionals as they focus on others' needs; carers may avoid self-identification of mental health problems due to their lived reality that the ill family member cannot afford for them to be sick or not coping. As such, the mental health needs of carers may remain unidentified and unaddressed, which may have long-term ramifications for both their own wellbeing and the wellbeing of the care recipient.

> Carers may avoid self-identification of mental health problems due to their lived reality that the ill family member cannot afford for them to be sick or not coping

One of the key aspects of caring that can impact on the mental health of carers is the level of burden involved in the caring role. Similarly to other caring roles, two types of burden associated with caring for a person with a mental illness are highlighted in the literature: objective burden and subjective burden. Objective burden relates to the specific tasks associated with caring, for example managing finances or doing housework, and subjective burden relates to the feelings and cognitive appraisals associated with caring, such as finding particular behaviours embarrassing, worrying about the future and dealing with excessive demands (Baronet, 1999; Williams & Mfoafo-M'Carthy, 2006). The degree of burden is most often related to the degree of impairment or severity of the disability and symptoms associated with the illness of the care recipient (Magliano et al., 2002; Wittmund, Ulrich Wilms, Mory, & Angermeyer, 2002).

It is important to state, however, that caring has positive elements for some caregivers (Marks et al., 2002; Saunders, 2003; Williams & Mfoafo-M'Carthy, 2006) and is not necessarily universally harmful to carers' psychological wellbeing (Choi & Marks, 2006). For example, in the 2003 ABS Survey of Disability, Ageing and Carers, which examined carers of people with a range of disabilities, 35% of carers indicated that caring had brought them closer to the recipient, compared to 18% who said it had placed a strain on the relationship and 42% who reported no change (Hales, 2007). Caregiving can be a source of achievement, bearing in mind that the experience of caregiving is not necessarily unidimensional either—it can, for example, be difficult and rewarding or burdensome and gratifying (Lemoine, Lavoie, Poulin, Poirer, & Fournier, 2005).

The caring relationship is often thought of as involving only caregiving and care receipt. However, Horwitz, Reinhard and Howell-White (1996) bring attention to the reciprocity involved in caregiving for people with serious mental illnesses—whilst not necessarily a specific and equal exchange, many people with a mental illness are involved in reciprocating support in some way, rather than just being passive receivers. As a result, the caregiving relationship may have some benefits for all parties.
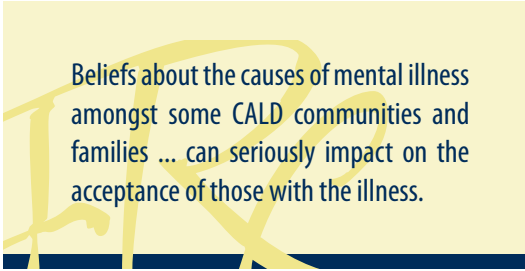
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3. A "primary carer" is defined by the ABS as "a person who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self-care)" (p. 77).

Social contact and networks

Evidence suggests that caring can have a negative impact on carers' social support and networking, an important consideration as support for carers may be a protective factor that helps to alleviate some of the stresses involved in their role. One large-scale Italian study of carers of people with schizophrenia showed that carers had significantly lower levels of social contacts and practical supports than non-carers, but similar to those caring for people with a physical illness (Magliano et al., 2006). An earlier study by the same working group found that whilst two-thirds of relatives of a person with schizophrenia felt someone would care for them if they became physically ill, only about one-third felt they could rely on friends when they were psychologically distressed (Magliano et al, 2002). The onset of caring appears to play a direct role in reducing social support; the 2003 Survey of Disability and Carers showed that almost one quarter of the carers surveyed indicated that their contact with friends had decreased since they had begun caring.

A complexity exists for carers' receipt of social support in respect to the stigma associated with mental illness. In a study investigating the links between stigma, depressive symptoms and coping amongst caregivers, Perlick et al. (2007) found that stigma may erode the morale of carers and result in withdrawal from potential supporters. This could be especially true for families from a CALD background, particularly from cultures that have a strong emphasis on family and community connectedness. Beliefs about the causes of mental illness amongst some CALD communities and families, such as mental illness being a result of bad deeds, criminal behaviour or bad karma, or that mental illness is contagious, can seriously impact on the acceptance of those with the illness (Bakshi, Rooney, & O'Neil, 1999). There may be considerable concern for families about the effect of having a relative with a mental illness on the family's standing in the community (Kokanovic et al., 2006) and in some cultures this may impact on events such as the marriage of children (Youssef & Deane, 2006).

