Submission by

Katy Curtis

Terms of Reference:

1. **The factors that increase the risk of abuse and neglect occurring and effective preventative strategies.**

'Early in life' programs; through in home service, neighbourhood playgroup, preschool and school, provide robust preventative strategies. Interventions are ideally; A/ strength based (not deficit-based and therefore stigmatising, viz interventions targeting 'risk' factors, where this approach has been demonstrated to throw up 'false' positives), B/ attachment-based viz promote the carer-child relationship, C/ develop the competence and social confidence of the carer, and D/ promote the cognitive and Speech & Language development of children (closely linked with attachment – and independent of the attachment figure's IQ) Programs which meet the above include Parent-Infant Mother Goose Playgroup (www.nald.ca/mothergooseprogram) and Warrnambool-based "Reading Discovery" (www.readingdiscovery.org.au)delivered in the home. The Warrnambool agency works with disadvantaged, indigenous and refugee families. It also works with parents and their children in out of home care, as a tool for building the parent-child relationship and a bridge towards re-unification.

2. **Strategies to enhance early identification of risk, including the role of adult, universal and primary agencies.**

Collocated consultancy roles, between agencies where particular issues within CP client groups are over-represented in the CP system, provides a cost-effective and robust mechanism for; understanding presenting issues through a specialist framework; identifying issues early in their presentation to CP; accurate information regarding relevance to parenting capacity and impact on children; consideration of and nature of appropriate support. The Bendigo project (Collaborative Family Practice, 2004 – 2007) was a recommendation of an investigation into mental health issues of parents of children on statutory orders (Child Maltreatment and Parental Mental Health Problems, O'Connor, 2002). The Report, commissioned by Bendigo Health, recommended the placement of my Adult Mental Health colleague's position locally and also a CAMHS consultant in the Community Adult Mental Health teams. The Collaborative Family Practice Project had an Interim evaluation (2005) and a final evaluation (2007). Both evaluations identified the usefulness to both staff and families of the consultancy positions. The Interim evaluation also identified that in 2004, 50% of dependent children whose parents were then receiving case management from Community Adult Mental Health Teams in Bendigo, either had a history or had current involvement with Child Protection. The three reports are attached.

CP staff are not specialists in intellectual disability, mental health or Drug & Alcohol knowledge, for example. Yet they repeatedly need to make judgements about recognition, degree of severity and suitable interventions of such issues. Effectively they 'triage' these issues when it is neither their brief nor their training. In my own field I have concern regarding the level of mental health issues in the CP population, stated by DHS to be less than 30%. My anecdotal impression is that it is far higher, closer to 70% or 80%. De Bellis et al (2001) determined the levels of diagnosable mental illness in parents and carers of children in the US Child Protection system to be between 80% and 90%, with multiple co morbid psychiatric diagnoses. Their work excluded

diagnosis of Personality Disorders, which is an additional mental health concern. While the local CP system is very arguably not an equivalent of the US system, the discrepancy and my own experience would indicate the prevalence of mental health issues is far higher than current recording methods indicate.

3. The quality, structure, role and functioning of . . .:

Through ChildFirst or Child Protection, families are referred to Family Services (voluntary) agencies. Should the families not engage (it appears common), agencies have limited options for providing support and intervention. It would be relevant to explore the link between CP re-notification rates and these families. Family Services provide programs funded for fixed time interventions. This stymies efforts to match support to families' needs. More flexible funding and service delivery models are needed the base structure of which is built round the needs of families. Family Services staff need robust working knowledge of child development, attachment promoting interventions, the effects of trauma and appropriate interventions. Training through such sources as Dr Bruce Perry (www.childtrauma.org)is excellent and up to date, in a fast emerging area of knowledge.

4. The Interaction of departments and agencies . . .

Support for family services agencies in their recognition, understanding and work with families where there are parental mental health issues, is currently provided by the "Families where a Parent has Mental Illness" (FaPMI) program. The funding for this program, while an excellent start, is currently extremely under-resourced for the tasks assigned to it.

As indicated in 2. (Strategies to enhance early indication of risk . .), where particular issues, such as mental health, D&A and ID are disproportionate in the client population, targeted collocated consultants would provide much more adequate support for workers, as well as providing a means of developing and strengthening interagency understanding, relationships and cooperation.

7. Measures to enhance the government's ability to: plan for future demand for family services, . . .

Current funding formulas, based largely on population, result in very small numbers of staff in rural regions, who may then be thinly distributed over large areas. This leaves rural staff isolated professionally and personally, having responsibilities for covering great distances (research indicates 25% of EFT is lost to travel). They can also carry significant clinical burden in their geographical areas because of this, despite support provided by phone or through videoconferencing.

Rural families are required to travel hours for services, leaving commitments and family members for blocks of time. Instead, it is recognised that many families opt not to receive services. Realistic service structures need to be developed which provide adequate clinical cover (eg during absences such as Annual Leave and Sick Leave), provide sufficient staffing to meet relevant criteria to function in a Team format (eg discipline diversity allowing for collaborative work, a range of role functions, adequate EFT to provide accessible and sustainable services to families, and support/consultation to other agencies, as a minimum).

A number of issues contributing to the complexity of families involved with Child Protection and Welfare agencies have their roots in modern societal changes. The ‘modern’ family seems to spend much less time interacting (eg eating and talking together at the dinner table, or seeking enjoyment and entertainment as a family unit), leading to increased risk to vulnerable family relationships, and to inadequate socialisation including inadequate speech and language development. Humans evolved interacting in communities. Secure and meaningful human interaction is still required for the optimal promotion of development and wellbeing in the young.

Exposure to themes, once considered “adult” , are now much more common experiences for children and young people (eg themes in pop songs, behaviours of ‘celebrities’, advertising of alcohol relating to ‘desirable’ images etc). Strong leadership is required to protect children and young people in our society, so that adults understand much better, and protect, the needs of the young, while the adults retain opportunity to exercise personal choices.

Child Maltreatment and Parental Mental Health Problems

An investigation into the mental health issues of parents of children on statutory orders - Final Report

11 June, 2002

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Foreword

The initiative for an investigation into the mental health issues of parents of children on statutory orders came from those working in the field. They identified the mental health issues of this group as an area requiring further investigation. They recognised that significant changes in the framework for both Department of Human Services Child Protection and Psychiatric Services have had a direct impact on service delivery.

This investigation examined existing frameworks for service delivery and provides the groundwork for a more coordinated response to the often complex needs of families with mental health issues who are also involved with Child Protection.

This report is also a timely contribution in an area that has received little research attention in the past. The report identifies the paucity of Australian research in this area and makes recommendations for further research initiatives. There are clear benefits to be gained from a greater understanding of risk and protective factors for these families.

I am confident that this document will provide the impetus both for further research initiatives in this area and for strategies to provide a more co-ordinated response to families affected by mental illness who are also involved with Child Protection leading to better outcomes for these vulnerable young people and their families.

Professor Fiona Judd
A/Executive Director
Bendigo Health Care Group
Psychiatric Services

Executive Summary

This project was initiated by the Bendigo Health Care Group and funded by the Department of Human Services as a result of concerns that many children under statutory orders in the Loddon Campaspe/ Southern Mallee Area may have parents with mental health problems. The specified purpose was to undertake consultation with key stakeholders involved in the area of mental health issues of parents of children on statutory orders and examine available literature and data, with the aim of identifying appropriate models of service delivery.

The literature review by necessity almost totally concerned non-Australian studies, as there was found to be a virtual absence of published scientific investigations or evaluations from Australian sources. This revealed the value of service collaboration and integration (both within mental health - eg. between CAMHS and Adult Psychiatric Services - and between mental health and other agencies such as child protection), and the key role of community-based early intervention programs.

The absence of practices advocated in the literature and local consultation indicated that Protective Services and Psychiatric Services were not collaborating to the extent needed to meet the interests of children and adult clients. The agencies were found to be poorly coordinated and distrustful. This resulted from resource constraints and the emphasis placed by Adult Psychiatric Services (in particular) on the parent as primary client, and misconceptions held by both agencies about the roles and statutory responsibilities of the other. However both agencies also recognised the need for improvement.

It was recommended that an enhanced program to identify and potentially reduce the role of parental mental health problems in child maltreatment would consist of four elements:

1. An increased orientation of Adult Psychiatric Services towards the children of their clients, facilitated by a new position trained in child and adolescent psychiatry but located in Adult Psychiatric Services. This position would also work with CAMHS to enhance their work with parents and understanding of Adult Psychiatric Services.
2. Improved communication, collaboration, and joint understanding of the needs of Protective Services and Psychiatric Services, achieved by an Adult Psychiatric Services officer being co-located with Protective Services.
3. A prevention/early intervention home visiting program, conducted by community nurses (such as child and maternal health nurses) and directed to parents during the period from prenatal to two years of age. While this program is outside the mandate and responsibility of either Psychiatric Services or Protective Services, it would play a valuable preventative role as well as facilitate the early identification of at-risk families and their referral to appropriate services.
4. Initiation of a Family Support Consultative Committee (FSCC), a forum to discuss and promote the participation of the full range of health and community services in joint service planning and service provision concerned with child abuse. The proposed FSCC would also act as an advisory group to the proposed early intervention home visiting program.

The basis for the recommended options are described and detailed in Chapter G.

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A Introduction

A1 The project

This project was initiated by the Bendigo Health Care Group as a result of concerns that many children under statutory orders in the Loddon Campaspe/ Southern Mallee Area may have parents with mental health issues. The specified purpose was to undertake consultation with key stakeholders involved in the area of mental health issues of parents of children on statutory orders and examine available literature/ data to investigate:

- the mental health issues of parents whose children are on statutory orders under the Children and Young persons Act 1989 with the Department of Human Services Protective Services and
- possible model or models of service delivery for parents of children on statutory orders which could be trialed and evaluated

Specific outcomes were to be:

a. A critical review of the literature in relation to mental health issues of parents whose children are on statutory orders, and models of service delivery for meeting the needs of these individuals.
b. Identification of existing databases which provide information relevant to parents of children on statutory orders who have mental health issues.
c. The identification and critical evaluation of existing models of service delivery of this target group both in Australia and overseas.
d. Collection of relevant data with a focus on local experience, from Psychiatric Services staff and staff of Protective Services in the Loddon Southern Mallee Region.
e. Identification of legal and ethical issues that will need to be addressed before further research can be undertaken.
f. A project report that
    (i) summarises the findings of work including the literature review, critical analysis of strengths and weaknesses of existing models of service delivery, summary of existing data and local experience, and
    (ii) identifies gaps in knowledge and proposes priority areas for research, and
    (iii) describes a proposed model or models for service delivery in the Loddon Southern mallee Region.
g. Identification of possible sources of funding for research in this area.

A2 Method

The project composed of two primary elements, of equal importance:

- consultation with professionals in Mental Health and Protective Services to understand the local situation issues and identify locally appropriate approaches[1] ; and
- A literature review of information relevant to the mental health issues of parents of children on statutory orders.

While this project had the aim of investigating the mental health issues of parents of children on statutory orders, it was soon discovered that there is *virtually no literature on this group per se.*

There is, however, a literature on parents who engage in child abuse, and on the mental health problems of these parents. Hence the approach was adopted to explore evidence on the relationship between adult mental health problems and child abuse, which would concurrently identify features likely to be relevant to parents of children on statutory orders.

[1] Discussions were not held with parents or families due to concerns with the sensitivity of the issues raised

B Evidence on the relationship between child abuse and parental mental health problems

B1 Parental mental health problems can be a risk factor for child abuse

B1.1 'Mental health problems' and the 'ecological perspective'

Child physical abuse and neglect[2] were once seen as essentially social problems, conflicts precipitated by social stress: parents who maltreated children were not considered to be suffering from a psychiatric disorder (Reder and Duncan, 2000).

This approach has been modified following evidence that child abuse and neglect is frequently associated with parental depression, personality disorder, and substance abuse. As many mental health professionals do not consider such conditions to represent psychiatric disorders, Reder and Duncan (2000) have suggested that these aspects may be best referred to as 'mental health problems'[3].

The current dominant view is the 'ecological perspective' (Kaplan, Pelcovitz and Labruna, 1999), with child maltreatment seen to result from complex interactions between risk factors within the individual abuser (eg. psychiatric disorder), family factors (eg. single-parenthood) and environmental stresses (eg. social isolation)[4].

B1.2 Association between child abuse and parental psychoses

There is evidence of an association between child abuse and parental psychoses. Glaser and Prior (1997) reviewed the cases of all children whose names were on the Protection Registers of four English local authorities, and found parental mental illness including suicidal attempts, anorexia nervosa, depressive psychosis and schizophrenia was present in 31 percent of cases (cited Reder and Duncan, 2000).

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[2] While local data is not freely available, health and human services face a major challenge in developing effective responses to child abuse. The available evidence suggests child abuse is widespread, and fatal abuse a major cause of death for very young children. UK estimates suggest 5% to 14% of the child population suffer from physical abuse at the hands of their parents (Oates, 1997, using a broad definition of non-accidental injury). In the US there were almost 1 million substantiated cases of child maltreatment in 1997 (Repucci et al, 1999). Moreover in both the UK and the USA, child maltreatment is one of the top five most common causes of death to young children (Creighton, 1993, cited Browne, 1995), with the youngest the most vulnerable to fatal abuse. In the U.K. 60% of all child homicides involve a child under the age of five and 22% on the first day of life (Oates, 1997). In the U.S. in 1996 more than 75% of maltreatment fatalities involved children younger than age 3 years (Kaplan, Pelcovitz and Labruna, 1999). Australian data revealed child protection substantiations of 6.3 per 1,000 in Victoria in 1999–00 (AIHW, 2001).

[3] For example, Westman (2000) suggests that 'from a psychiatric perspective, personality disorder is diagnosed when adults present with abnormal patterns of behaviour, which do not represent the presence of a mental illness and are distinguishable from any co-morbid process. The maladaptive behaviour may or may not cause distress to the individual but usually causes distress in intimate interpersonal relationships and in the individual's relationship with society.'

[4] See also MacMillan (2000)

The association also applies to cases of severe or fatal abuse. Taylor et al (1991, cited Oates, 1997) examined cases of parents convicted of serious child abuse in Boston, USA. More than half of the parents had received psychiatric treatment and almost a third had been admitted to hospital; 42% of the mothers were found to be suffering from either major depression or schizophrenia.

In the UK a study commissioned by the Department of Health of parental psychiatric disorder and fatal child abuse revealed that 25% of the perpetrators were mentally ill, and of these ill perpetrators 40% were schizophrenic with high rates of admission, recent psychiatric contact and drug co-morbidity (Falcov, 1996, cited Oates, 1997).

In addition a review of world literature on parents who murder their children concluded that 67 per cent of the murdering mothers and 44 per cent of the fathers had been psychotic, while depression was evident in 7l per cent of the mothers and 33 per cent of the fathers (Resnick, 1969, cited Reder, McClure and Jolley, 2000a).

B1.3 Maternal depression a risk factor

Maternal depression appears the mental health problem most commonly cited as being associated with child abuse.

Chaffin et al (1996) reported a survey of 7,103 parents to prospectively examine whether "substance abuse disorders and other psychiatric disorders", are risk factors for physical abuse and neglect. Depression, along with substance abuse disorders, were concluded to be strong risk factors for physical abuse, while social and demographic variables were found to be limited predictors of maltreatment

Kaplan, Pelcovitz and Labruna (1999)[5] observed that compared with controls parents who maltreat their children are often shown to be depressed, or to have a history of attempted suicide (citing Hawton et al, 1985). Falkov (1997) also found an association between parental depression and child maltreatment (cited Reder and Duncan, 2000).

Oates (1997) observed that among women who injure their children the commonest psychiatric diagnosis is a mixture of mild depression and anxiety associated with personality dysfunction.

B1.4 Substance abuse associated with child abuse

Chaffin et al (1996, see B1.3) concluded that substance abuse disorders were strongly associated with the onset of both abuse and neglect. In contrast, Wilson et al (1996) reviewed 118 studies that examined the association between antenatal psychosocial risk factors and adverse postpartum outcomes in the family. They concluded that while child abuse (and abuse of the mother by her partner) were strongly correlated with a history of lack of social support, recent life stressors, psychiatric disturbance in

[5] Kaplan et al reviewed 'clinically relevant literature on the physical and emotional abuse and neglect of children and adolescents published during 1988 and 1998'.

the mother and an unwanted pregnancy, child abuse was only mildly associated with alcohol or drug abuse.

Kaplan, Pelcovitz and Labruna (1999) reported that numerous studies have found substance abuse disorders, as well as maternal affective disorders, to be related to parent-child interactions marked by verbal aggression directed toward children and decreased emotional nurturance.

Reder and Duncan (2000) observe several studies have indicated that parental substance abuse is a risk factor for child abuse, eg. citing Famularo et al (1986) reporting that 52% of cases of serious child abuse or neglect brought before the courts had at least one parent with a history of alcoholism, and citing Murphy et al (1991) who reported involvement in 43% of cases.

It appears there have been difficulties in separating substance abuse and other factors related to that misuse and child abuse. Drummond and Fitzpatrick (2000) observed that there appears have been little work studying families where substance misuse occurs but is not associated with other evidence of family dysfunction.

B1.5 Parental personality disorder and risk to children

Fellow-Smith (2000) notes that personality disorders are likely to be associated with functional problems such as unemployment, social isolation, relationship difficulties, aggression, irritability, hostility, alcohol, drugs and offending behaviour, all of which influence parenting.

Westman (2000) also observed that as personality disorder can be considered to be a disorder of interpersonal functioning, its presence in a parent who experiences pervasive and persistent symptoms, associated with chronic psychiatric problems and social and interpersonal impairment, "is bound to impact upon child care".

Westman noted the study of Rutter and Quinton (1984, cited Westman, 2000) who conducted a 4-yr prospective study of the families of 137 newly referred psychiatric patients with children at home aged under 15 yrs. Teacher questionnaires were obtained yearly for all children of school age in the families and for age, sex and classroom matched controls, along with a control group of families in the general population. Rutter and Quinton found that patients' families had much higher level of family discord as compared to control families, and that the children of psychiatric patients had an increased rate of persistent emotional/ behavioral disturbance. This disturbance was interpreted to be greatest where there were high levels of exposure to hostile behaviour in the home associated with parental personality disorders, as compared with the risks associated with parental depression and psychosis.