> Beliefs about the causes of mental illness amongst some CALD communities and families ... can seriously impact on the acceptance of those with the illness.

Caregiving and work

The impact of informal caring on participation in the labour market appears significant. In an analysis of carers involved in the HILDA study,[4] Bittman et al. (2007) found that there was time-competition between anything more significant than light care responsibilities and labour market participation, with informal caring duties more likely to win out. As the duration of care increased, income and earnings decreased, possibly as the recipient's health deteriorates. However, some combination of caregiving with an external work role may be beneficial to carers. Bainbridge, Cregan and Kulik (2006) found that individuals caring for a person with a mental disability (including dementia) did benefit from outside work, with fewer stress outcomes the more time they spent at work. What characteristics of the paid employment experience worked to influence caregiver stress outcomes remains unclear, but a *combination* of social interaction, respite and income, all of which are not necessarily offered by other alternatives such as respite care or volunteer opportunities, may be influential.

Specific impacts of caring on the mental health of caregiver

Several studies have specifically examined the mental health impacts of caregiving on the carer, many with a focus on a specific disabling condition or types of condition and/or different groups of carers. Overall, there is consistent evidence that informal caregiving is associated with poorer mental health. The evidence base includes a number of recent large-scale Australian surveys. Edwards et al. (2008) interviewed 1,002 people receiving carer payment or carer allowance. Carers who were looking after family members who had one or more disabilities, including acquired brain injury, physical, intellectual and psychiatric disabilities, were shown to have very high rates of mental health problems, including higher rates of depression than the general population. Family members of the carer also experienced higher rates of depression, with risks greatest in the first year of care. In another Australian study, Cummins et al. (2007) examined the mental health and wellbeing of carers and found that carers had lower collective wellbeing than any other group previously examined in the survey (including sole parents and people who were unemployed). In addition, more than one-third of carers were found to be severely or extremely depressed.

There are a number of factors that may explain the poorer mental health of carers compared to those who do not provide care, such as unemployment, physical health issues, lack of positive social support or financial

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4. Carers in the HILDA study were identified through a mixture of responses to interview questions and the survey questionnaire asking about caring responsibilities, rather than a specific caring question, and may have been caring for people with a range of disabilities. See Bittman et al. (2007) for more details.

difficulties (Cummins et al., 2007). Magliano et al. (2002) found that more than two-thirds of carers of patients with schizophrenia reported feelings of loss, cried or felt depressed, neglected hobbies or had difficulties taking holidays because of the needs of the person with a mental illness. These outcomes indicate the impact of caring on the current mental health of carers, but they may also constitute risk factors for future, more serious, mental health problems.

The relationship between spouses' mental health and caregiving has its own unique set of complexities. The birth of a child may be noteworthy, with one study finding that men whose partners suffered from postpartum depression were more likely to report poor psychological health than those who did not (Roberts, Bushnell, Collings, & Purdie, 2006), possibly impacting on their ability to support their partner effectively. Children may also be affected, with some indication that a father's depression may independently affect infant development in a negative way, and/or exacerbate the impact of a mother's depression on child development (Fletcher, Matthey, & Marley, 2006). As a result, men's mental health in the postpartum period may require more attention from health professionals.
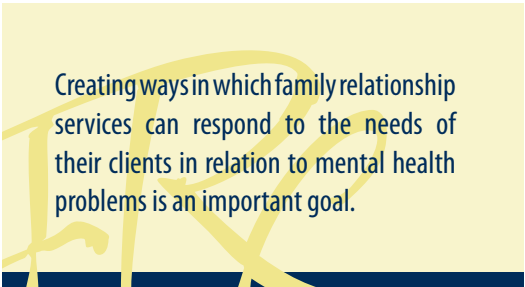
This section has provided a brief overview of research on the impacts on carers of caring for people with a mental illness. It is evident that the interplay between mental health problems in a family member and family functioning is complex. Particular families may also have a susceptibility to mental health problems and/or a lack of particular skills, for example social competencies, which may influence mental health outcomes. Therefore, pinpointing the focus for intervention and responding appropriately is challenging. However, focusing on mental health problems in the context of family relationships may be an important component of a community-wide response to mental health, with some indication that interventions at a household level can be a key strategy to address mental health problems (Butterworth, Rodgers, & Jorm, 2006). Family relationship services, therefore, are in a key position to screen for, identify and deal with mental health problems as they become evident in the therapeutic process. Services have the opportunity to not only address the impact of mental health problems on couple and family relationships, including parenting, but also the impact of these family relationships on mental health and wellbeing.