An alternative way of considering the Rutter and Quinton findings was put by Reder and Duncan (2000). They observed that the children were primarily affected by their parents' general functional behaviour, and that it is the ***manifestation of the parents' problems through their behaviour*** that best describes the effects of parental psychiatric disorder on children's psychological welfare and development. The children of those with less severe mental illness and alcoholism appeared to do worse

than those with psychotic parents, despite the fact that the latter had more acute illnesses and more hospitalisation.

Westman (2000) observed that community surveys have given prevalence rates of personality disorder as 10-13 per cent of the population, and many of these individuals will have dependent children. Westman stressed that unlike the symptoms and signs of mental illness, and as with measurement of traits in the normal population, personality dysfunction can only be inferred from maladaptive behaviour. As a result the reliability of the diagnosis in clinical practice is poor.

Westman concluded a diagnosis of personality disorder had limited utility in child maltreatment. The factors responsible for this were:

- the diagnosis had difficulties with validity, reliability, and impact on clinical care, and remained a controversial diagnosis in adult mental heath practice.
- family focused intervention were more important than considerations of whether the parent has underlying abnormalities of personality.
- in the context of adult mental state psychiatric assessment in child care proceedings, failure to reveal symptoms meeting criteria for a personality disorder could lead to the erroneous assumption that the individual's parenting ability is adequate.

B1.6 Generational transmission of parental mental health problems, and potentially child maltreatment

There is evidence that psychiatric morbidity in adults and child maltreatment can lead to children developing the anxiety and mood disorders characteristic of many of their maltreating mothers (and possibly parents), with the potential for continuing a cycle of maltreatment.

De Bellis et al (2001) in a study of 53 maltreating families with DSM III R and IV psychiatric diagnoses and their children reported that the majority of the maltreated children and adolescents reported anxiety disorders, especially post-traumatic stress disorder (from witnessing domestic violence and/or sexual abuse), mood disorders, suicidal ideation and attempts, and disruptive disorders. Most maltreated children (72%) were seen to suffer from both emotional and behavioural regulation disorders with the consequent likelihood of intergenerational transmission of maltreatment.

Consistent with this, Lipman et al (2001) examined the prevalence of, and association between, childhood abuse and psychiatric disorders in single and married mothers. Using a self-administered questionnaire to collect information on childhood physical and sexual abuse, they concluded that mothers who reported having experienced childhood abuse went on to experience more psychiatric problems when they themselves became mothers.

B2 Conclusion

Many adult psychiatric patients are parents (eg. Oates,1997, and most psychiatric patients can and do parent adequately (Reder and Duncan, 2000).

While there is an association between fatal abuse and parental psychoses, the most common forms of mental health problem cited in association with child abuse seem not to be psychoses, but, eg. maternal affective disorders, and hostile behaviour to children that might be termed personality disorders. A recent community survey (Walsh et al, 2002) confirmed the association between psychiatric disorder and child abuse, particularly in the presence of parental personality disorder. Substance abuse seems also to be commonly found where there is family dysfunction. The picture is further complicated by the interactive role of other environmental and family factors such as poverty, unemployment, young maternal age and single parent hood (see MacMillan, 2000). The possibility of inter-generational transmission of child abuse related to adult mental health problems (and by extension the importance of early intervention programs) has been indicated by the work of De Bellis et al (2001).

Even where psychiatric morbidity is classified and confirmed, child abuse and neglect can often be most fruitfully considered as the product of a poor parent-child relationship (Browne, 1995), or, as put by Reder and Duncan (2000), the effects of parental psychiatric disorder on children's psychological welfare and development are best described by the manifestation of the parents' problems through their behaviour.

Actions mental health services can take to identify possible adverse parenting behaviours from parents with mental health problems and collaborate to ensure the safety of children are discussed in **Chapter C**.

Programs that have shown benefit in supporting appropriate parenting behaviours and preventing harmful behaviours of adults towards children are discussed in **Chapter D**.

C When parents with mental health problems encounter mental health services: the need for investigation and service coordination

C1 The interdependency of the mental health of parents and children

It is apparent from the literature discussed in section B that recognisable parental mental health problems are a risk factor for child maltreatment, and investigation of the presence of children and the nature of parental behaviour towards their children is indicated in the day to day operations of adult mental health services.

This is supported by a recent chorus of calls for action. Thus Reder and Duncan (2000) state that adult mental health and substance misuse specialists should not focus exclusively on their patients as individuals, but be more sensitive about risks to children in the family, and, in turn, children's services have a responsibility to keep

colleagues working with adults informed and aware of child protection issues and to refer to them at an early stage parents whose mental health is causing concern.

In other words a focus of service delivery should include the parent-child unit. While there is a need for specialist children services and specialist adult services, there are times when they need to work together for the best outcomes. A change of perspective and service integration is needed to encompass parenting.

Such a move towards considering and addressing the social context of parents and children is supported by evidence that parental psychiatric disturbance tends to be associated with children with psychiatric disturbance.

Reder, McClure and Jolley (2000a) noted for example evidence of linkages between maternal depression, and depression, conduct disorder or substance misuse in their children (citing Schwartz et al, 1990); parental psychiatric diagnosis and children's disruptive behaviour and obsessive compulsive disorder (citing Hibbs et al 1991); and between criticism shown by mothers with anxiety disorders and the occurrence of psychiatric disorders in their children. (citing Hirshfeld et al, 1997).

Singer, Tang and Berelowitz (2000) described a study of a community sample of mothers with major mental illness (at leat one hospital admission, and currently attending outpatients) and with children between 6-16 years of age. Out of 29 mothers, 12 allowed access to their children, and it was reported that the children had exceptionally high rates of psychiatric disturbance, including potentially treatable problems. Many of the children's problems had started early and persisted or recurred, but there seemed to be no pattern to the children's diagnoses. They also found that both mothers and children needed to be interviewed, and that interviewing only mothers would have missed 27 per cent of the morbidity, and interviewing only children would have missed 33 per cent. Almost as many again failed to participate. Seven of these mothers suffered from a psychotic illness, and it was considered these children could have represented an even greater pool of need.

Singer et al concluded that the mental health needs of these children were generally not being addressed and the risk of long-term difficulties were likely to be accumulating. They suggested child and adolescent mental health professionals should be aware that children's symptoms may be directly related to psychiatric disturbance in their parents, and all practitioners must recognise that the needs of parents and children intertwine[6].

Duncan and Reder (2000) also mentioned the importance of early intervention before the problems become too severely entrenched or disturbing to development, and the need for the effect of a parent's disorder on other members of the family to be considered by the adult mental health team at the point of referral.

In more general terms, Reder, McClure and Jolley (2000a) have pointed out there is a significant overlap between the psychological functioning of the parents and their children: the mental health of one will profoundly affect the mental health of the

[6] In this respect the Loddon Southern Mallee report 'Crossing the Chasm: Women and the Public Mental Health system' identified that mother are often frightened of losing their children when they become unwell, suggesting that clear plans for children would relieve parental distress.

other. 'Even if they live apart, because of parenting or psychiatric break-down, the meaning that each has for the other continues to affect their lives' (Reder, McClure and Jolley (2000a, p.4). Reder and Lucey (2000) have further argued that appreciating the children's relationship to the presenting problem can give an important dimension to history and a greater understanding of the patient's disorder.

In conclusion, Australia needs to develop a greater emphasis on the significance of the social and family circumstances of patients.

This has already occurred in the UK. Reder, McClure and Jolley (2000a, p.10) report that the UK ***Care Programme Approach*** encourages a needs-led as opposed to services-lead system, where clinicians are encouraged identify the range of interventions that might be needed to meet each patient's various needs and to declare the gaps in available service provision. In this context the individual's relationship with other family members becomes a relevant clinical focus.

C2 Obstacles to liaison between adult and child services

Cleaver el al (1999, cited Singer et al, 2000) found persistent problems in formal collaboration between UK services for adults and children due to a variety of professional, legislative and structural reasons, resulting in boundaries around children's services which are difficult to penetrate and undermining a holistic approach. McLure and Wells (2000) also report that little collaboration is unfortunately the pattern.

Obstacles that have been reported include the following:

- Lack of necessary expertise, and fear of being unable to meet demands

Barnett and Parker (1998, cited Westman, 2000) suggest that adult services often fail to respond to the knowledge that patients have dependent children because they feel they lack expertise in child development to identify difficulties or understand how to address concerns. They suggest adult services may also fear additional demands being made upon their resources.

- Conflict of interest between their role with the parent and the needs of the child

Oates (1997) proposes that traditionally adult psychiatrists have been more concerned with their patient's family of origin, than with the family of procreation. When considering the management of the seriously mentally ill, the family is regarded as a potential source of stress or care, and little attention is given to the role of the patient as a parent. Barnett and Parker (1998, cited Westman, 2000) suggest that adult psychiatrists may perceive a conflict of interest between their primary role with the parent and the needs of the child.

- Dominance of medical model

Reder, McClure and Jolley (2000a) suggest factors that have traditionally emphasised the differences between the age groups rather then their interrelationship include differing theories and knowledge bases, the organisational structures of services, and the ways that professionals are trained. Unlike children's services, psychological principles have not been fully integrated into adult psychiatric practice, which has remained primarily concerned with `concepts of organic pathology, syndromal description and classification, and physically oriented treatments' (Reder, McClure and Jolley, 2000a, p. 6/7).

C3 Service elements for ensuring the parent-child relationship is considered and where necessary addressed

C3.1 Family history included in adult mental health assessments

Singer, Tang and Berelowitz (2000) suggest that the needs of the children need to be explicitly detailed in the parent's care program, while talking to parents about the impact their illness may have on their children is recommended to increase the parents` understanding and ability to access support for their children.

Reder and Duncan (2000) suggest it may only require a few simple questions about the number of children, how they are and how the parent is getting on with them. Reder and Lucey (2000) propose that a history can be taken that includes mention of the children, and information about the family structure can be organised and summarised through a genogram. They also point out that adding a small number of questions about the history of family relationships to the standard interview allow the adult's condition to be understood within its wider context, with the potential for treatment strategies to be devised to take these influences into account.

Oates (1997) argues strongly that an important part of any risk assessment of a patient is the likelihood of that patient doing harm to another, and as intimate intense relationships have a capacity to trigger resentment and violence more easily than for strangers, children are particularly vulnerable (very small children cannot escape or otherwise protect themselves). Not only has violence to be considered but the possible effects of preoccupation, emotional blunting and limited lifestyles.

Reder, McClure, and Jolley (2000b) also stress the need for adult psychiatric services to identify which of their patients are experiencing parenting problems because of mental health problems, and to overcome problems of access to children.

Oates (1997) suggests that a patient who is a parent should always be asked about the effects of their mental illness on their children. Specific questions should be asked about anger and violence towards children *particularly when patients are complaining of irritability and difficulty in controlling their emotions and loss of control with children*. She also recommends that the management of patient’s severe enduring

mental illness include a discussion of parenting issues, including the capacities needed to meet the responsibilities of parenthood.

Oates (1997) goes on to recommend the addition of questions relating to childcare to the Health of the Nation Outcome Scale (HoNOS; Wing et al, 1995)[7], including the effect of the illness and disability on the physical and emotional development of the child, and the patients' ability to manage the responsibilities of childcare.

Oates argues that it is important for those involved in the care of adult patients to remember that the best interests of the child should be a priority, and that confidentiality and loyalty to the adult may have to take second place.

C3.2 Coordination and collaboration between mental health services

Poole (1996, cited Duncan and Reder, 2000, p.5) suggested that `general adult psychiatrists cannot give a truly expert opinion on parenting skills'. While the psychiatric prognosis is a clearly significant issue it needs to be integrated with a detailed appraisal of the child's experiences of their parent's behaviour, with complementary assessments as required by different experts. Oates (1997) points out that the knowledge base and assessment skills required for assessing risk to children are different to those required for a general risk assessment of an adult patient, and suggests adding questions to the HONOS scale to include parent-child relationships. Singer, Tang and Berelowitz (2000) suggest that adult psychiatrists and social workers could together screen the children of patients.

Reder and Duncan (2000) argue that services need to liaise regularly together and be prepared to undertake parallel assessments from the parent's perspective and from the child's, as well as considering the overlap and distinctions between them. Reder, McClure and Jolley (2000a) stress the need to focus on liaison between different mental health teams, while Reder, McClure, and Jolley (2000b) propose a need for a specialised team with its own identified budget and appropriate skill-mix of staff.

Westman (2000) suggests that parent-patients with personality disorder require management across adult and child mental health services, 'requiring close professional liaison, flexible and intensive intervention and considerable professional tolerance and patience - with the patients and each other'. Westman suggests there is a need to increase the quality of liaison between adult and child services at a local level, with concerns about inappropriate demands addressed at an early stage. Drummond and Fitzpatrick (2000) similarly recommend close collaboration between substance misuse and child and adolescent specialists.

Reder, McClure, and Jolley (2000b) propose that the most crucial liaison initiatives required are those between CAMHS teams and adult mental health teams in the community and hospitals; between adolescent and substance misuse services; and between mental health and perinatal services.

[7] Reid et al (1998) also report the development of an instrument to assess the psychosocial health of pregnant women and their families, the Antenatal Psychosocial Health Assessment (ALPHA) form.

In general a needs-led as opposed to a service-led system is favoured, services invoked as indicated (Duncan and Reder, 2000).

C3.3 Access to, and integration with, a broad range of community services

Oates (1997) argues that the adult psychiatric team should work collaboratively with both social services and child and family psychiatrists to keep families together and safe, with practical social assistance in the home and access to child care and respite care[8].

Duncan and Reder (2000) reinforce the need for regular liaison from child mental health workers, stating that liaison may be necessary with social workers, either placed in the mental health teams or available in the community, with health visitors[9], or community psychiatric nurses. Issues about the children's understanding of their parent's disorder can also be addressed at planned family interviews. Reder, McClure, and Jolley (2000b) also stress the need for regular dialogue between GPs and health visitors.

Reder, McClure and Jolley (2000a) recommend collaboration between mental health and other welfare services as a necessary focus. Considering parental anxiety disorder in particular, Fellow-Smith (2000) suggest comprehensive inter-agency treatment packages are needed, involving child mental health, adult mental health, social services, and the education department. Where treatability is low and significant parental disorder persists, separation of the child from the parent may be in the best interests of the child, but that generally improvement can be achieved with good liaison between child and adult mental health services. See also Maitra and Jolley (2000).

Reder, McClure, and Jolley (2000b) in discussing the UK experience recommend a need for inter-agency forums and a general approach of joint planning at the systems, program, and client levels, to develop services that no longer divide adults from children (citing recommendations of Blanch et al, 1994, New York State Force on Mentally Ill Parents with young Children).

Reder, McClure, and Jolley (2000b) also state that adult mental health services remain a missing link in the child protection network. They recommend that adult psychiatrists or psychologists sit on (existing) Area Child Protection Committees, along with Department of Social Services, attending child protection conferences and participating in local information sharing and service planning.

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[8] Case managers could potentially liaise with agencies who provide these services such as community health, local government etc.

[9] These comments are from mental health practitioners in the UK, where all families receive 'health visitors' whose charter includes supporting adults in their role as parents and ensuring the well-being of children. Guidelines direct health visitors to address child abuse concerns with the family and other professionals and agencies. See Dent and McIntyre, 2000; Browne, 1995; and discussion in section D4.

C3.4 Specialist mental health programs when children are considered to be at risk

There are some claims in the literature that special programs can minimise adverse affects of parental mental health problems, particularly concerning mothers with affective disorders.

Kaplan, Pelcovitz and Labruna (1999) report that some programs claim a lasting improvement in appropriate parent-child emotional interactions (citing Beardslee et al., 1997), and greater rates of secure mother-child attachment (citing Lyons-Ruth et al., 1990). Oates (1997) also claims that psychological treatments can help women to develop effective coping strategies with children and improve the mother-infant relationship.

In a rare Australian evaluation, Armstrong, Fraser, et al (1999), described the evaluation of a home visiting program. The program targeted women recruited on the basis of self-reported vulnerability factors in the immediate postpartum period, with mothers randomly allocated in a double-blind controlled trial to receive either a structured program of nurse home visiting supported by a social worker and paediatrician (n = 90), or to receiving standard community child health services (n = 91). It was reported that after six weeks the women receiving the home-based program had significant reductions in postnatal depression screening scores, and that maternal-infant attachment was more likely to be positive. While these early results seemed promising, the absence of any further follow up information or data on child abuse prevents any conclusions regarding the possible benefits of the program.

Barlow & Coren (2001) reported a Cochrane systematic review of 23 group-based parent-training programs for improving maternal psycho-social health, and concluded that while there was evidence of positive effects, the long term effectiveness of such programs had yet to be demonstrated.

C3.5 Specialist programs for parents after abuse has occurred

Herbert (2000 describes the role of Behavioural Parent Training (BPT) for cases of neglect and maltreatment[10]. Herbert argues that findings from several studies of BPT in child protection work have indicated improved child care and management, and/or a reduction in the re-occurrence of child abuse (citing e.g. Gough. 1993; Carr, 1999; Paley, 1990). Such programs usually involve elements such as self-control training, problem solving, the encouragement of attachment behaviour, as well as tackling wider issues including being cared for by a parent with a mental health problem where parenting may be inconsistent, alcohol abuse, characteristics of the child (eg. non-compliant aggressive problems), interference of maternal authority by grandparent, environmental factors (poverty, overcrowding, social isolation).

Wolfe and Wekerle (1993) reviewed cognitive/behavioural approaches and concluded they helped maltreating parents improve several of the conditions that predisposed them to abuse and neglect. Such programs were seen to produce improvements in

[10] See also Wasik and Roberts (1994)

parenting skills (eg. ability to interact positively with their children and not overly rely on negative child management techniques). However evidence of the long term outcomes of such programs was again lacking.

Kaplan, Pelcovitz and Labruna (1999) in their review concluded that where there were high rates of depression, substance abuse, and antisocial behaviour in abusive parents, social support, anger control, and parent training would be of limited effectiveness in preventing further abuse and required the diagnosis and treatment of parental disorders.[11]

C4 Conclusion

As stated by Oates (1997), adult psychiatrists need to be aware that the majority of their patients are parents, many caring for young children, and they have a duty of care to consider the well-being of these children and act appropriately. From a service development perspective, Reder, McClure, and Jolley (2000b) state there is a need to change the mind set of those planning and providing mental health services, to recognise that adults and children have overlapping needs in addition to individual needs[12].