The following section proposes a number of ways to formulate a family relationship service response to issues outlined in previous sections. The appropriateness of and investment in each response will vary according to service type, practitioner experience and client need, but this section provides a broad guide for matching responses to circumstances.

Section 3: Responding to mental health problems in family relationship services

Despite the challenges of mental health assessment and response within the family relationship services sector, there is an undoubtable public health opportunity within the sector for mental illness prevention and early intervention. As such, creating ways in which family relationship services can respond to the needs of their clients in relation to mental health problems is an important goal. However, one of the most difficult tasks that may arise for practitioners is assessing the scope of a mental health problem for a client, and judging the extent to which it can be dealt with in the current service model. Three approaches seem appropriate. Mental health problems of a less serious nature may be amenable to being dealt with in the context of family or couple relationship counselling or therapy, depending on the skills and knowledge related to mental health problems that the professional possesses. Serious mental illness and substance use or dual diagnosis are likely to require referral to specialist care before family or relationship issues can be addressed.

A third option would be to employ a collaborative approach between specialist family relationship services and mental health treatment services, with a close interface between sectors at a local level to manage the complex interplay between interpersonal relationships and mental health. An example of such a collaborative approach that is currently being developed is the Family Mental Health Demonstration Projects, funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. The Mental Health Support Project at the Family Court of Australia is another example, having established a number of "memorandums of understandings" between individual registries of the Court and local service providers, including mental health services.

> Creating ways in which family relationship services can respond to the needs of their clients in relation to mental health problems is an important goal.

Assessment of mental health problems

Assessment procedures and referral options are the cornerstone of any of the above approaches, as is the extent to which the mental health problem can be dealt with in the context of the work being already undertaken with the client/s. Unfortunately, no simple mental health assessment exists that would indicate the most appropriate approach for any one individual. Complicating this issue is that potential clients with mental health problems may choose family relationship services as they are not directly associated with mental illness, thus reducing the stigma attached to help seeking. Unless a client willingly discloses mental health problems, standardised questionnaires used to determine mental health status need to be utilised with great sensitivity to ensure that the client does not feel that such an approach is inappropriate or impersonal. Approaches need to "do no harm" in terms of engagement and psychological wellbeing, and there is a need to ensure that any responsibility for, or guilt regarding relationship dynamics is not automatically assigned to a client who does have mental health problems.

> Potential clients with mental health problems may choose family relationship services as they are not directly associated with mental illness, thus reducing the stigma attached to help seeking.

In the absence of information gleaned from formal assessment tools, indicators of mental health risk may include an inability to fulfil daily roles (e.g., parenting, work), a feeling of being overwhelmed by life circumstances, a fear of "losing it" (particularly with children), and/or specific suicidal thoughts.

Suicidal clients

Suicidal thoughts and behaviour can be considered one of the most extreme manifestations of mental illness, although it is important to point out that mental illness is not necessarily a precursor and nor does mental illness always lead to suicidal behaviours. There is a continuum of suicide risk that must be kept in mind as part of a legal duty of care towards any clients attending family relationship services. Organisations should have a written plan of action for dealing with screening and assessment for suicide risk and to respond to varying levels of need, for example, referring to emergency services or crisis mental health services. Members of staff need to be familiar with the recommended procedures, and may need training in responding to suicidal people. A plan for assessing and managing distressed clients on the telephone may also be appropriate in order to manage concerns for their safety.

Referral

If there is no immediate suicide threat, referral to specialist mental health services will primarily depend on two factors: the availability and accessibility of appropriate services; and the willingness of the individual to utilise appropriate strategies and access help.