The evidence of association between adult mental health problems and child maltreatment and the general interdependency of the mental health states of parents and children indicate that the needs of children should be routinely considered when parents present to adult mental health services.

However there are obstacles to this occurring. These include lack of child development expertise in adult psychiatric services[13]; fear of being unable to meet demands given the pressure of the existing scope of adult services; a perceived potential conflict of interest between what is perceived as their primary role with the parent versus the needs of the child; and the dominance of a medical model in Adult Psychiatric Services where the role of interpersonal factors has traditionally been neglected in favour of a stress on organic explanations.

[11] Kaplan, Pelcovitz and Labruna (1999) noted that determining a child's risk for continued maltreatment is important to aid child protective agencies triage cases and determine the level of case supervision required - risk factors found to predict recurrent abuse were suggested to be young age of victim; number of previous CPS referrals; and caretaker characteristics, such as emotional impairment, substance abuse, lack of social support, presence of domestic violence, and history of childhood abuse.

[12] and presumably the knowledge and ability to identify the skills and appropriate tools to bring such a change about

[13] And perhaps lack of expertise in Adult Psychiatric Services on the part of CAMHS staff

With this as a background, the literature identifies a number of service elements that should be introduced for the effects of parental mental health problems on children to be adequately addressed[14]. These are:

- the investigation of family structure and functioning as a part of adult mental health assessment;
- coordination and collaboration between mental health services, particularly between adult mental health teams and CAMHS teams, but also including substance misuse services and perinatal services;
- access to and integration with a broad range of community services including child protection services, social workers, GPs, and community nurses;
- the participation of the full range of health and community services in joint service planning for addressing child abuse.

To some extent these elements might be introduced with relative ease. However a full implementation of these elements requires that the obstacles outlined earlier be addressed.

The first major issue is that of resourcing. As stated by Reder, McClure, and Jolley (2000b, p.325), 'Where will the resources come from for all this extra liaising, auditing, family interviewing, and training?' Their view is that additional resourcing is clearly needed, but that the expertise could at least in part come from CAMHS teams. For example they recommend that sessions be established within all mental health teams for family focused work, and that one means of achieving provision of expertise within AMH teams would be for CAMHS to provide sessions within those teams as a formal staff member with a specific brief for children. An alternative suggestion was that special family clinics be staffed by CAMHS.

Another more systemic issue concerns the training of specialists in adult psychiatry. Reder, McClure, and Jolley (2000b) recommend that those intending to work in child or adult specialties should also have to undertake family mental health training.

Evidence that increased liaison and collaboration between services will produce more effective outcomes is not yet available, but the need for development and promotion of service collaboration and integration seems clear. As observed by Westman (2000), 'while it would be idealistic to assume that a different pattern of working together would prove to be the panacea for the difficulties of dysfunctional parents and their children, if more comprehensive mental health responses could prevent or reduce the suffering of one generation of children and modify the intergenerational transmission of maladaptive behaviours the effort would be justified'.

The proposed service developments are required, but addressing potential child abuse in families currently in contact with treatment-orientated health and welfare services

[14] As discussed, there is also some evidence of effectiveness of specialist mental health programs for improving maternal psycho-social health in cases of maternal depression, or cognitive/ behavioural approaches for maltreating parents to improve parenting skills after abuse has occurred. These might be considered for pilot programs.

will fail to identify many 'invisible' families where parental mental health problems contribute to child abuse[15].

This issue is considered in **Chapter D**.

[15] and/or only identify such families after child abuse has occurred and adverse parental behaviours have become entrenched

D At-risk groups and service delivery: support for preventing child abuse through nurse home visiting

As noted previously, the predominant view of child maltreatment is that it reflects the action of many combined factors - individual mental health problems, family level factors, poverty, unemployment, fragmented social services, social isolation, etc.[16]. Reflecting this view there has been a proliferation of community-based programs seeking to intervene and support parents prior to child abuse occurring and/or before it becomes too severe, accompanied by efforts to assess the effectiveness of such programs. These community-based programs and their reported effectiveness are reviewed in this chapter.

D1 Seeking programs that prevent child maltreatment

As previously discussed, reviews have suggested that parent training programs improve maternal global adjustment and child-rearing skills, and enhance parenting knowledge and attitudes (eg. Wolfe and Wekerle,1993; Reppucci et al, 1999). At the same time the effects of these programs on child maltreatment have not been clearly demonstrated. The child maltreatment literature lacks longitudinal evaluations that compare participant and matched non-participant groups using appropriate measures of child abuse and neglect (Reppucci et al, 1999).

An example of a study that entailed a controlled group and suggested evidence of effectiveness was that by Britner and Repucci (see Repucci et al, 1999), an evaluation of a 12-week group parenting program conducted for primarily African-American unmarried teenaged mothers in an urban setting, where members of the program group were reported to be less likely than members of a matched non-participant group to have substantiated reports of maltreatment 3-5 years after the birth of their children. However as pointed out by MacMillan (2000), the study was not a randomized controlled trial and information on subject entry into each group was not provided. Hence clear conclusions are not possible.

Most program types have provided little hard evidence of success, and sometimes the opposite. For example, MacMillan (2000) reported a program where comprehensive health services provided by a multi-disciplinary team (including prenatal, postnatal and pediatric care) appeared to result in a tendency for an *increase* in abuse (reports for neglect of 10.6% for the intervention group, and 4.1% for the control group). It was concluded that a surveillance bias was responsible, i.e. there were more opportunities to detect abuse with the intervention group.

Tomison in a review of child abuse prevention programs for the Australian National Child protection Clearing House (Australian Institute of Family Studies), observed that in spite of the 'vast number of program evaluations that have been performed on a variety of child abuse prevention programs, …. very few rigorous evaluations have been done in Australia or internationally' (Tomison, 2000, p.91). He further cited the US National Committee on the Assessment of Family Violence Interventions

[16] the 'ecological perspective', Belsky (1980, cited Repucci et al, 1999)

conclusion that there is very little evidence on 'what works, for whom, and under what conditions' (Chalk and King 1998, p.91, cited Tomison, 2000).

However Tomison also observed, as have many others, that there is one type of child abuse prevention program that has been clearly demonstrated to work: the prenatal to early infancy home visiting program developed by David Olds and colleagues.

D2 A successful intervention model: nurse home visiting (Olds et al)

Olds et al (1986) described a randomised, controlled trial of a program of home visiting by nurses as a method of preventing health and developmental problems in children, now commonly known as the Elmira[17] study.

Visits were made to mothers who were expecting a first child and who were either teenagers, unmarried, or of low socioeconomic status. Pregnant women were recruited from a free antepartum clinic sponsored by the county health department and from the offices of private obstetricians. Women were recruited for the study if they had no previous live births, were prior to the 25th week of gestation, and were either young, unmarried, or of low socioeconomic status. 47% were younger than age 19 years, 62% were unmarried, and 61% came from households classified as of low socioeconomic status.

During home visits, the nurses promoted 3 aspects of maternal functioning:
- health-related behaviors during pregnancy and the early years of the child's life;
- the care parents provide to their children; and
- maternal life-course development (family planning, educational achievement, and participation in the work force).

Visits were held once every other week during pregnancy, once a week for the first 6 weeks postpartum, and then on a diminishing schedule until the children reached age 2 years. Nurses completed an average of 9 (range, 0-16) visits during the mother's pregnancy and 23 (range, 0-59) visits from the child's birth to second birthday.

The results were that those who received home visits by a nurse had fewer instances of verified child abuse and neglect during the first 2 years of their children's lives. Four per cent (4%) of the nurse-visited families had a verified maltreatment report before the child's second birthday in contrast to 19% in a comparison group receiving routine perinatal care. The visited mothers were also reported to restrict and punish their children less frequently, and their babies were seen less by physicians less frequently for accidents and poisonings than comparison group babies.

In the next of a series of follow up studies, Olds et al (1994) reported on the 3rd and 4th years of the children's life, the families now dispersed among 14 states. This time there was found to be no treatment differences in the rates of child abuse and neglect from 25 to 48 months of age, but nurse-visited children did have 40% fewer injuries and ingestions and 45% fewer behavioral and parental coping problems noted in the physician record; they also made 35% fewer visits to the emergency department than

[17] Elmira is a small, semirural community in upstate New York (population 40,000)

did children in the comparison group. Olds et al (1995) also reported that children who had been identified as maltreated and whose families nurses visited during pregnancy and the first two years of life had less serious expressions of care giving dysfunction. This was attributed to earlier and more comprehensive detection of child maltreatment on the part of nurse-visited families.

While reduced child maltreatment had not been detected during the 3rd and 4th years of the children's lives, Olds et al (1997) reported a 15-year follow-up of the Elmira study. They found that reports[18] of child abuse and neglect among the women visited by a nurse prenatally and through infancy were fewer in number than those among women in the control group (incidence 0.29 v. 0.54; $p < 0.001$).

The conclusion was that the Elmira program of prenatal and early childhood home visitation by nurses reduced the use of welfare, child abuse and neglect, and criminal behaviour on the part of low-income, unmarried mothers, for up to 15 years after the birth of the first child. This non-contested result is currently the single largest influence on the development of child abuse prevention programs.

As discussed by MacMillan (2000; see also MacMillan et al, 1993), the Elmira trial was replicated by the same group (Kitzman, Olds et al, 1997, cited MacMillan, 2000), using nurse home visitors but to primarily African-American, low-income and unmarried first-time mothers in Memphis, Tennessee[19]. At two years children whose mothers were visited at home had fewer health care encounters for injuries and ingestions than those whose mothers were not visited at home (0.43 v. 0.56; $p = 0.05$). The number of days that children were in hospital because of injuries or ingestions was also significantly lower in the intervention group.

As described by Leventhal (2001), the good news was that Olds' intervention first tested in Elmira was able to have important (although less pronounced) effects in a population with different characteristics in Memphis.

Among many emphasising the importance of Olds et al (1997) results, Kaplan et al (1999) observed that Olds et al have demonstrated that intensive and comprehensive home-visitation by nurses are able to improve the behaviour of parents at risk of perpetrating maltreatment, decrease child behavioral difficulties, and that the benefits are durable, high-risk mothers participating in the program half as likely to be reported for child abuse/neglect over a 15-year period compared with mothers not in the program (see also Guterman, 1999).

D3 Important elements of the Olds models: visits by nurses, occurring frequently, prenatally and through infancy

Further randomized controlled trials that followed the example of Olds et al but used *lay home visitors* (eg. Johnson et al, Marcenko et al, and the Hawaii's statewide child

[18] Eighty-one per cent of the families were located for the follow up. Verified reports of child abuse and neglect were abstracted from state records.

[19] See Kitzman, Olds et al. Effect of prenatal and infant home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: a randomized controlled trial. *JAMA* 1997; V278:644-52.

abuse prevention program 'Hawaii Healthy Start'; see MacMillan, 2000), found no evidence to support differences in child maltreatment between experimental and control groups.

MacMillan (2000) pointed out that the success of the Elmira and Memphis trials was dependent upon several key features. They were that home visitation occurred frequently, extended from the prenatal period to the child's second birthday, and was provided by nurses. Supporting earlier findings of a review by MacMillan MacMillan and Offord (1993), MacMillan concluded that the strongest evidence is for frequent home visitation by nurses, and that home visitation programs should bear close resemblance to the model shown to be effective by Olds and colleagues.

Leventhal (2001) also highlighted, as have many others, the importance in the Olds models of the use of nurses, health professionals accustomed to making clinical assessments and giving advice about health, development, and family issues. In contrast, para-professionals (trained non-professionals, who often come from the community being served) were seen to be less skilled at making clinical assessments, and less knowledgeable about health, development, and family issues.

Evidence of the importance of *regular and intensive visiting* was provided by MacLeod and Nelson (2000). In a review of 56 programs designed to promote family wellness and prevent child maltreatment, they concluded that the lowest effect sizes for home visitation programs on child maltreatment were for programs with 12 or fewer visits and less than a 6-month duration[20].

D4 Community nurse 'health visitors' in the UK: a potentially valuable service in need of support?

While it is the US that has been the focus of experimental programs, in the UK nurse home visitors have been active since the establishment of the NHS in 1946.

Dent and McIntyre (2000, p.181) describe how every family with young children receives visits for the first five years of each child's life by a fully qualified nurse and midwife, home visits being provided with the aim of identifying health and relationship problems within the family and initiating any necessary actions on behalf of 'children in need`. The health visitor 'seeks to encourage and empower adults in their role as parents, but also to ensure that the children's well-being is not being jeopardised'.

Browne (1995) observed that the health visitor's role is unique because visits are unsolicited, are concerned with health education and promotion of the family as a whole, and visits to families in need are made over a long period of time. Guidelines directing health visitors to address child abuse concerns with the family and other professionals and agencies are provided. While there is no mandatory reporting of child abuse and neglect in the UK, Gilardi (1991, cited Browne, 1995) reported that

[20] They also concluded that high levels of participant involvement, an empowerment/strengths-based approach, and a component of social support had higher effect sizes than programs without such elements

97% of health visitors had been directly involved in at least one case of child abuse and neglect and 70% in more than five cases. In 42% of these cases the health visitor was the first to suspect abuse, and 40% had been involved in the preparation of court proceedings. The study also found that a majority of health visitors felt that their initial training in child protection was less than adequate.

Browne (1995) stated that there is little doubt that the health visitors have limited the amount of physical neglect and malnutrition suffered by children in the UK, but also that health visitors were not now being adequately resourced and were forced to undertake fewer home visits. Greater support and training was recommended for community nurses if they were to adequately support families and prevent child abuse and neglect.

This concern was supported by a survey of health visitors by Dent and McIntyre (2000), who reported that while nurses felt 6 per cent or so of visited families may include a parent with 'mental health problems', they lacked the time or training to respond adequately. While the Department of Health were advocating that formal child protection investigations be undertaken only as a last resort, the nurses reported that social workers and adult mental health specialists were unwilling to assist (adult psychiatric services were reported to treated individual adult parents but not liaise with nurse visitors). The result was felt to be a failure to address the impact of mental illness on parenting or the family.

D5 Screening for risk, and targeting

Given the cost of home visiting programs, and the ever present pressure on healthcare budgets, considerable efforts have been made to identify risk factors for child maltreatment and hence identify a sub-set of families that should receive home visiting programs.

D5.1 Risk factors for child maltreatment

MacMillan and co-workers (MacMillan et al, 1993; MacMillan, 2000) reported the results of a major on-going Canadian task force investigating child maltreatment screening. Risk indicators for committing physical abuse were reported to include maternal psychiatric impairment, low maternal education level, lack of attendance at prenatal classes, substance abuse, male sex, and recent life stressors (MacMillan, 2000), as well as low socioeconomic status, low maternal age, large family, single-parent family, parents' childhood experience of physical maltreatment, spousal violence, social isolation or lack of social support, unplanned pregnancy or negative attitude toward pregnancy (MacMillan, MacMillan, and Offord, 1993).

Risk indicators for neglect included parental sociopathic behaviour and substance abuse (although there are methodological problems in this area), and risk indicators for sexual abuse include low maternal age and parental death (MacMillan, 2000).

For further review and discussion see Kaplan, Pelcovitz and Labruna (1999), Browne (1995).

D5.2 The failure to develop models that can distinguish maltreating families (only)

The potential value of risk factors is to identify high-risk individuals to be targeted by cost-effective programs[21], MacMillan et al (1993) noting that the concept of screening people for risk of maltreating children had received intensive investigation over the preceding two decades. Efforts have included staff-administered checklists, self-administered questionnaires, and standardized interviews.

MacMillan et al (1993) concluded that the main problem with the available instruments was their high false-positive rate. A large proportion of the people and families identified as being "at risk for child maltreatment" would never go on to commit abuse. This was coupled with the potential harm associated with mis-labelling people as child abusers, many proposing that the stigma of such a label would put people under increased stress and interfere with their ability to function as parents, possibly placing children at greater risk than before the prediction.

MacMillan (2000) examined further studies (updating the review of McMillan et al, 1993), and again concluded that the main difficulty with approaches to screen for risk of child maltreatment continued to be the unacceptably high false-positive rate. She noted that several authors have emphasized that prediction of individuals at risk for child maltreatment is not possible. As with the 1993 study, it was concluded that the use of screening instruments in a primary health care setting to identify individuals or families at increased risk of committing child abuse is not warranted, and is likely to do more harm than good (MacMillan et al, 1993, had cited Kaufman and Zigler, 1989, in that "accurate prediction of individual cases is not possible" and that "efforts at predicting individual cases of child abuse be abandoned").

Browne (1995) clearly illustrated the shortcomings of attempts to target narrow special groups, describing the results of an evaluation of a UK checklist developed from demographic and epidemiological to identify non-accidental injury to children.

The check list contained 12 items of information[22] that could be routinely and easily obtained by health visitors. It was evaluated on all children born in 1985 and 1986 in three health districts of Surrey, England, a total of 14,252 births screened for potential of child abuse and neglect. Of these 7% (964) were identified as 'high risk'. The population cohort was followed up for 5 years. It was found that the checklists (with a relative weighting for each factor) correctly classified 86% of cases, representing correct identification of 68% of abusing families (and non-identification of 32%), and correct classification of 94% of the non-abusing families.

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[21] For example Kaplan, Pelcovitz and Labruna (1999) note that efforts at primary prevention of physical child abuse and neglect have focused on targeting teenage parents (citing Britner and Reppucci, 1997), impoverished single parents (citing Wolfe et al., 1995), parents expecting their first child (citing Affleck et al., 1989), substance-abusing parents (citing Blau et al., 1994), or parents with cognitive limitations (citing Feldman et al., 1992).

[22] including record of psychological problems or socialization difficulties, history of violence, age of mother, time period between pregnancies, post-delivery separation, evidence of prematurity/low birthweight/handicap, family with separated or single parent, and socioeconomic problems

Unfortunately, and the most worrying aspect of the checklist, 6% of the non-abusing families were incorrectly identified as at high risk of committing child abuse, as they had a number of heavily weighted risk factors. In fact of 964 cases identified as high risk, only 72 cases later went on to commit child maltreatment - 892 were false positives.

Browne concluded that the low prevalence of child abuse, combined with even the most optimistic estimates of screening effectiveness, would necessarily result in large numbers of false positives.

A result of the failure to develop sensitive models for identifying at-risk parents has been to further emphasise the value of ecological models. Risk factors thought to predispose families to child abuse have not been seen to offer sufficient causal explanation, with, for example, the likelihood of parental mental health problems leading to child abuse mediated by other compensatory factors such as social support. As a consequence, the value of family support programs of the Olds type or the UK health visitor program (if properly resourced) are seen to be further strengthened (see Browne, 1995[23]).

For example, Barker (1999) commented on Browne's UK screen and its capacity to label 35 innocent families for every one abusing family. Barker described screening as a contentious strategy, of dubious effectiveness, and that a more positive alternative in the UK was to adequately resource health visitors so that support and encouragement could be given for the first year or two of life to all parents living in areas of social stress[24].

D5.3 The probable reduced effectiveness of programs with severely at-risk families

The effectiveness of nurse home visiting seems limited for severe at-risk groups. Browne (1995) cited work from Ayoub et al. (1995) in Boston that suggested certain families do not benefit from home-based intervention. Families presenting with depression, withdrawal, low self-esteem, limited parenting skills and unrealistic expectations of their children were described to be most unlikely to show change, and that families with family violence or chemical dependency were likely to deteriorate further.

MacLeod and Nelson (2000) reviewed 56 programs designed to promote family wellness and prevent child maltreatment. They concluded that both home visitation and intensive family preservation interventions achieved higher effect sizes with participants of mixed socioeconomic status (SES) than participants with low SES.

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[23] Browne, a UK researcher, described the research of Olds et al as providing a good example of effective interventions in promoting parental competence and self-confidence in dealing with the care and the management of the child, interventions which improve mother-child play and reduce physical punishment and the incidence of child abuse and neglect

[24] Barker suggested that parents found to be lacking in care and understanding would merit increased support visiting, with labelling occurring only when any incidents of abuse or suspected abuse were noted.

A limit on the effectiveness of such programs was confirmed by Eckenrode et al (2000), who reported a further examination of the Olds et al intervention. They found that the treatment effect decreased as the level of domestic violence increased: women who reported 28 or fewer incidents of domestic violence (79% of sample) had significantly fewer child maltreatment reports during the 15-year period than mothers not receiving the longer-term intervention (P =01), *but this intervention did not significantly reduce child maltreatment among mothers reporting more than 28 incidents of domestic violence* (21% of sample). They concluded that the presence of domestic violence seemed to limit the effectiveness of interventions to reduce incidence of child abuse and neglect.

Guterman (1999) provided further (indirect) evidence that screening-based approaches could limit effectiveness by favouring the enrolment of hard-to-treat groups, reporting findings from Protective Service data that population-based approaches to reduce maltreatment had weighted mean effects of 3.72%, while screening-based approaches reported weighted mean effects of - .07%.

Guterman suggested that psychosocial screens might serve to enrol higher proportions of families with problems that home visitation services are unable to address (eg. substance abuse, domestic violence etc). Psychosocial screening for the purpose of accurately locating a target pool of service recipients may heighten the inability of the intervention services to meet families' needs.

D6 Conclusion: nurse visiting services targeting broad community populations, not individual families

The high false positive rates of individual screening methods, the resistance to change of the more severe at-risk groups, and the success of the Olds program(s), has lead to a virtual consensus that screening individuals is not recommended in prevention programs, and that interventions should be targeted at all members of broad at-risk communities.

MacMillan (2000, citing Olds and Kitzman) advocates targeting particular communities with high rates of poverty and of single and teenaged parenthood, where making the program widely available reduces the problem associated with labelling a person as in need of the program (as noted by Reppucci et al, 1999, programs can then be promoted as family support initiatives rather than child abuse prevention efforts). Guterman (1999) recommends that scarce resources be deployed by providing non-screening programs in community niches holding high proportions of sub-populations most likely to benefit from services.

A further common emphasis is the importance of maintaining a reasonably high level of visiting. Gomby (2000), in discussing the implications of Eckenrode et al (2000) that home-visitation services are unlikely to produce large benefits for all families, stressed that this must not result in policy makers economising by using staff other than nurses, increasing caseloads, or decreasing the number of visits authorized per family. Gomby maintained that the starting point for programs should be ensuring the presence of the elements associated with program success (i.e. Olds et al), and that it

is only through the delivery of the best services possible that home visitation will benefit families with young children.

E The frameworks of Mental Health and Protective Services in Victoria

This section outlines the legislative framework for the delivery of Mental Health and Protective Services in Victoria.

E1 Mental Health Services

In 1994 Victorian Mental Health Services adopted a 'Framework for Service Delivery' which established key principles for health service reform (see DHCS, 1996). These principles were:

- to put people first, rather than institutions or systems
- to ensure a fairer distribution of limited resources
- to obtain value for taxpayer funds
- to provide a better health status and outcome for all Victorians

This lead to growth in community-based services and the redevelopment of inpatient and community residential services, and the main-streaming of direct management and delivery of services, with mental health services now delivered through locally based general health providers and non-government organisations.

In 1996 Victorian Mental Health Services incorporated an emphasis on patient-focused health outcomes measurement (DHCS, 1996), advocating:

◊ the use of systematic consumer outcome measures as an indicator of agency effectiveness.
◊ services being responsive to the needs of consumers and carers.
◊ the use of budget incentives to improve the quality of agency service delivery.
◊ the systematic use of consumer and carer satisfaction measures as indicators of service quality.
◊ the application of key performance indicators.

E1.1 The legislative framework - the Mental Health Act (1986)

The Mental Health Act (1986) provides the statutory framework for administering services to people who undergo treatment or care for mental illness in Victoria.

The Act has a rights, patient-orientated approach, and requires that all treatment be provided in the leat restrictive way possible. It also sets out the criteria for involuntary treatment of a person in the community.

(i) When can a person receive treatment against their will?

The Mental Health Act (1986) requires all of five criteria to be met for a person to be detained as an involuntary patient. In essence it is required that the person:

a. is mentally ill

b. requires immediate treatment or care and the treatment can be obtained through admission to and detention in a psychiatric inpatient service
c. should be admitted and detained for that person's health or safety or for protection of members of the public
d. has refused or is unable to consent to the necessary treatment or care
e. cannot receive care in a manner less restrictive of that person's freedom of decision and action

(ii) Which behaviours are not to be considered evidence of mental illness?

Of particular relevance to this project, while mental illness is not defined in the Act, The Mental Health Act (1986) explicitly specifies certain behaviours as not to be considered evidence of mental illness.

These include:
- engaging in immoral conduct
- engaging in illegal conduct
- taking drugs or alcohol
- having an anti-social personality

As O'Hanlon and Obradovic (1999) point out, these provisions mean that many behaviours that seem to the general community to place others in danger, such as sexual offending or violence, or appear self destructive, are not alone considered evidence of mental illness and are ***therefore not the responsibility of mental health services***.

On the other hand the 1996 Victoria's Mental Health Service 'The Framework for Service Delivery: Better outcomes through Area Mental Health Services' referred to establishing a specialist service to provide services and promote expert practice across the state for people with personality disorders[25], and discusses possible changes to legislation to enable better treatment and more responsive service provisions for persons with a severe personality disorder.

(iii) When may information be shared about a person's treatment?

The Mental Health Act (1986) also specifies the conditions under which information may be shared about a person's treatment. Section 120A prohibits any staff member of a psychiatric service from giving out information in relation to persons who are or have been in receipt of psychiatric services. However there are exceptions to these confidentiality requirements. Section 120A(3) permits the release of information:
a. with the prior consent of the person;
b. to the court in the case of criminal proceedings;
c. if it is communicated in general terms, or if it is communicated to the next of kin;
d. to the Australian Red Cross in relation to tracing blood;
e. in connection with the further treatment of the patient;
f. to the Australian Statistician;

[25] leading to the establishment of the 'Spectrum' service

g. for the purposes of medical or social research, if the research has been approved by the in-house ethics committee and if it doesn't conflict with provisions of the Act;
h. in connection with hearings before the Mental Health Review Board or the Guardianship and Administration Board;
i. if in the opinion of the Minister it is in the public interest.

The confidentiality provisions also allow information about a patient to be given to a person who is pursuing her or his statutory duties, that is, duties set down in legislation. Thus other Commonwealth and State legislation can override the confidentiality provisions of the Mental health Act 1986 (Vic)[26].

E1.2 Specific cross-reference from The Children and Young Persons Act 1989 (Vic)

The Children and Young Persons Act 1989 (Vic), which charges a 'protective intervener' with the duty to investigate the situation of a young person 'at risk', specifically states that information provision does not constitute a breach of professional ethics *or section 120A of the Mental Health Act 1986* (see O'Hanlon and Obradovic, 1999).

The Children and Young Persons Act 1989, Section 64 (DHS, 2001) also states that certain designated professionals (including nurses and doctors) must report to Child Protection Services, when in the course of their professional duty:

- [they] form the belief on reasonable grounds that a child[27] is in need of protection… [because] the child has suffered , or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type; or
- the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type.

The act also guarantees the confidentiality of the informant (Children and Young Persons Act 1989, Vic. S.64, S.67).

E2 Protective Services

E2.1 The framework for Protective Services: a continuum of primary, secondary, and statutory services.

The Department of Human Services, Child Protection Unit in Victoria considers that no one professional agency is able to provide for the total needs of endangered

[26] Note that while services are generally willing to share information and there are no legal barriers to this, there were anecdotal reports of barriers to this, such as threats to worker safety from clients if information was disclosed to Protective Services.
[27] A 'child or young person' is defined as being aged 17 years or under.

children and vulnerable families. In recognition of the shared role of services and agencies in family welfare and child protection, the Department of Human Services in Victoria moved from the earlier direct provision of continuing placement, support and rehabilitation services to children and families, to their provision by non-government agencies (Ross, 1999).

However DHS-Protective Services have continued to have the statutory authority and responsibility for investigating notifications of abuse and neglect, and retain case planning responsibilities for children who are subject to protection orders made by the Children's Court.

The broad system[28] of Primary (universal) services, Secondary services, and Tertiary (statutory) services is as follows:

- **Primary services -** these are *offered to everyone,* eg. antenatal services, maternal and child health services, preschool education, GPs, community education and awareness programs.

  Primary services provide support and education for children and families before problems arise, and '*in many cases, primary services help to prevent abuse and neglect occurring*' (DHS, 2001, p.12).

- **Secondary services -** offer programs that *identify and reduce the personal and social stresses on parents that can lead to family breakdown and/or child abuse.*

  These are provided by community based organisations which deliver financial or family counselling, parenting and self-help groups, and in-home Family support (required family willing to seek and accept support and able to engage); Strengthening families (assertive outreach by workers to engage with families, i.e. families approached by eg. St. Lukes after referral from Protective Services); Families first (where within 72 hours is likelihood of removal of children).

- **Tertiary services** or statutory services - these include services for children who have been at risk of significant harm where intervention is needed to ensure the ongoing safety of the child: child protection, juvenile justice, placement, police, adoption to permanent care[29].

From 2000 government policies re-emphasised early intervention and the role of the broader service system in protecting children from abuse, and engaged in a strengthening of the secondary service sector.

[28] DHS (2001)
[29] While child protection is a statutory service and can work with involuntary clients, child protection also work with families in a voluntary capacity i.e. (a) without the need for a court order and (b) some clients self refer.

E2.2 The Role of the Child Protection Service

The Children and Young Persons Act 1989 mandates Protective Services to investigate notifications regarding children who are at risk of significant harm and work with children and their families to reduce the risk of harm. This service only comes into play when primary and secondary services are unable to ensure voluntarily the safety and welfare of the child in collaboration with the family. The Child Protection Service is considered a ***service of last resort***. Protective Services has the legal mandate for intervening in situations when a notification of child abuse is made. The role of Protective Services is to investigate and assess cases of child abuse and, if deemed necessary, intervene to ensure the safety and wellbeing of the child.

"Where a child/young person is not safe within the family, even with support, Protective Services will intervene and remove them until the parent/s are able to resume their custodial responsibilities and provide adequate care and protection". (H&Cs 'Protecting children: Standards and Procedures for Protective workers Delegations', 1994: p.2).

The authority for Protective Services to receive and investigate notifications of alleged child abuse and neglect (from people who 'believe on reasonable grounds that a child is in need of protection' or 'form a belief that the child may be at risk of harm'), and to pursue statutory action, is provided through the Children and Young Persons Act 1989 (Vic) (CYPA).

The function of the Child Protection Service (DHS, 2001) is to:

- receive notifications from people who believe on reasonable grounds that a child is in need of protection.
- provide advice to people who report such concerns.
- investigate matters where it is believed that a child is at risk of significant harm.
- refer children and families to services that assist in providing the ongoing safety and wellbeing of the children.
- take matters before the Children's Court if the child's safety cannot be assured within the family.
- supervise children on legal orders granted by the Children's Court.

E2.3 What is a statutory order?

A statutory order is where the Children's Court has placed a child on a legal order in an attempt to ensure a child's safety and wellbeing. The magistrate's decision is based on evidence provided to court by DHS protective workers, family members and other interested parties. When a child is deemed to be at significant risk of harm and the family are not "able" to ensure the child's safety a legal order is issued.

The Children and Young Persons Act 1989 (Vic), Section 85, sets out the types of orders granted by the Children's Court as:
'a. any one of the following protection orders:

i. an order requiring a person to give an undertaking;
ii. a supervision order;

iii. a custody of a third party order;
iv. a supervised custody order;
v. a custody to Director-General order;
vi. a guardianship to Director-General order; or
b. an interim protection order.'

In essence the type of order is dependent on the level of risk to the child. Hence an interim protection order (IPO) is for a three month assessment period: if risk of harm to the child is minimised, for example if the family are working actively with services and risk of harm to the child is reduced, than an IPO expires at term. At the other end of the scale is the guardianship order, which places the child under the custody and guardianship of the Department of Human Services.

E2.4 When is a child in need of protection?

The Department of Human Services 'Policy Advice and Practice Guidelines' for Protective workers describes child abuse as physical injury which results from abuse or neglect, sexual abuse which refers to situations where a person uses their power or authority over a child to involve the child in sexual activity, emotional abuse which includes situations where a caregiver repeatedly rejects a child or uses threats towards a child, or neglect when a caregiver fails to provide a child with the basic necessities of life.

Specifically Section 63 of the Children and Young Persons Act 1989 states that a child is in need of protection if any of the following grounds exist:
'(a) The child has been abandoned by his or her parents and after reasonable inquiries-
(i) the parents cannot be found; and
(ii) no other suitable person can be found who is willing and able to care for the child;
(b) The child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child;
(c) The child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
(d) The child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
(e) The child has suffered, or is likely to suffer, emotional or physical harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
(f) The child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged, or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.'

E2.5 Phases of Protective Services intervention

In the Bendigo Child Protection Unit (CPU) office the response unit "carries" a case until abuse is substantiated. At point of substantiation the case is transferred to protective intervention team. (PIT) PIT workers formulate court reports and present the case to the magistrate. If abuse is found to be proven, a court order is issued and the case is then transferred to the case management team. The case management team investigates a case for children aged 0-12 years, (or older children if part of a sibling group) until abuse is substantiated. The CMT works with clients aged 0-12 and some adolescents who are in sibling groups who are on court orders.

The adolescent protective team (APT) investigates cases for young people aged 13-17 at risk of abuse or displaying adolescent risk behaviours. While the response unit hand over to the Protective Intervention Team (PIT) once a case is substantiated, the APT carries a case from investigation through to closure of court order. Both PIT and APT can work with a client and family for 90 days without a court order. If it is assessed that a court order is required, PIT or APT take the matter before the Children's Court. Once the court order is obtained APT continue to work with the young person while PIT transfer their case to the Bendigo Case Management Team.

The Swan Hill and Mildura CPU work with children 0-17. However each office manages transfers to various teams at different stages.

Child Protection also accepts notification in regard to unborn babies. Whilst CPU do not have the mandate to enforce parents to work with services, prior to birth, CPU attempts to encourage families and agencies to work together in an attempt to ensure the safety and wellbeing of the unborn child.

The following outlines the phases of Protective Services intervention.

1. Intake

This phase refers to the period following the making of a notification by a professional or community member to Protective Services, up to the point where the Protective Services office makes a decision about the need for formal direct investigation. Intake includes the notification itself and follow-up contacts with other professionals for further information or clarification. In the Loddon Mallee Region, Protective Services employ a central intake unit that receives all notifications.

Notifications are provided to CPU either by phone, office visit or in a written form. Community members contact CPU to notify them of their belief a child may be at risk of harm. Protective workers in the intake team gather information from various sources including Psychiatric Services to formulate a risk assessment.

Intake may involve calling a case conference for the purposes of sharing information and making decisions, but does not involve direct contact with the child or young person or their family.

The intake team attempts to formulate risk assessments within the first seven days of receiving a notification. This allows the response team to begin working with the

family prior to fourteen days after a notification is received. If a significant risk is indicated the case is "further actioned" or transferred to the response team for initial investigation. If significant risk is not indicated the case is closed.

2. Initial investigation

The initial investigation begins with the response team and APT. Protective Services is responsible for planning the initial investigation, although a joint investigation with the Victorian Police may occur if the Police are pursuing a criminal investigation. The investigation considers:

- type and severity of the reported abuse and neglect.
- age and vulnerability of the child or young person.
- degree of urgency.
- history of the family's involvement with Protective Services.
- opinions of other professionals involved.

Following Initial Investigation one of the following occurs.

a. Development of a protective plan.
The response team or APT aim to make a decision about the level of risk a child may be subjected to within 28 days. If the investigation indicates that significant protection issues are involved, it is Protective Service's responsibility to manage and facilitate the development of a protective plan to address and reduce the risk to the child or young person. A case conference of relevant professionals can be convened to assist in information sharing and planning. Immediate decisions may be taken to secure the child's safety and welfare, and in the most severe case, the child can be placed out of the family home. If a decision is made to substantiate risk of harm, and the risk of harm is ongoing, the case is moved to the protective intervention team.

b. Case closure.
The case is closed if the risk of harm is not identified or is reduced. This decision may be made at a case plan meeting where the development of a protective plan occurs and the family are working with services and supports.