The availability of specific mental health services will vary between geographical locations. Some areas have dedicated mental health services whereas others will offer mental health responses as part of a more general approach; others may have few or no specialist mental health approaches. Service providers and practitioners will also vary in their level of understanding of, sensitivities towards, and expertise in dealing with mental health problems. General practitioners (GP) and/or Community Health Centres are a typical first port-of-call in many areas, which may be partly attributable to people's perception that there is less stigma attached to visiting these services for mental health problems (Judd et al., 2006). A referral from a GP may also be necessary to access some specialist services, and is needed to claim the Medicare rebate for appointments with a psychologist. Options such as visiting specialists or tele-counselling (e.g., Lifeline, Mensline) may be the only available response in some areas of Australia. Many tele-counselling users have expressed satisfaction with, and benefits from, these services (Urbis Keys Young, 2003). For young people in particular, web-based help services may be helpful, particularly for stigmatised problems such as mental illness (Nicholas et al., 2004).

Many individuals may be resistant to the suggestion of specialised mental health care, even if they are clearly in need of help. Resistance may be a result of a number of issues, including:
- stigma associated with mental health problems;
- concerns about the influence of any disclosure on court proceedings, particularly in the case of family law issues and/or child protection;
- concerns about the financial cost of treatment; and/or
- beliefs about the efficacy of treatments, or side effects of treatments, especially certain medications.

Each of these may need to be addressed by reassuring individuals and their families that mental health problems are common and that they are likely to benefit from care, particularly when received early. The provision of accurate information regarding treatment options, including costs, can be provided and certain myths dispelled (e.g., that modern antidepressants are "addictive"[5]). The level of ongoing support that can be offered by the professional, if referral outside the organisation occurs, may need to be addressed, and appropriate lines of responsibility between the two agencies established.

Dealing with mental health problems within the family relationship service (rather than referring to another service)
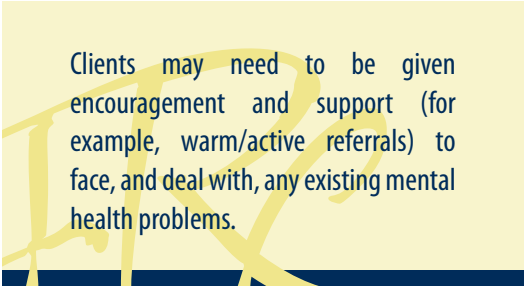
Depending on the circumstances for the client and service, there may be an opportunity to deal with presenting issues in the context of family and relationship interventions. This section provides guidelines for three key ways in which practitioners can help to alleviate mental health problems.

Information

Information on recognising mental health problems, local sources of treatment and support, and self-help approaches that promote wellbeing or alleviate psychological distress should be readily available to both practitioners and clients. Sources of information and resources are provided in the Useful Resources section of this paper. Fact sheets on many aspects of mental illness can be downloaded from a range of websites as provided.

Encouragement to deal with mental health problems

Clients may need to be given encouragement and support (for example, warm/active referrals) to face, and deal with, any existing mental health problems. In the case of family separation, clients may feel comforted to know that distress and depression are a common and normal response, but it is equally important not to assume that the passing of time will automatically lead to healing. Immediate support and information can help individuals feel better under many circumstances, and encouragement to pursue efficacious self-help strategies and professional treatments may be important for more serious issues.[6]

> Clients may need to be given encouragement and support (for example, warm/active referrals) to face, and deal with, any existing mental health problems.

Problem solving

Problem solving skills as a form of active and positive coping tend to be assumed in many cases, yet particularly when an individual is under stress, teaching or reinforcing these skills may be important in preventing and ameliorating mental health problems. Individuals who access family relationship services may have many competing worries, such as financial difficulties, housing, parenting or work-related problems, and possibly serious concerns such as domestic violence or child abuse. Problem solving skills may help them to deal directly with, or minimise the stress related to, one or more of these issues across prevention, early intervention, treatment and recovery phases, which may help to relieve the pressure for clients.

As stated previously, all of the above suggestions will be dependent on service models and the skills and experience of service providers and practitioners. In services where mental health and mental illness are openly discussed and addressed, and resources are available, many of these suggestions will be a matter of common sense. It is more critical, instead, to be aware of the needs of a service where staff members are less likely to have a knowledge base that includes mental health issues. This has the potential to result in a lack of confidence and skill in assessing and responding to these issues, resulting in limited effective engagement and management of clients with mental health needs. However, due to the prevalence and impact on families and relationships, overall, family relationship services should incorporate strategies to promote mental and psychological wellbeing and reduce mental health symptoms as part of their everyday operations.