3. Protective Intervention

From date of notification of significant concerns, Protective Services can stay involved with a family for up to 90 days without a court order.

4. The Children's Court

Where the child continues to be at serious risk or is unable to safely remain in their family's care, Protective Services may make a protective application to the Children's Court. The CMT or APT then works with families after a magistrate has "proven" a protection application. In other words, if a magistrate has agreed with protective workers that a child is at significant risk of harm.

In the Bendigo area, only approximately 7% of cases appear before the court and have ongoing Protective Services involvement.

If the child is considered to be in immediate and critical risk the child may be placed in safe custody pending a hearing at the next sitting of the Children's Court.
If the risk is not immediate, a notice may be served on the child and parents/carers to attend the Children's Court on a predetermined date, and in these circumstances the child is likely to remain in the care of their parents/carers.

When Protection Application is issued professionals involved in the case may be asked to provide a report or give evidence at the court hearing. A Subpoena may be served on the professional requiring attendance at the hearing.

E3 The potential for problems arising from the differing frameworks of Mental Health and Protective Services

All notifications are the responsibility of the Child Protection Unit and their role is to investigate significant risk to children and young people. It has no direct role in service provision, and must work through a broad continuum of other services. Once involved in investigation, DHS is now reliant on collaboration with other agencies for information, placement, support and rehabilitation services for children and their families.

In contrast, Mental Health Services are relatively autonomous and possess a much more circumscribed clientele. They operate under the Mental Health Act, which specifically excludes all individuals from **Psychiatric Services'** responsibility unless they independently have a psychiatric diagnosis (including those with illegal, immoral, anti-social, or drug-taking behaviour, although not specifically personality disorder)**.**

This means that while collaboration between Mental Health Services and Child Protection is possible (and indeed mandated by the Children and Young Person's Act where a doctor or nurse forms the belief a child is in need of protection), the general thrust of the Mental Health Act is to define the core business of mental health services as a different population to that of concern to Child Protection.

The result is that while CPU works with **families** on both a voluntary and involuntary basis with a primary focus on risk to the child, Adult Psychiatric Services has a primary focus on the **adult client**. This difference is seen by many workers, including Protective services workers, to be the source of important obstacles to inter-service collaboration. While such differences do not prevent collaboration between Mental Health and Child Protection Services, they can lead workers in the two services to view the other's primary focus as inappropriate or irrelevant. The result can be frustration and inefficient communication when collaboration is required.

This is discussed in the following chapter.

F The interface between Mental Health Services and Child Protection in the Loddon Campaspe /Southern Mallee

The following material reports and considers issues raised in the Loddon Campaspe / Southern Mallee Area service following consultations held with local service providers.

Firstly, while data was scarce, community agencies tended to describe the local context as one of increasing numbers of families with mental health problems. Protective Services also reported that notification and re-notification rates have escalated in recent years. There were also seen to be particular geographic areas of prominence, characterised by concentrations of populations with lack of extended family support and high proportion of single mothers. Some sub-groups were also of particular concern, for example a high rate of Koori children were placed in care[30].

In terms of interaction between Mental Health Services and Protective Services, information exchange or referral can potentially be initiated by either party. For example, the Mental Health CAT (Crisis Assessment Treatment) team may alert Protective Services that a child may be neglected. Alternatively Protective Services might contact Psychiatric Services to indicate concern that a parent may have a psychiatric disorder, or to seek an opinion on the parenting behaviour of a current Psychiatric Services client (as advised in Protective Service policy guidelines[31]).

This potentially symbiotic relationship does not, however, operate smoothly. A range of problems was raised in the process of consultation with Mental Health and Protective Services workers. In large part these problems reflected both the nature of much current psychiatry (eg. the Adult Psychiatry emphasis on the individual client[32], and the differences in the statutory frameworks of Mental Health and Child Protection[33].

F1 Protective Services are reliant on other agencies

As would be expected given the framework described in E1, Protective Services reported that they relied heavily on support from other agencies, having no service system other than placement.[34]

They reported families as needing access to the full range of primary and secondary services, but were concerned that many do not have access to this full range, appearing to receive only a 'snap-shot' depending on the point of entry to the service

[30] Indicating a group that might benefit from an early intervention/ prevention program, described in Chapter D

[31] 'Parental Mental Illness: Policy advice and Practice Guidelines for Protective Workers' November 1996; DHS (1996).

[32] see Chapter C

[33] see Chapter E

34 Adult Psychiatric Services also reported their dependence on community services, eg. any client who hasn't a psychosis or suicidal tendencies will be referred from Adult Psychiatric Services services to community services, who now have extensive waiting lists.

system, a comment indicating the potential value of a community home-visiting program (described in Chapter D); their clients were seen to have multiple problems, including stress generated by Protective Service interventions.

Protective Services need specific help from Mental Health Services, regarding both adults and children. Protective Services currently consult with CAMHS on any young person they feel may have mental problems via a CAMHS liaison person co-located with Child Protection. Protective Services also endeavour to liaise closely with Adult Psychiatric Services (although there is no Adult Psychiatric Services liaison officer as exists for CAMHS).

For example, if Protective Services encounters a parent who is a client of Adult Psychiatric Services, they seek to assess if the parent's mental health status has affected their parenting, and approach Adult Psychiatric Services to obtain information and advice. Protective Services seek to find out: what is the parent's disorder? Has this disorder affected their parenting? Are they on medication? Has this medication stabilised their ability to be a parent? That is they are seeking information regarding the effect of a diagnosed mental illness on parenting skills.

Another common reason for approaching Psychiatric Services would be to seek an assessment of a parent whose behaviour Protective Services considers 'disturbed', but who is not currently a Psychiatric Services' client.

F2 Protective Services concerns regarding Adult Psychiatric Services

Given the framework within which Mental Health services operate, and the tradition in Adult Psychiatric Services of focussing on the needs of the individual client and maintaining confidentiality, it is probably not surprising that Protective Services workers reported that Adult Psychiatric Services tended to manage individual adults but 'did not check on families'. In the words of a Protective Services worker, 'Adult psychiatry think adults are the only client, children's interests are not considered'.

Instances were reported of difficulty in getting Psychiatric Services Triage to take Protective Services concerns seriously, with Triage unwilling to send an assessment team when a parent was acting in what Protective Services felt was a very disturbed manner. At the same time it was observed that things could work well, in cases where a good working relationship had been established between an individual Protective Services worker and a Triage officer.

It was reported that Adult Psychiatric Services was often unwilling to provide an opinion on the parenting ability of an Adult Psychiatric Services patient, other than to state, for example, that the person did not have a psychiatric diagnosis. Frustration was also reported at the CAT teams unwillingness to assess people who have potential mental problems and drug abuse, the CAT team 'wont assess anyone who is currently drug affected'[35]. Adult Psychiatric Services was perceived as frequently

35 In the words of one Protective Services worker: 'One hurdle for protective workers in relation to clients/caregivers health issues is assessment by psychiatric service staff. For example if a protective

unsympathetic and unhelpful. The frustration of Child Protection workers was palpable.

Note, however, that many of the concerns reflected a lack of understanding of the mandate under which mental health services operate, for example, the focus on those who have a diagnosed psychiatric disorder (or who are judged likely to have, and hence merit assessment), and that parenting assessments per se are not part of the responsibility of Mental Health. In this respect it was observed that a significant problem has been the belief on the part of the Child Protection Unit that Psychiatric Services offers counselling - CPU workers then became frustrated when clients referred for counselling to Psychiatric Services were not accepted.

F3 Psychiatric Services concerns regarding Protective Services

F3.1 Inappropriate demands from Protective Services

Just as Protective Services were frustrated with Psychiatric Services, so Psychiatric Services were with Protective Services. Protective Services were perceived as often making inappropriate requests - for example, contacting Triage to request an examination of a parent for a court report to determine if the parent was psychiatrically unwell and an unsuitable parent.

Another proffered example of an inappropriate request concerned a mother who was reported as using drugs and neglecting her child. Protective Services requested an assessment to see if the child should stay with the mother.

As Triage saw the core business of public psychiatric services to be mental illness and clinical treatment needs, it considered it inappropriate for scarce public mental health resources to be consumed checking if an adult's parenting was satisfactory. Moreover if a person did not want to be assessed, then they could not be without consent.

F3.2 Protective Services failed to involve Psychiatric Services when they should

In contrast to the above, Psychiatric Services also gave examples of what were seen to be inadequate contact from Protective Services. For example, Protective Services was reported to have precipitated a severe reaction in a mentally ill patient by taking the person's children away in the main street, and adult psychiatry had not been informed this was about to occur. Another informant reported that historically Protective

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worker has observed a client behaving in a manner suggestive of mental illness and 24 hours later the client has also misused substances and risks have risen, it may be difficult to gain assessment or support from Psychiatric Services as the client is deemed to be substance affected and not “suitable” for psychiatric assessment/support. The effect of this may be a child removed from a family’s care thus exacerbating trauma for child and family.’

Services only contacted Psychiatric Services to attend when children were being removed and the parent was believed to have a mental illness.[36]

As Protective Services had a limited understanding of mental health, so Psychiatric Services had a limited understanding of the imperatives placed upon Protective Services. Clearer understanding of each other's roles seems essential.

F3.3 Unwillingness to contact Child Protection due to concern that this would exacerbate the adult client's mental illness

As also reported in the literature, and as a complement to the previous issue, one Adult Psychiatric Services informant reported reluctance to involve Protective Services through
the concern that this could 'make the (parent) client go over the edge'.

Such cases indicate the complexity and difficulty of decisions (requiring a lot of skill and experience) when Psychiatric Service workers need to juggle the needs of the mentally ill parent with the needs of the child.

F3.4 Protective Services seen to need a better understanding of mental health (and Adult Psychiatric Services of children's needs)

One Adult Psychiatric Services source said that Protective Services needed educating that mental illness did not automatically mean inadequate parenting. Another observed that adult Psychiatric Services also needed to develop their own capacity to recognise children's needs.

F4 Mutual concerns

F4.1 Need for more consultation and interaction between the two agencies

Despite their complaints regarding the 'unreasonableness' of each other (behaviour quite understandable to the outsider given the differing frameworks and priorities of the two services), Protective Services and adult Psychiatric Services both felt the need for more liaison, regular case discussion, and educational meetings, although this view was held much more passionately by Protective Services (again, as they rely on other services their need is greater, i.e. it reflects their framework for service delivery).

Protective Service felt strongly that an Adult Psychiatric Services worker needed to be attached to Protective Services, either through secondments between Psychiatric Services and Protective Services, or an Adult Psychiatric Services worker co-located as consultant to Protective Services.

[36] It was also reported that Adult Psychiatric Services case managers may not know if Protective Services was involved with the family of the adult being treated

Additional vehicles for interaction were also supported, eg. joint training sessions, where Adult Psychiatric Services give talks to Protective Services, and Protective Services give talks to Adult Psychiatric Services. Another suggestion was that Adult Psychiatric Services might provide a mental health training program to Protective Services, as opposed to the current situation where Protective Services' mental health training is conducted at head office in Melbourne.

These initiatives were seen to be needed to facilitate understanding and effective relationships, as well as to increase Protective Services understanding of parenting issues and skills when parents have a mental illness. Protective Services observed that each service's staff should be able to assess the need for further investigation by the other.

Psychiatric Services staff also felt that more effective interaction with Protective Services was needed. An example was given of where in another Region Protective Services had a mental health consultant for weekly case discussion and education meetings. Another suggestion was that Psychiatric and Protective Services meet, say, every 2-4 weeks to 'touch base', eg. On how a psychotic mother and her child in foster care were progressing.

It was also proposed that inter-agency meetings be formally established between Protective Services and Adult Psychiatric Services, to establish a shared view, and clarify respective roles. A move to legitimise inter-agency liaison 'needs to happen', to schedule meetings and to identify problems. Another psychiatry worker suggested forums between Adult Psychiatric Services and Protective Services, to say: 'here we are, this is how we work, and why'. There was a perceived need to better understand each other.

It was also recommended that an Adult Psychiatric Services liaison person be allocated to Protective Services (as already exists for CAMHS), to educate Protective Services about mental health issues.

An existing mechanism that might also be drawn on is the Working Together Strategy[37], which sets out strategies to facilitate routine communication between Protective services and psychiatric services, covering the sponsorship of joint training, professional development and research across the sectors, development of output/outcome key performance indicators for integrated service provision, and involvement in joint service forums that explore and extend a local understanding and implementation of collaboration.

[37] 'The Working Together Strategy: A quality improvement initiative involving Mental Health, Protection and Care, Drug Treatment Services and Juvenile Justice'. The stated purpose of the strategy is to improve the quality and consistency of outcomes for clients of Drug Treatment, Juvenile Justice, Mental Health and Protection and Care Services, to be achieved through: identifying best practice for clients requiring access to two or more services; determining effective service relationships; ensuring understanding of existing programs and program innovation; establishing ongoing inter sectoral discussion, and program innovation and processes for continuous service improvement (see DHS, 1999, p.1). However the strategy had at the time not yet gone to units external to DHS.

F4.2 Rural areas have special problems

Both services observed that there were additional problems in rural areas. An example was the critical lack of people available to provide urgent placements for children. For example, it took workers nearly 9 months to obtain an alternative carer for a newborn baby. This was only achieved by the child being placed on an order so that a community agency could allocate a carer (due to the shortage of carers, the agency was obliged to give priority to statutory clients). These problems tended to reflect problems of distance from regional centres and associated facilities, and difficulties with transport and timely access.

There was seen to be a great need for services that could offer support and prevention programs prior to Protective Services involvement, not just take statutory clients.

F4.3 Assessment tool to flag cases

Protective Services desired a screening tool for workers to use to flag prospective mental health issues. Unfortunately the literature indicates that sensitive and specific instruments are yet to be developed. None the less the possibility deserves consideration.

F5 In Conclusion

Reflecting the lack of understanding of each other's services, and compounded by the inevitable poor experiences that result, there is currently a poor working relationship between Protective Services and adult Psychiatric Services. Current services are badly coordinated, sometimes distrustful, and Adult Psychiatric Services is wary of being required to pick up greater responsibility for an area which it sees as not its core business.

Both areas will quote cameo cases to illustrate the unreasonableness of the other service: Protective Services report Adult Psychiatric Services refusing to advise on the implications of an adult patient's psychosis for their parenting ability; Adult Psychiatric Services report Protective Services requesting an assessment of the parenting ability of an adult who has no evidence of serious mental illness.[38]

The actions of both services can have major repercussions for the other, as well as for the clients (adults and children). None the less, Adult Psychiatric Services sees many less problems with the current state of affairs than do Protective Services. For Adult Psychiatric Services its core population is adults: it has boundaries in place, and child issues are a secondary focus.

The stance of Adult Psychiatric Services could be viewed as partly reflecting the demands of servicing their 'core' constituency (adults with a psychiatric diagnosis)

[38] If there is no mental health diagnosis it is understandable that Adult Psychiatric Services may advise Child Protection to obtain a private assessment. On the other hand where there is a mental health diagnosis, providing advice on implications for parenting once requested seems necessary.

with the limited resources at their disposal, and partly as indicating an overly constrained role - as argued in Chapter C3, it is desirable that Adult Psychiatric Services places significant emphasis on the child's interests, for the child's sake and because parental mental health is influenced by their relationship with their child.

In contrast, for Protective Services the mental health of parents (and children) is a primary focus. As it said, it 'keeps the client' (the child and family), it cannot walk away[39].

None the less, both Agencies recognise that the state of affairs must be improved, and, despite their frustrations with each other, both recognise the value of entering into a formal liaison mechanism to engage with each other and develop a more effective relationship.

[39] Noting of course that Protective Services do not actually provide services – they rely on other services - and in some cases have been seeking services that are outside the brief of psychiatric services, eg. parenting assessment per se.

G Options for improving service delivery to children at risk of abuse and neglect whose parents have mental health problems in the Loddon Campaspe / Southern Mallee Area Mental Health Service

The literature reviews (see Chapters C and D) identified service elements that are indicated for the negative effects of parental mental health problems on children to be adequately addressed. These are:

- the investigation of family structure and functioning as a part of adult mental health assessment;
- coordination and collaboration between mental health services, particularly between adult mental health teams and CAMHS teams, but also including substance misuse services and perinatal services;
- access to and integration with a broad range of community services including child protection services, social workers, GPs, and community nurses;
- the participation of the full range of health and community services in joint service planning for addressing child abuse;
- the development of a prevention/ early-intervention program based on home visiting by community nurses to areas containing large numbers of at-risk families.

Chapters E described how the frameworks for Psychiatric and Protective Services were in many ways quite different, while Chapter F reported the results of consultations and revealed how historic service differences had contributed to a situation where Psychiatric Services seemed unprepared to examine the welfare of the children of adult clients, where protective and Psychiatric Services held a poor understanding of the nature and imperatives of each other's service, and where the current inter-service climate was characterised by a low level of positive collaboration exacerbated by a high service load.

This chapter sets out conclusions and recommendations based on the literature and consultation process.

G1 The parameters of a suitable model

G1.1 Historical differences in theoretical and statutory frameworks need to be overcome to ensure Psychiatric Services conduct appropriate investigations, psychiatric and protective services collaborate effectively, and parents and their children are considered as a unit

As outlined in Chapter E, Protective Services place great emphasis on the principle that in general the best care and protection of a child or young person is provided by their family, and only minimal intervention should occur when required to ensure adequate care and protection (Ross, 1999; statutory orders are seen as very much a 'last resort').

Moreover the view of the Department of Human Services in Victoria is that no one professional agency is able to provide for the total needs of endangered children and vulnerable families, and the direct provision of continuing placement, support and rehabilitation services to children and families is now by non-government agencies.[40] In effect the approach of Protection Services embodies the ultimate holistic view, where family circumstances are seen to be complex and inter-dependent, with the appropriate response necessarily involving a range of services.

This approach is to some extent, essential, as Protective Services no longer provide direct services to families. Dependent as they are on other services, Protective Services would benefit from a greater appreciation of the demands placed on Psychiatric Services when requesting their assistance. The core business of Psychiatric Services is the clinical treatment needs of clients, in particular those having a mental illness (meriting a psychiatric diagnosis). Protective services need to realise that Psychiatric Services are not responsible for providing them with parenting assessments, although Psychiatric Services might reasonably be asked to advise on the effects of a mental illness on parenting (quite a different matter).

In fact both services need to move from historical roles and adopt significant changes in their approach to service delivery.

Adult Psychiatric Services tend to consider only the adult client, and not the broader family situation or the effects of the client's condition on other family members. In the past they worked with institutionalised clients; now they work with people who are also part of families. There is a need to broaden the view of psychiatry to one that encompasses the parent-child unit so as to effectively address parent-child issues.

Psychiatric Services also need to develop an improved relationship with Protective Services, based on a clear understanding of their differing frameworks and responsibilities. The aim should be to collaborate effectively for mutual benefit.

In this regard it is of interest that a number of the concerns aired by Psychiatric Service workers regarding Protective Services, mirrored issues reported in the literature as obstacles to investigating parent-child relationships (see C2), i.e.:

- lack of necessary expertise, and fear of being unable to meet demands - it would be difficult to expect Adult Psychiatric Services to play a substantially greater role in assisting Protective Services without additional funding and/or training.
- conflict of interest between the therapists role with the parent and the needs of the child - the importance of emphasising the needs of the children has yet to be fully accepted in adult psychiatry.
- the dominance of the medical model - there is a need to ensure that organic/individual pathology of the parent is not considered to the exclusion of inter-personal/ intra-familial factors (the inter-dependency of the welfare of parent and child).

[40] DHS-Protective Services retains the statutory authority, responsibility for investigating notifications, and case planning responsibilities for children on protection orders

The consultation findings also mirrored a recent report on Australian programs concerning children of parents affected by a mental illness (AICAFMHA, 2000). This described a pattern of disconnection between services for adults and children (very similar to that in other countries and as described in the UK). It found that in Australia:

- children of parents affected by mental illness may never present to a mental health agency but instead come into contact with other agencies (including GPs) where their needs may not be recognised.
- a holistic family-friendly approach was needed to better support the children, spouses, other family members and parents with mental illnesses themselves
- barriers to such collaborative service delivery existed due to the 'individualistic and medical' model within most adult mental health services
- mental health services needed to take a leadership role in developing protocols, linkages and coordination across all sectors involved with children
- there was a need for greater collaboration between mental health services and general health services, general practitioners, and welfare, family court and education sectors
- mental health services needed to ensure children of adult clients (and direct carers) are identified in data collection (proposed as part of the National Mental Health Information Strategy)
- mental health promotion and prevention needs to support and involve children and their parents

It is evident that the way services currently operate prevents the interests of children at risk of abuse and neglect, and whose parents have mental health problems, being appropriately addressed. As discussed, other evidence indicates that parents with mental health problems would also benefit if services recognised the importance of the parent-child relationship to both children and parents, and acted correspondingly.

G1.2 Recognition that there are no legal (or ethical) barriers for Psychiatric Services to collaborate with Protective Services

At the beginning of the consultancy it was thought that many Psychiatric Services staff considered the Mental Health Act to hinder collaboration with Protective Services, due to the need to maintain client confidentiality. In fact, in consultations confidentiality issues were never raised in terms of the legal framework preventing effective communication. To the contrary, a number of mental health informants observed that discussing the client with other care service workers (eg. GPs, family support workers, etc) was not a 'legal' confidentiality matter, but was influenced by whether or not the disclosure was in the interests of the patient (a question of professional ethics, not of legal controls).

To be quite clear, the Mental Health Act (1986) does specify that behaviours such as engaging in illegal conduct, taking drugs or alcohol, and /or having an anti-social personality are not to be considered as a mental illness, and, as O'Hanlon and Obradovic (1999) point out, these provisions mean that such behaviours (which may

be associated with child abuse and neglect) are therefore not the responsibility of mental health services[41].

However where the Adult client does have a psychiatric diagnosis and/or child abuse or neglect is suspected or has been notified, the sharing of information with Protective Services is permissible and/or required by the Mental Health Act and the Children and Young Persons Act.

Thus the confidentiality provisions of the Mental Health Act 1986 allow information about a patient to be given to a person who is pursuing her or his statutory duties (see earlier Chapter E). The Children and Young Persons Act 1989 specifically states that information provision does not constitute a breach of professional ethics or section 120A of the Mental Health Act 1986 (see O'Hanlon and Obradovic, 1999). The Children and Young Persons Act 1989, Section 64 requires designated professionals to report to Child Protection Services when in the course of their professional duty they form the belief on reasonable grounds that a child is in need of protection.

In conclusion, the provisions of the Mental Health Act (1986) and the Children and Young Persons Act (1989) together mean that there are no legal barriers to effective collaboration between Mental Health services and Protective Services.

G1.3 Recognition that there is currently no evidence that screening tools are likely to be of major help: there is no evidence of a screening 'magic bullet'

At the beginning of the consultancy many workers hoped that screening tools might usefully flag individuals with mental health problems who were prospective child abusers. Both Adult Psychiatric Services and Protective Services workers expressed interest in such an assessment tool for workers.

Unfortunately the evidence is that a screening tool to identify families likely to be at risk of child abuse as a result of mental health problems is not around the corner. There would seem to be little evidence of a screening 'magic bullet', and despite repeated efforts (see section D5), attempts to identify sensitive and specific screening tools have come to nought.

The multi-factorial nature of child abuse, and the reported high false positive rates found when individual screening methods have been developed, indicates that the vast majority of families identified using such methods would not normally proceed to abuse their children. Certainly when applied to a large at-risk population, the instruments developed to date seem to unfairly stigmatise individual families with no demonstrable benefit.

This is not to say that an instrument for application to families currently involved with Protective Services to identify those with mental health problems that could be associated with abuse is out of the question, but available studies do not provide the

[41] Although Psychiatric Services may provide services to people with personality disorders.

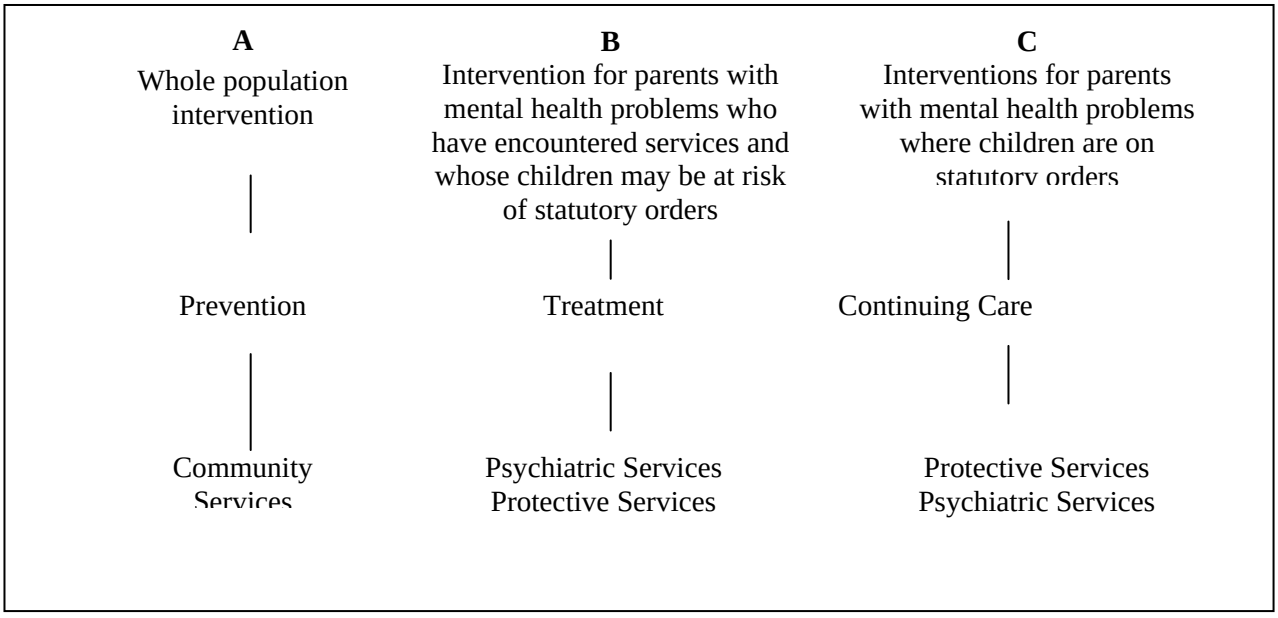
information that would be needed to form this more specialised tool. A dedicated research effort could conceivably be fruitful some time in the future.

G1.4 Troubled families need the opportunity to receive support across the full breadth of the acuity spectrum

Protective services reported that families in need of intervention often entered the service system too late, that they had not received primary or secondary services that might have prevented severe situations developing.

Those parents with mental health problems who are struggling to cope with the parenting role need interventions that will help prevent these situations from progressing to the point where they come to the attention of Protective Services or (even further down the track) the children are placed on a statutory order.

If the needs of parents of children at risk of coming into contact with Protective Services and/ or who are already involved with Protective Services are looked at in the context of three different target groups[42] of the service system they might look like below:



Programs with a whole-of-population orientation, ie. for Group A, are outside the mandate and resources of Mental Health and Protective Services, and would need to be negotiated with community agencies such as community health or local government. However as made evident in Chapter D, it is nurse visiting programs that target broad community populations, not individual families, that have been most conspicuously successful.

[42] This model is adapted from The spectrum of interventions for mental health problems and mental disorders in Commonwealth Department of Health and Aged Care 2000 **Promotion, Prevention and Early Intervention for Mental Health – A Monograph,** Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra p.28

On the other hand programs targeting Groups B and C are within the framework of Psychiatric Services and Protective Services, and concern the populations initially targeted by this project.

Programs targeting Group B (parents with mental health problems who have encountered services and whose children may be at risk of statutory orders) are potentially most beneficial as crises for family members (children and adults) that can be precipitated by statutory orders have not yet occurred, and might be avoided. Such programs need to consider early identification and support (including referral to community programs, respite, etc), where Adult Psychiatric Services can potentially play a major role.

Programs for Group C (parents with mental health issues where children are on statutory orders) may, in the words of one DHS Protective Services specialist in head office, often be a case of 'locking the door after the horse has bolted. However improving service collaboration can have potentially beneficial effects here to. Close contact and liaison between Adult Psychiatric Services and Protective Services can overcome the current problems of where Protective Services may be unsure of, say, whether the psychosis of a mother is now well controlled by medication and the child could be returned. The consultations clearly indicated an immediate need for much more sympathetic, informed, and effective support from Psychiatric Services to Protective Services in this area.

G2 Recommended initiatives

In a comprehensive program aiming to address parental mental health problems and reduce the likelihood of child maltreatment there would be four elements:

1. a new emphasis in psychiatry on considering the role and interdependence of families[43];
2. enhanced liaison, collaboration, and integration between Psychiatric Services and Protective Services;
3. a primary prevention community based home visiting program by health professionals to areas containing large numbers of at-risk families (while this intervention is outside the brief of both Psychiatric Services and Protective Services, it would fit well with community agencies such as community health or local government);
4. a mechanism for coordinating and integrating the broad range of services concerned with child abuse and neglect[44], including the proposed primary prevention program.

The following programs are suggested as potential means for developing a more effective, integrated, and comprehensive response to adult mental problems and child abuse.

[43] the literature revealed how Psychiatric Services have traditionally paid little attention to the current family (partner and dependents), possibly as in the days of institutionalisation the family of procreation was not a significant issue; it is de-institutionalisation that has allowed people with mental illness to form families

[44] under the Working Together strategy such a committee has been established by DHS Loddon Mallee

G2.1 Program A: Broadening the focus of Adult Psychiatric Services and child and adolescent mental health services to focus on the parent and child as a unit

Aims:
- the investigation of family structure and functioning as a part of adult mental health assessment;
- coordination and collaboration between mental health services, particularly between adult mental health teams and CAMHS teams

Suggested method: Location of a mental health worker trained in child and adolescent psychiatry in Adult Psychiatric Services, to enhance the ability of Adult Psychiatric Services to investigate issues affecting children where the parent has a mental illness.

Resources required: 0.5 EFT

This program would act to broaden the perspective of adult psychiatry to take into account the adult and dependent children. Adult Psychiatric Services clinicians do not currently have the skill base for considering family issues. The new position would represent child issues to Adult Psychiatric Services, provide training to Adult Psychiatric Services regarding aspects of parenting and the effect of mental health problems on parenting, and investigate children where needed. It is suggested that the position focus on consultation to other mental health workers, with a secondary hands on role with some families. Specifically the position would help Adult Psychiatric Services:
- identify which of their patients are experiencing parenting problems (including identifying if parents are involved with protective services), and assist in suggesting elements to add to care plans (entailing collaboration with other services etc; this in turn raises the vexed issue of how best to support people with mental illness to adopt good parenting practices)
- conduct assessments of the risk of the adult patient doing harm to their child, including the possible effects of preoccupation, emotional blunting and limited lifestyles (argued by Oates, 1997)
- manage parenting issues of patients with mental health problems, possibly including planning regarding parenthood and identifying needs for support in providing effective parenting.

The position could facilitate these aspects by assisting in the revision of the adult mental health assessment form, given that historically CASP documentation has not included information regarding dependent children beyond a genogram, which may or may not be completed. Revisions would require information on the nature of the relationship between the parent and children to be gathered as a matter of course. New information to be gathered could include:
- number of children, how they are and how the parent is getting on with them
- the history of family relationships
- specific questions about anger and violence towards children, particularly when patients are complaining of irritability and difficulty in controlling their emotions and loss of control with children

- an explicit detailing of the needs of the children in the parent's care program.

As Reder and Lucey (2000) argued, adding a small number of questions about the history of family relationships to the standard interview allows the adult's condition to be understood within its wider context, with the potential for treatment strategies to be devised to take these influences into account. The process would help bring about a change in perspective that includes the child.

The second aim of the position is to bridge CAMHS and Adult Psychiatric Services, to enhance the work of CAMHS with parents, and their understanding of Adult Psychiatric Services. Reder, McClure, and Jolley (2000b) identified one of the most crucial liaison initiatives required as that between CAMHS teams and adult mental health teams in the community and hospitals.

In this respect the position would need to collaborate closely with the existing CAMHS worker who serves as a liaison officer with Protective services (described further in G2.2 below). The worker could also provide clinical support to the case manager (clinical case consultancy).

This new position would complement existing programs in Psychiatric Services such as 'Kids with Confidence'[45], and Women's Mental Health[46].

G2.2 Program B: Enhanced liaison and collaboration between Adult Psychiatric Services and Protective Services

Aim:

- Enhanced liaison and collaboration between Adult Psychiatric Services and Protective Services, complementing that operating between CAMHS and Protective Services

Suggested method: Location of a Mental Health worker representing Adult Psychiatric Services in Protective Services. The person would need to have training in Child and Adolescent psychiatry but be part of the Adult Psychiatric Services team, ie. the same individual who conducts Program A above.

Resources required: 0.5 EFT

[45] The 'Kids with Confidence' project oversees the implementation of practices that are responsive to the needs of children of parents with a mental illness. The project supports the families of these children by the provision of information; liaison with psychiatric services; linking families to relevant skill building programs and assisting families to access resources. In particular the project has targeted the development of appropriate resources for young people whose parents have been admitted to the in-patient ward, provision of support to families at times of crisis and developing service links with relevant providers.

[46] A significant aspect of Women's Mental Health is work in the area of women with mental illness who are pregnant or have children 0-5 years of age. The aim of this work is to facilitate up-skilling of clinicians and general health workers in the assessment and management of mental illness in women who are pregnant and or have young children 0-5. It also aims to provide resources to both psychiatric services staff and staff of other agencies on issues relating to mental illness and parenting.

The literature stresses the need for close collaboration between psychiatry and protective services, particularly with Adult Psychiatric Services. The process of consultation indicated that all parties saw an urgent need for an Adult Psychiatric Services liaison officer with Protective Services.

The role of the position would be to train/ support Protective Services to know when and how to contact / communicate with Adult Psychiatric Services, and to increase their understanding of adult mental health problems in general. The position could advise workers when cases arise where it may be felt that diagnosable parental mental illness may be involved, as well as advise Protective Services on how to assess and act in other cases where non-diagnosable mental health problem behaviours may be involved.

The analogous position is the CAMHS liaison position in Protective Services, whereby Protective Services can consult with CAMHS on any young person they feel may have mental problems.

The CAMHS liaison position appears to operate well, and to some extent has played a de-facto role in advising Protective Services how to approach Adult Psychiatric Services. The CAMHS liaison officer provides general advice on how to understand and 'work' the Psychiatric Services system, eg. how to approach Triage, how to frame a request in such a way that Psychiatric Services will understand and more importantly, assist! And how in turn to interpret the response Protective Services may receive. In turn the CAMHS liaison person has come to understand how the protective system operates, with the result that Protective/CAMHS relations appear to work relatively smoothly.

It is clear from the consultation, and the success of the CAMHS liaison position, that an Adult Psychiatric Services/Protective liaison position would be highly valuable. The position should include an important educational role, ensuring that Protective services workers are clear about exactly what can be offered by Psychiatric Services (eg. assessing parenting skills per se are unlikely to be). Many of the comments gathered during the consultation conveyed a lack of understanding on the part of Protective Services workers of Psychiatric Services, and hence the expectations of these workers for service delivery could not be met. Thus one Adult Psychiatric Services source said that Protective Services needed educating that mental illness did not automatically mean inadequate parenting (another confirmed that Adult Psychiatric Services needed to develop their own capacity to recognise children's needs).

It is suggested that the position also facilitate case conferences where multiple agencies are involved, where all can meet as equal partners to draft care plans that are in the interest of all the family members. A protocol for this would need to be agreed, to be sensitive to the needs of different clients.

The position should develop a framework for clear communication between the two services to overcome the misunderstandings arising from limited knowledge of the brief of the other's service. This should include forums and training activities jointly attended by Protective Services, Adult Psychiatric Services, and CAMHS. These

initiatives should be supported by changes in existing documentation and the development of protocols to ensure clear communication.

The precise specification of duties and activities of this person carrying out the work of Programs A and B should be determined in close consultation with Adult Psychiatric Services and CAMHS; the position(s) should be structured to complement and collaborate with the position of CAMHS / Protective Services liaison officer[47].

The brief of the new positions could also include the development of strategies for gathering the input of families receiving services, with consumer views to be examined in a future evaluation of the effectiveness of the new positions and program elements.