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5. See http://www.beyondblue.org.au/index.aspx?link_id=7.981&tmp=FileDownload&fid=723 for more information on antidepressants.
6. See http://www.beyondblue.org.au/index.aspx?link_id=1.13 for more information on efficacious treatments.

Particular needs of carers

A recent report on living with a mental illness identified the following needs of families and carers (Wesley Mission, 2007):

- support, for dealing with issues such as challenging behaviours;
- education, particularly at the onset of an illness;
- understanding and empathy, for example, someone to listen to the difficulties they face; and
- respite for exhausted families, who may also need assistance with feelings of guilt.

Outcomes of a carer consultation by the Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI) show that supportive professionals have an enormous impact on carers' ability to care effectively and access appropriate treatment for the person with a mental illness. Professionals allowed carers to discuss how the mental illness was affecting their lives, and facilitated access to other carers in a similar position (ARAFEMI, 2007). Reinforcement of social networks and addressing barriers that influence relatives' access to social networks and group support is important (Magliano et al., 2006), as social support is seen as a protective factor that facilitates effective family functioning and coping (Perlick et al., 2007; Saunders, 2003). As stated by Edwards et al. (2008), the challenge is to give families an opportunity to care whilst minimising the associated social and economic costs.

Transitioning into a carer role appears to be a key point at which early intervention may assist the carer's role adjustment. Marks et al. (2002) found that both men and women experienced a greater increase in depression and decline in happiness, compared to non-caregivers, when transitioning into spouse care. Spouse care is likely to incorporate important medical and life decisions, and any existing marital disagreement may make this even more difficult, leading to further distress and demoralisation for the carer (Choi & Marks, 2006). A spouse's burden could also be an important point of intervention when maternal depression is evident, as supportive partners are an important factor in protecting women from relapse (Burke, 2003). Burke argued that joint assessment and education is important for couples for two reasons; carers need to know how to cope in order to effectively help, and one partner's health affects the other's health.

> Both men and women experienced a greater increase in depression and decline in happiness, compared to non-caregivers, when transitioning into spouse care.

Stigma

Fear and stigma relating to mental health, in both professionals outside the mental health service system and in the community, cannot be underestimated. Many studies have indicated that stigma is the most prominent issue related to seeking help for mental health problems (Corrigan, 2004; Kelly & Jorm, 2007). As stated previously, family relationship services are in a good position to respond to mental health problems as they are not necessarily directly associated with mental health service delivery. Whilst a comprehensive discussion regarding stigma and responses to addressing stigma is outside of the scope of this paper, it seems timely to consider the specific role that non-mental health services can play in ameliorating the damaging effects of stigma related to mental illness.

Summary

Mental health disorders are a common occurrence in Australian society and affect people of all ages, gender and socio-economic status. Mental health problems and illnesses can have a considerable effect on families and relationships, with issues such as a lack of diagnosis, treatment use and efficacy, chronicity and propensity all impacting on a family's experience of mental illness. Likewise, relationship and family problems can have a significant impact on mental health. Both living with and/or caring for someone under these circumstances not only impacts on the wellbeing of the person with the illness, but those around them.

Considering the circumstances under which many clients would access family relationship services, it would seem likely that mental health and wellbeing would play a prominent role in their reasons for seeking help. Responding to mental health issues will depend on the level of practitioners' understanding, knowledge and skills, as will the extent to which they can intervene, assist, and/or incorporate such issues into service provision. Whilst providing mental health treatment to a person who has a mental illness may be outside of the scope of the practitioner's role and/or knowledge and skill base, working with the family surrounding the person, or working with the person with a mental health problem regarding their relationships and family, may still be an option.

The needs of carers and family members who are impacted upon by a member's mental illness should be attended to in their own right. This is in contrast to many current responses in the mental health service system that only consider these needs in relation to how they may benefit their unwell family member. There is also a public health opportunity within family relationship services to help ameliorate the stigma associated with mental illness and intervene early to prevent and reduce the risk and onset of mental health problems.

Resources: Mental health and families

Australian Drug Foundation

http://www.adf.org.au

The Australian Drug Foundation provides a range of information on drug use for workers, individuals and families.