G.3 Program C. Development of a home visiting program by community nurses to areas containing large numbers of at-risk families

Aim:

- the development of a prevention/ early-intervention program based on home visiting by community nurses to areas containing large numbers of at-risk families.

As noted earlier, a home visiting program by community nurses is outside the brief of both Psychiatric Services and Protective Services, in terms of mandate, resources and skill.

However the majority of facets of child maltreatment appear to respond better to prevention than treatment (eg. Browne, 1995), and the success of the Olds et al programs (Chapter D) has been striking. As described in Chapter B, the majority of parents with mental health problems do not abuse their children, and may be less likely to maltreat their children if they receive programs that provide general community and/or child care support. Such programs might also be more acceptable. Singer et al (2000) found that support programs to mothers with psychiatric disorder and young children were more acceptable to the mothers if made by agencies other than mental health (such as school, GP, or child and family social worker). Psychiatric departments or family or individual psychotherapy were seen as unhelpful or upsetting. Child maltreatment is a complex problem, but most argue (eg. Browne, 1995) that the majority of facets appear to respond better to prevention than treatment. Certainly the success of the Olds et al programs (see Chapter D) has been striking.

If possible, a pilot program might be introduced that follows Olds et al, ie. home visitation that:

1. extends from the prenatal period to the child's second birthday
2. occurs frequently (similar to Olds et al)

[47] The position description of the person acting as CAMHS liaison officer states the positions purpose as: to provide high quality consultation services to staff of protective Services and Juvenile Justice; to take a prime role in the development and maintenance of a collaborative relationship between DHS and CAMHS; to assist in the functioning and development of CAMHS through case management and review supervision, training, education, and policy development

3. is provided by a respected health professional such as a community nurse (so that programs can be promoted as family support initiatives rather than child abuse prevention)
4. targets geographic communities with high rates of poverty and of single and teenaged mothers (so scarce resources are deployed to those most likely to benefit from services)

The program might be a development of the role of child and maternal nurses employed by local government. This would further reduce the possible stigma of the program, so increasing its likelihood of success. Child and maternal nurses are well located to pick potential problems, are well respected, and have the advantage of providing services to everyone. There has been some suggestion that they are seeing some of these problems and could be interested in strategies to address these issues.

The program would be expensive. However as observed by Browne (citing Wolfe, 1993), 'the transition from a reactive to a proactive child protection strategy will be gradual and no doubt expensive in the short term'. Such a program might be less expensive if it links into that provided by maternal and child health nurses[48].

Irrespective of whether the program proceeds or not, the visiting nurses should be invited to participate in joint consultation and service planning via the Family Support Consultative Committee described below. This forum could facilitate inter-agency referral processes for when a child and maternal nurse identifies problems which are beyond her mandate.

G2.4 Program D. Establishment of a Family Support Consultative Committee (FSCC)

Aim:
- the participation of the full range of health and community services in joint service planning and provision for addressing child abuse
- integration of the proposed new home visiting program into a comprehensive and mutually supportive service network

As discussed in Sections C3.3 and C4, there is a clear need for service collaboration and integration ('while it would be idealistic to assume that a different pattern of working together would prove to be the panacea for the difficulties of dysfunctional parents and their children, if more comprehensive mental health responses could prevent or reduce the suffering of one generation of children and modify the intergenerational transmission of maladaptive behaviours the effort would be justified'; Westman, 2000).

The problems faced by families cut across service boundaries and involve a diverse range of services. There is a need for a forum where new inter-service strategies can

[48] A pilot program could, for instance, be located with the City of Greater Bendigo, targeted at selected estates, and using child and maternal health nurses to provide the intervention. This part of the model would have to be negotiated with the City of Greater Bendigo. Additional resources and upskilling for their staff would likely be needed to undertake such a project.

be developed, as well as enhancing the continuity of services and integrating service development[49].

Towards this end it is proposed that a Family Support Consultative Committee be formed, composed of representatives of all agencies involved in child protection problems. This might include Adult Psychiatric Services, CAMHS, Protective Services, St. Lukes, Hospital Maternity Wards, GPs, Child and Maternal Health Nurses, substance abuse services, Education, etc.

The FSCC could be a liaison mechanism that would involve agencies on an as-needed basis. It could:

- facilitate service liaison and coordination relating to parents with mental health problems and/or child abuse
- coordinate child abuse prevention and early detection programs
- develop new inter-service planning strategies
- act as an advisory group to the proposed broad-based home visiting program.

A needs-led as opposed to a service-led system is required, services invoked as indicated (Duncan and Reder, 2000). The Family Support Consultative Committee could play a valuable role in developing the collaboration and integration required for this to come about.

G2.5 Perceived obstacles to the Programs

Programs A and B are within the mandate of Psychiatric Services and Protective services. The primary obstacles to Programs A and B are likely to be resourcing, i.e. to fund the 1 EFT required.

Obstacles from differences in paradigm will be present as described, i.e. Protective Services is a child focused, family orientated organisation, while Adult Psychiatric Services's clients are traditionally exclusively adults, and the medical model is dominant. However there was acknowledged by all parties and individuals to be a real issue to be resolved, that communication and liaison was very much needed, and the various workers needed to get to know each other better and learn how to work together. There would seem to be no statutory obstacles.

Program C is outside the mandate of Psychiatric Services and Protective services. However it is highly desirable that it be pursued in whatever way possible.

Program D could be initiated by any party. It is recommended that it proceed, and that the proposed forum meet when and as needed.

[49] this is consistent with the framework of the Department of Human Services in Victoria, which considers that no one professional agency is able to provide for the total needs of endangered children and vulnerable families.

H Gaps in the literature and priority areas for research

H1 Evaluation of the proposed programs, including the assessment of consumer views

Consumers were not included in this project due to limitations on resources, the sensitivity of the issues involved, and the fact that this was more a review not original research. However it is desirable that information from the point of view of the consumers concerning the appropriateness and value of the proposals outlined be gathered in the future.

As noted earlier, it is suggested that the brief of the new positions (G2.1 and G2.2) include the development of strategies for gathering the input of families receiving services. Evaluation data from consumers will be important in measuring the outcomes from the project.

H2 Research on parents with mental health problems whose children are on statutory orders.

No literature was discovered that directly and effectively addressed this issue. Two potential projects that would be of value are as follows:

a. The identification and documentation of family case studies (say 6-10) of parents with mental health problems whose children are on statutory orders. The aim would be to understand in some detail how the service system has responded to such families

b. A research study to develop and trial an instrument to screen current family clients of protective services for mental health problems. This study would first need to conduct a feasibility analysis to ensure that adequate data was available and accessible - several hundred documented cases would be needed. It should be clear that the availability of such cases would not be a sufficient condition for a successful screening instrument to be formed (given the difficulties already noted in developing screening instruments in this area).

Both projects would need access to detailed records from both Protective services and Psychiatric Services for the same families.

H3 Basic information, such as how many admitted patients have dependent children, and how many have Protective Services involvement

The difficulties with the existing lack of data (and the RAPID patient information system) are obstacles to the development and evaluation of any new program. Issues of information storage and access would need to be considered carefully. Questions of access to the information system operated by Protective Services also need to be addressed.

H4 Effectiveness of enhanced liaison and collaboration between existing services

While there have been many recommendations for changing the way health and human service treatment services are coordinated, integrated, and delivered, there seem to be as yet no studies indicating the effectiveness of such changes (cf. Reder, McClure, and Jolley, 2000b)

H5 Understanding conditions required for cost-effective home visiting programs

The acclaimed success of the Olds et al programs has not meant that research in this area is complete. In particular research is needed on to what degree modifications to the program alter the effectiveness of the intervention. (see MacMillan 2000)

H6 Effectiveness of special mental health programs in reducing child maltreatment for parents with mental health problems

As described, there is a shortage of long term follow up studies to indicate the effectiveness of programs aimed at improving parent-child interaction to prevent or minimise child abuse. Examples of research areas are the effectiveness of programs targeting maternal depression in reducing child abuse

H7 The relationship between substance abuse, mental illness and child abuse

There were frequent reports of particular problems where these factors co-existed, and it was suggested as a priority area for further research.

H8 Finally. almost any Australian evaluation to do with child maltreatment and adult mental health issues

In a review of the evaluation of Australian child abuse programs, Tomison (2000) observed that with few exceptions no systematic research had preceded the implementation of primary and secondary child maltreatment prevention programs in Australia. The significance of this lack of information is that almost any controlled evaluation of a program to do with child abuse would be a substantial step forward. The generalisability of the results of studies from North America or the UK is unknown, and in this area (much more so than physiological medicine) such studies are needed. There currently seems to be little or no Australian evidence regarding the role of parental mental health factors in child abuse, the need for increased service

liaison and collaboration[50], and the effectiveness of community based prevention services.

[50] with the occasional exception, eg. the AICAFMHA (2000) scoping report, described in G1.1

List of Abbreviations

APT	Adolescent Protective Team
BPT	Behavioural Parenting Training
CAMHS	Child and Adolescent Mental Health Services
CATT	Crisis Assessment and Treatment Team
CMT	Case Management Team
CYPA	Children and Young Person's Act
CPU	Child Protection Unit
DHS	Department of Human Services
IPO	Interim Protection Order
PIT	Protective Intervention Team

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Collaborative Family Practice Project Evaluation Report

January 2007

The Collaborative Family Practice Project Evaluation was undertaken by the Centre for Rural Mental Health in collaboration with Child and Adolescent Mental Health Services, Bendigo Health Care Group.

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Glossary

AMHS: Area Mental Health Service

CP: Child protection

JJ: Juvenile Justice

CAMHS: Child and Adolescent Mental Health Service

CFPP: Collaborative Family Practice Project

Mental illness: is a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities. Mental disorders are of different types and degrees of severity and include depression, anxiety, and psychosis. The term 'mental disorder' is synonymous with mental illness (Commonwealth Department of Health and Aged Care 2000, p.3).

Mental health problems: interferes with a person's cognitive, emotional or social abilities but to a lesser extent than a diagnosable disorder. Mental health problem are more common than disorders, less severe and of a shorter duration. Mental health problems include the mental ill health that is temporarily associated with major life stressors (Commonwealth Department of Health and Aged Care 2000, p.3).

Personality disorder: is an enduring pattern of experience and behaviour that deviates markedly from the expectations of an individual's culture, is pervasive and inflexible, and is stable over time. People who experience these conditions display personality traits that are inflexible and maladaptive and cause significant functional impairment and subjective distress (American Psychiatric Association, 2000).

Important Note

In reporting the findings of the study pseudonyms have been used to protect the privacy of participants. Identifying details in some of the comments have been removed to ensure participants' identity is concealed, however the meanings of these comments have not been altered. For example the two consultants who have been employed as part of the Collaborative Family Practice Project are referred in participants' comments as 'the consultant'; however their real names were used during interviews. Minor amendments have also been made to the participants'

comments, including the use of ellipsis (denoting the omission of a word) to enhance readability.

Executive Summary

It is widely acknowledged that families affected by parental mental illness, and those involved in the child protection or juvenile justice system can face profound challenges. It is also known that there is significant overlap among this group: parental mental illness is a key risk factor for involvement in the child protection system, and involvement in the child protection system is a predictor of juvenile offending. Therefore there are many advantages to the key agencies supporting these young people and families – mental health services, child protection and juvenile justice services - working closely and collaboratively. Yet a range of barriers to collaboration exist. The different focus, protocols and legislative requirements of each organisation, in concert with high workloads, high staff turnover and the frequent means linkages and partnerships can be difficult to initiate and sustain.

In 2004 the Department of Human Services, Loddon Mallee Region funded the Collaborative Family Practice Project (CFPP), a pilot initiative designed to improve the provision of services to young people and families involved in the mental health, child protection and juvenile justice systems. The project has been undertaken by the Loddon Campaspe Southern Mallee Area Mental Health Service, in collaboration with Department of Human Services Child Protection and Juvenile Justice Units. To the best of our knowledge it is the only service of this type in Australia. The CFPP consists of two senior mental health clinicians (0.4 EFT respectively), one child and adolescent mental health consultant attached to the Area Mental Health Service adult mental health team and one adult mental health clinician located with the Department of Human Services Child Protection and Juvenile Justice Units. The following report details the evaluation of this intervention. The evaluation used a mixed methodology and included respondents from Child Protection, Juvenile Justice and the Area Mental Health Service. Families who have been affected by parental mental illness also participated in this study (for full details of the project methodology please see Methodology, page 17).

Key Findings

Demonstrated Need for the Collaborative Family Practice Project

The evaluation identified that there is clear need for the CFPP. Epidemiological data clearly indicates that mental health problems are widespread throughout the Australian community (Andrews, Hall, Teeson et al., 1999), and are particularly concentrated among low income, disadvantaged families (Butterworth, 2006). Reflecting these findings, over 70% of child protection (CP) and juvenile justice (JJ) workers reported that parental mental illness was present in a substantial proportion of their clients' families.

Similarly, approximately 60% of Area Mental Health Service (AMHS) clinicians reported that a proportion of their clients were the primary carers of children. However the number of clients alone does not reveal the full extent of the need in this area. Qualitative interviews highlighted that the complex issues faced by these families and young people place high demands on workers' time, services and resources.

Enhanced Wellbeing and Functioning Of Families and Clients

> I don't know where I would have gone without the consultant… My daughter is really loving... but she disappeared from me, being the nice little girl, she came back a monster. With the consultant' help, sort of like him convincing her, yes it is right, Mum gets sick, and we have to act when Mum's sick, but Mum's not always sick, it made her more confident with me…Now she is so proud, she wants to show me off all the time…
>
> **Lydia, mother**

Families and staff emphasized the significant benefits of the CFPP for parents, young people, children, and families. Parents reported increased family harmony, improvements in children's mood and behavior and increased competence in domains such as school work and social functioning. Parent's also reported that improved child and family functioning had benefits for their own mental health, and for some reduced the symptoms of their illness.

Workers reported that through either direct or secondary involvement of the consultants, parents had gained insights into the impact of their behaviours on

children and developed strategies to create a more child-focused family environment. In certain instances this had reduced the need for, or duration of, out-of-home placements for children. Within the JJ sector the involvement of the consultants had in some instances also allowed young offenders to remain in the community rather than serving custodial sentences.

Acceptable To Staff and Clients

The evaluation found that 80% of CP and JJ and 90% of AMHS respondents had direct contact with the consultants. Interviews and survey data identified that the CFPP was well received and acceptable to staff and clients. For staff, the co-location of the consultants was fundamental to the effectiveness and success of the project as it enables easy and flexible access to the information and support staff require.

The regular contact between the consultants and workers also promotes trusting relationships to be developed. Workers in each agency also reported that the co-location gave the consultants a greater understanding of the constraints of each organisation. Thus, more appropriate support and advice could be provided.

Families also found the intervention acceptable. Parents emphasized the interdependency between their mental wellbeing, parenting capacity and family functioning. They welcomed the opportunity to focus specifically on child and family issues in concert with their mental health treatment. Families also valued the warm and respectful manner in which support and education were delivered.

Enhanced Functioning Of the Service System

> Prior to the consultant, I had a mother and there was lots and lots and lots of interaction between St Luke's worker [family support] and child protection. It took a lot of my time to find out where they were, what was happening… Since we have had the consultant in place my experiences have been totally different. We have communication and, if we find that we don't, we get onto the consultant and say, "Well hang on, what is happening here?", and the next thing we know we have got a phone call from a worker.
>
> **AMHS respondent**

Workers from both agencies emphasized the importance of the consultants in facilitating improved interactions between the AMHS, JJ and CP and more appropriate use of each of these services. Prior to the commencement of the CFPP, staff reported that they had made, or received, inappropriate or ambiguous requests for services that resulted in frustration and wasted time. Through the work of the consultants a greater understanding of the role of CP, JJ and AMHS service delivery pathways were developed and interagency communication was enhanced.

The evaluation identified that 70% of CP and JJ staff reported improved working relationships with the AMHS, and 65% reported an increased knowledge of mental health resources. A similar proportion of AMHS staff (60%) of also reported an improvement in their interactions with CP staff. The data also indicated that there had been an improvement in the responsiveness of agencies leading decreased hostility which had previously been present in inter-agency exchanges. The project had also moved organizations away from a 'silo' mentality as staff developed a more collaborative approach to practice.

Increased Skills and Confidence of Staff in Working with Family Mental Health Issues

Increased levels of skill and confidence working with families were reported by 85% of mental health staff and 96% of CP and JJ staff since the implementation of the Collaborative Family Practice Project. Interviews with the staff also identified that with the support provided by the consultants, they were more likely to explore family mental health issues with clients. Interviews among child-protection staff found that the consultants' roles had changed practice among staff who had a greater awareness and focus on how parental mental health issues contributed to abuse and neglect.

Increased Satisfaction and Reduced Stress among Staff

> Debriefing of stuff is a big, big issue, but people's head is so full with the job they don't have space. I have used the consultant as a debrief… The consultant seems to be able to cut through crap and says "This is the problem." Then I can move on from that point.
>
> **CP/JJ Respondent**

Interviews with staff from both organizations highlighted how the CFPP had reduced the levels of stress and increased job satisfaction among staff. The complex,

demanding and emotionally intense nature of CP, JJ and mental health work has been well documented, as have elevated burn-out rates and compassion fatigue among this group of professionals (Armstrong, 1979; Conrad & Kellar-Guenther, 2006). The CFPP consultants provided staff with an important opportunity to discuss complex cases and empowered them to develop useful strategies for working clients, their families and other services. This opportunity to process stressful or traumatic events has been suggested as a key factor in preventing burnout among workers (Conrad & Kellar-Guenther, 2006). Developing greater insights and knowledge, and facilitating more positive outcomes for clients and families also increased workers' sense of efficacy and job satisfaction, another important factor in promoting staff welfare (Conrad & Kellar-Guenther, 2006). This finding has clear implications for the retention and wellbeing of staff across the three services.

Gaps in the service system

Mental Health Service for Families Involved In the Child Protection System

Through the interviews it emerged that many of the mental health problems experienced by families involved in the CP system did not fall within the remit of the Area Mental Health Service. Public mental health services within Victoria continue to be focused on those experiencing serious mental illness (Victorian Government Department of Human Service, 2002). The mental health problems of clients described by CP and JJ staff often fell outside this criterion yet have a profound impact on social and family functioning. Thus, CP workers can be faced with complex mental health issues that need to be addressed in order for maltreating behaviour to be resolved. However currently there are only limited services available to meet the needs of this group.