Australian Institute for Suicide Research and Prevention (AISRAP)

http://www.griffith.edu.au/health/australian-institute-suicide-research-prevention

The aim of the Australian Institute for Suicide Research and Prevention is to promote, conduct, and support comprehensive intersectoral programs of research activities for the prevention of suicidal behaviours in Australia.

Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet)

http://www.auseinet.com/

Auseinet assists a range of sectors to implement mental health promotion and illness prevention approaches in their respective settings. The website provides up-to-date information, practical resources, an online journal, workforce development tools and an alert service, amongst many other features. The site has separate sections on Aboriginal and Torres Strait Islander and consumer/carer information.

beyondblue: The National Depression Initiative

http://www.beyondblue.org.au

beyondblue aims to increase community awareness of depression. The website provides an enormous amount of information on depression, anxiety and bipolar disorder, with resources, research reports, information on projects, symptom checklists and links. There is also a directory of Medical and Allied Health Practitioners in mental health available.

BluePages

http://cmhr.anu.edu.au/bluepages.php

A comprehensive online source of information about depression, including symptoms of depression and how it is diagnosed, summaries of medical, psychological and alternative treatments that work for depression (and those that don't) and an extensive list of people, organisations, books, web-sites, and other resources that may be helpful to people who are depressed.

Children Of Parents with a Mental Illness (COPMI)

http://www.copmi.net.au/

COPMI provides information and access to resources, support programs and tips for family members across Australia where a parent has a mental illness and for people who care for, and work with, them. The resources are accessible through the website. COPMI also works with the media, researchers, educators, service organisations, consumers, carers and others.

DepressionNet

http://www.depressionet.com.au/

Resources to locate help and healthcare professionals as well as information about causes, symptoms and various treatment options in managing depression.

LIFE: Living Is For Everyone

http://www.livingisforeveryone.com.au/

The Living Is For Everyone (LIFE) website is a world-class suicide and self-harm prevention resource. Dedicated to providing the best available evidence and resources to guide activities aimed at reducing the rate at which people take their lives in Australia, the LIFE website is designed for people across the community who are involved in suicide and self-harm prevention activities.

Mental health and wellbeing: Australian Government initiatives

http://www.mentalhealth.gov.au

This site hosts information on the Australian Government's role and contributions to mental health reform activities in Australia.

Mental Health First Aid

http://www.mhfa.com.au/

Mental Health First Aid is the help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves. The course is a 12-hour course developed in 2000 by Betty Kitchener and Professor Tony Jorm with the aim to improve the mental health literacy of members of the Australian community, and is conducted throughout Australia.

Multicultural Mental Health Australia (MMHA)

http://www.mmha.org.au/

MMHA provides national leadership in building greater awareness of mental health and suicide prevention amongst Australians from culturally and linguistically diverse (CALD) backgrounds. MMHA actively promotes the mental health and wellbeing of Australia's diverse communities through a series of campaigns, projects and information fact sheets. MMHA also produces a series of resources and training for specialist and mainstream mental health professionals.

Reach Out!

http://www.reachout.com.au

Reach Out! is a service that helps young people get through tough times. It provides information and support on a range of issues including depression and anxiety; drugs and alcohol; family, friends and relationships problems; suicide, loss and grief; sex and sexuality; and dealing with the pressures of school and university.

SANE Australia

http://www.sane.org.au

SANE supports education and research in mental health, with factsheets, information, resources, extensive links, guides for families and people with mental illnesses, stories, etc.

Suicide Prevention Australia

http://www.suicidepreventionaust.org/Home.aspx

Suicide Prevention Australia is a non-profit, non-government organisation working as a public health advocate in suicide prevention. SPA is the only national umbrella body active in suicide prevention throughout Australia, promoting community awareness and advocacy; collaboration and partnerships between communities, practitioners, research and industry; information access and sharing; local, regional and national forums, conferences and events.

Youthbeyondblue

http://www2.youthbeyondblue.com/ybblue/index.aspx?link_id=62

Youthbeyondblue aims to give advice on ways to recognise depression and how to talk about it, and to let young people know what services are out there to help. Youthbeyondblue's all about getting the message out there that it's okay to talk about depression, and to encourage young people and their family and friends to get help when it's needed.

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