Mental Health Services for Young People Involved in the Juvenile Justice System

Mental disorders and offending have common antecedents and young offenders are at elevated risks for developing serious and lifelong mental health problems (Loeber, Wung, & Keenan, 1993). While addressing mental health issues is an important component of resolving offending behaviours, young offenders face an array of

barriers in accessing mental health services. Discussions with the Youth Parole Board revealed that the chaotic nature of young people's lives can limit access and effectiveness of community based treatments. Late adolescence is a time when prodromal symptoms of conditions such as schizophrenia can manifest (American Psychiatric Association, 2000), and while early intervention can be useful for this group(McGorry, Edwards, & Mihalopoulos, 1996), the non-specific nature of the symptoms may limit diagnosis and access to appropriate care. The high rate of substance misuse among young offenders further complicates their entry into mental health services.

Interviews also indicated that, similar to those involved in the CP system, the common mental health problems experienced by young offenders such as mild to moderate depression and anxiety did not always fall within the realm of public mental health services. In addition, as young offenders are less likely to continue their schooling (Fagan & Pabon, 1990) they are often unable to access services that provide care to young people experiencing these problems such as those counseling provided by the student wellbeing branch of the Department of Education and Training.

Barriers TO Family-Focused Service Provision in Adult Mental Health Care

There is a growing emphasis on developing family-focused adult mental health services within mental health research and policy (Australian Health Ministers, 2003; Commonwealth Department of Health and Aged Care, 2001). While this represents a positive step, there continues to be little acknowledgment of the challenges faced by the workforce in achieving this goal. It emerged through the evaluation that the majority of mental health case managers were mindful of family issues but due to resource limitations (particularly time), skill-level and the mandated focus of their roles on individual clients they were not consistently able to address family issues. Case managers also reported that meeting the needs of families was not always consistent with meeting clients' needs as confidentiality and developing rapport could be compromised. Understanding and addressing the complex dynamics operating in family relationships could be outside the skill level of case managers who do not routinely undergo family therapy training. This highlights the current disjuncture between policy rhetoric, and the organisation and resourcing of mental health services in relation to families affected by mental illness.

Limited Service Provision in Rural Areas

The Collaborative Family Practice Project is based in Bendigo due to the pilot nature of the intervention and the available resources. While some services (primarily education) have been provided to rural areas, the program primarily focuses on the needs of clients and families living within the Bendigo region. Therefore, rural community mental health teams and CP services receive only limited support from the consultants. This is particularly concerning given the more generalized lack of mental health and medical services among rural communities (Parslow & Jorm, 2000; Caldwell, Jorm, Knox et al., 2004; Harding, 2000).

Needs of Non-Area Mental Health Service Professionals Working with Parents with Mental Illness.

The CFPP has shown important changes in the attitudes and practices of staff working within the mental health system around child and family welfare. However, it is well acknowledged that the vast majority of people experiencing mental health problems will never enter the public mental health system (Andrews, Henderson, & Hall, 2001). Those who do access services are most likely being treated by their general practitioner (Andrews, Hall, Teesson et al., 1999). Currently there are no clear mechanisms for general practitioners to access advice from the CFPP consultants regarding parenting and mental illness, or opportunities for general practitioners to be made aware of the potential impact a patient's illness may have on the welfare of their children.

Recommendations

Continuation and Expansion of the Collaborative Family Practice Project

The evaluation has clearly highlighted the need, acceptability and benefit of the CFPP to clients, their families and staff. Therefore it is recommended that the program be continued on an ongoing basis. While many advances have been made, the high turnover of staff and frequent organisational changes in human service agencies require that ongoing support for families and staff (working in mental health services, CP and JJ) be provided. There is also scope to expand the provision of direct support services to families affected by parental mental illness, lessening the impact of mental illness and enhancing family interactions. Further, this intervention has clear

applications for mental health teams, and CP services outside the Bendigo region (where it is currently located). Therefore it is recommended that these positions be increased from their current fractional appointments of 0.4 EFT to 0.8 EFT (Child and Adolescent Mental Health Consultant to Adult Mental Health) and 0.8 EFT (Adult Mental Health Clinician to Child Protection and Juvenile Justice). The total cost of this proposal is $172,307 (for detailed budget proposal please see Appendix One)

The increased time allocation of these positions would enable:

1. A more equitable distribution of the service across the Loddon Southern Mallee Region.
2. Increased scope for education and training activities to be undertaken.
3. More comprehensive support to be provided to workers and families.
4. Provision of education and support for non-AMHS professionals working with parents experiencing mental illness.

Child Protection Consultation to Mental Health Services

Strong links between child protection and those who work with parents with mental health problems are essential. It has been established that parents who maltreat their children have significantly higher rates of mental health problems (De Bellis, Broussard, Herring et al., 2001)and protective issues routinely emerge in the work of both child and adolescent and adult mental health professionals. While the work of the CFPP has increased the appropriate use of child protective services, further work is required. This is particularly important in light of the new CP legislation (*Children, Youth & Families Act 2005)* that is being introduced in Victoria. This legislation will result in changes to CP practices and will place greater responsibility for the protection of children on community based agencies including mental health services, and others who work with children of parents with mental health problems including general practitioners, psychiatric disability support and rehabilitation service staff and schools.

Therefore it is recommended that the Community Based Child Protection Workers provide consultation to the Area Mental Health Service. This would include an

increase in the training and education that is currently offered to AMHS staff and the provision of information to workers. Educating mental health workers about their responsibilities in light of the new child protection legislation would need to be a particular focus of these roles. In addition, ensuring clarity around referral pathways and the role of child protection would also be required.

Increased Collaboration among Child and Family Focused Programs within the AMHS

The Loddon Southern Mallee AMHS has a range of innovative child and family mental health initiatives including women's mental health officers, "Kids with Confidence" workers and the recently announced Families Affected by Parental Mental Illness coordinator. Increasing the integration of these programs could generate important benefits including increased knowledge sharing, greater consistency in service provision and more seamless delivery of services. Regular meetings and planning days would enable staff to identify gaps in the service systems and tailor services to better meet the needs of these client groups.

Mental Health Issues and Needs of Families and Young People Involved in Child Protection System and Juvenile Justice.

Reports of workers have highlighted that families and young people involved in the CP and JJ system experience a range of mental health problems and disorders. It was not within the scope of this evaluation to assess these issues in detail. Therefore it is recommended that further research that directly assesses the mental health problems and disorders experienced by young people and their families in these service sectors be undertaken.

Expanded and Ongoing Evaluation

This evaluation has made an important contribution to the knowledge base around interventions for families affected by parental mental illness, those involved in the CP system, and young people involved in the JJ system. However the scope of this evaluation has been limited and it has been undertaken from within the existing resources of the AMHS. If services are to fulfil their commitment to developing evidence-based interventions as recommended by the National Mental Health Plan

(Australian Health Ministers, 2003) and the White Paper (Office for Children, 2005), funding bodies need to make a stronger commitment to the rigorous and ongoing evaluation of interventions such as the CFPP. A particular focus of future evaluations needs to be family and client outcomes over the months and years following their involvement with services

Project Background

Child abuse and neglect (Australian Bureau of Statistics, 2003), juvenile offending (Homel, Freiberg, Lamb et al., 1999) and parental mental health problems (Cowling, 1999) are widespread in Australia, and the costs associated with these issues, both human and economic, reverberate throughout the entire community. Those who are directly affected can experience profound and life-long psychological distress, increased rates of mortality and morbidity, incarceration, poverty and homelessness. Costs to the community are incurred in the health, human services, justice, and education sectors.

While child abuse and neglect, juvenile offending and parental mental health problems can occur independently, they share common antecedents and are frequently co-exist in a family. Thus a shared understanding of the causes and appropriate interventions to prevent and treat these problems is required among the service providers working with this group of young people and families. Perhaps surprisingly, collaboration among these agencies is not standard practice and professional relationships are often characterised by poor communication and mistrust (Darlington, Feeney, & Rixon, 2005). The result for families can be poorer quality service, discontinuity in care and compromised outcomes.

A research project commissioned by the Bendigo Health Care Group and funded by the Department of Human Services, Loddon Mallee Region in 2002, found that services in this region reflected general trends. There was limited coordination or collaboration across the agencies and relations were typically strained (O'Connor, 2002). The report made a number of recommendations to address this issue, including the establishment of two mental health consultants – one child and adolescent mental health consultant to the adult mental health team and one adult mental health consultant to CP and JJ services. In 2005 Psychiatric Services, Bendigo Health in collaboration with Child Protection and Juvenile Justice, Department of Human Services developed the Collaborative Family Practice Project (CFPP) which encompassed these two positions. This initiative was funded by Department of

Human Services, Loddon Mallee, aimed at enhancing collaboration and improving outcomes for families. The aim of the current project was evaluate this intervention.

Aims of the Evaluation

The aims of the project were to:

1. Describe the issues experienced by families affected by mental illness and those involved with child protection and JJ agencies;
2. Evaluate the implementation of the *Collaborative Practice Project;*
3. Assess changes to attitudes, knowledge and practices of staff working with families affected by parental mental health issues;
4. Explore the perceived effect of the intervention on family functioning;
5. Identify gaps and issues in service provision to this group of families that could be addressed in future work in the area, and;
6. Develop key recommendations to guide the further development of the intervention.

Methodology

Key Evaluation Questions

The evaluation investigated the following key research questions:

- What are the particular issues experienced by families and young people who have participated in the intervention?
- How (if at all) has the intervention changed the services received by families?
- To what extent have self-reported attitudes, knowledge and practices of staff working with families and parental mental health issues changed since the commencement of the intervention?
- What are the perceived remaining gaps and issues in service provision to this group of families?
- What are the strategies needed to address remaining gaps in the provision of services to families?

Ethics Approval

This project received approval from the Bendigo Health Care Group Human Research Ethics Committee (HREC Reference Number: 7/2006)

Data Collection and Analysis

The Collaborative Practice Project is a multilevel intervention that includes different groups of staff and clients across three agencies. In order to adequately capture the impact of the, intervention, a mixed methodology approach was selected. Data collection included1) recording the activities of two Collaborative Practice consultants, 2) questionnaires and semi-structured interviews with staff involved in the program and 3) semi-structured interviews with parents who have been involved in the program.

1. **Activities of the intervention:** The two mental health consultants who deliver the intervention kept a record of the types of activities undertaken (e.g. staff education, client assessment, secondary consultation) as part of the project over a three month period (July 1 to September 30, 2006). This data was entered into the *Redevelopment of Acute & Psychiatric Information Directions* (RAPID) database

2. **Staff Questionnaires and Interviews:** staff working in CP, JJ and the Area Mental Health Service were invited to complete a brief questionnaire (see **Appendices Two and Three)**. Questionnaires were distributed to staff via team meetings returned using self-addressed envelopes. The questionnaires were anonymous.

   A number of staff also participated in an individual semi-structured interview (see **Appendix Four**). The interview focused on level of satisfaction with the CFPP and areas identified for improvement. Interviews were tape recorded and transcribed for later analysis.

3. Parents who had been involved in the project also participated in semi-structured interviews (see **Appendix Four**). Parents were recruited through the use of key informants. The key informants identified potential participants'

and provided them with basic information about the project. With participants consent their telephone details were then forwarded to the evaluator who contacted potential participants by telephone. These interviews explored parents' satisfaction with the intervention and any perceived benefits. Parents were also asked to comment on key areas for service improvement. Interviews were taped and transcribed for later analysis.

4. For ethical reasons no clients of CP or JJ were interviewed.

Data Analysis

The data from the questionnaires was analysed using Microsoft Excel. Data from the interviews was being analysed qualitatively using thematic content analysis.

Findings

Participants

Approximately 90 surveys were distributed and a total of 51 surveys were completed by 21 AMHS staff and 30 JJ and CP workers. In order to protect the anonymity of staff the surveys were both anonymous and unidentifiable. Therefore we are not able to determine an accurate response rate for the survey.

A total of fourteen interviews were undertaken as part of the project. The respondents included AMHS staff (five) CP staff (three), and JJ (two) staff. Four parents who have experienced mental illness and had contact with the CFPP consultant also took part in interviews. Three of the parents experienced bi-polar-affective disorder and one parent experienced an anxiety disorder. Three of the parents had numerous in-patient admissions due to the severity of their illness.

Issues for young people, parents and families involved in child protection, juvenile justice and/or affected by parental mental illness

The following sections detail issues that emerged through a literature review, interviews and surveys that affect the key client groups involved with the Collaborative Family Practice Project. These data sources highlighted that there are many common issues faced by these groups of clients. These are described below.

Parenting and Mental Illness

Parenting with a mental illness or mental health problems was common among both AMHS clients, families involved in the CP system and among parents of young offenders. Consistent with previous studies (Oyserman, Bybee, & Mowbray, 2002; Oyserman, Bybee, Mowbray et al., 2005; Seifer, Sameroff, Dickstein et al., 1996; Lundy, Field, Cigales et al., 1997), staff noted that the symptoms of mental illness, and/or the side effects of medication can impair people's ability to perform basic parenting tasks such as feeding and clothing, nurturing, and maintaining adequate discipline and supervision. These issues were most severe during acute episodes of mental illness. In the extract below one mother describes her experience.

> I smoked dope and I just went off my tree within 24 hours, no sleep for three days. It was just terrible for her [daughter], I wet the bed..... There was no one there to talk to her or tell her, and she didn't let me out of her sight because she didn't know what was wrong with me. She put an apron on and had a long wooden spoon. And she kept hitting me in the back and pushing me around the house to do things….apparently in the end she rang the police, and they came to get us in the divvy wagon.
>
> **Lydia, mother**.

Other parents described less severe, but more chronic problems such as the inability to consistently care for children (due to illness or hospitalisations), difficulty in providing healthy meals or adequate stimulation and problems maintaining consistent discipline and control.

Mental health problems can also impair the capacity of primary carers to bond and synchronise emotionally with their children (Rutter, 1989) increasing the likelihood of insecure attachments (Martins & Gaffan, 2000; Riordan, Appleby, & Faragher, 1999).

One young mother, Mary, talked about how the frequent episodes of her illness had compromised her early parenting.

> My son was about 18 months old when I was in hospital for a week and even from the very first one [episode of mental illness], I noticed a difference in my son… I had another manic episode and that was worse, I was in hospital longer, about a month, and so my son was cared for by Mum again, and after I got out from that I noticed that there was a difference in him too, because he had been away from me, and each time he gets further and further away from you.
>
> **Mary, mother**

Acute episodes of mental illness and ongoing mental health problems could profoundly impact the family dynamics. Parents spoke of the boundaries between children and adults becoming blurred and of the difficulty of re-establishing healthy family interactions.

> Because Lucy was a baby when I got sick, Naomi had taken it upon herself to get out of bed and she was making Lucy bottles, she was 5 ½ then. She would get the other kids up, get them organised, feed them, dress them, bathe them. She would do whatever was needed. So when my mother-in-law moved in she resented her being here.
>
> **Georgie, mother.**

Typically, there were considerable tensions within families as parents worked toward re-establishing discipline and control. Children could be wary of parents, disobedient or withdrawn. For parents who were continuing to deal with the ongoing symptoms or stressors associated with mental illness, these additional challenges could be very difficult to manage and may have implications for the welfare of children.

> I was getting angry and I even knew myself… I was getting worked up and at strangling point. Because she had no respect, because she didn't know what this illness was and she thought I had bought it all on myself.
>
> **Lydia, mother**

Reflecting the findings of previous research (Sands, 1995) staff also noted that there was be a tendency among some parents affected by mental illness to pay limited attention to their children's welfare. The symptoms of their illness could compromise their ability to be sensitive to the emotional and practical needs of children. Staff acknowledged that it was generally these types of stressor that contributed to inadequate parenting.

> I believe people want the best for their family, and they just don't have the skills or they are burnt out or there is something missing in their needs to provide what they want to provide
>
> **CP/JJ respondent**

While all parents in this study noted that parenting with a mental illness was taxing, all demonstrated a strong commitment to their families' wellbeing.

Parental mental illness and involvement in the child protection system

Parental mental health problems are commonly encountered among the families involved in the CP system(De Bellis et al., 2001). Consistent with the research literature (Adshead, 2003; Stanley & Bridget, 1999) CP staff reported that parents frequently experienced at least one disorder, most commonly depression, anxiety, substance abuse or personality disorders. Staff reported that achieving positive outcomes for these families could be particularly challenging as it was difficult to establish and maintain a positive, therapeutic relationship.

Child protection workers also reported that the services available for these clients were often inadequate. For a proportion of families, mental health issues needed to be addressed in order for child maltreatment to be resolved. While workers acknowledged the high demand on mental health services, they also reported their frustration with the mental health system which they perceived only provided support for clients in acute crisis.

Parents who experienced mental illness also reported that their relationship with protective services could be strained. Some parents felt victimised because of their illness and unsupported by the CP system.

> Every time I have been in hospital there have been women there who have had their children taken off them and I think it is really wrong. Not that I was innocent. Sure take her out of my hands because I was sick but not a bloody order for 12 months, bloody hell, [crying] my daughter is the only reason I live, it is unreal.
>
> **Lydia, mother**

Previous research has indicated that parents' perception that they are discriminated against on the basis of their illness can reduce their likelihood of contacting services

in times of need, due to fears of having their children removed (Fraser, 1997). Some AMHS staff also suggested that there could be an over-emphasis on parents' mental health problems.

> With a family that I was working with, there was a stage where they tended to focus in on the mental health issues rather than take a holistic view of the family. There were quite significant issues for the family and in fact the mental health issue was probably the least of their problems. The mental health issues were stable after a period of time but it was still a focus, even when there were lots of other issues in the family.
>
> **AMHS respondent**

Untangling mental health issues from other family dynamics and parenting behaviours and developing good working relationships, is challenging for both staff and families involved in the CP system. This issue can be further complicated by the difficulties for families in understanding and complying with court orders. As one CP worker stated:

> I have got to deal with the courts, and I struggle to understand that myself, and then I have to translate that to people who don't have great education….and I know that I hand documents to them and I know that they are not going to read this, they want me to just tell them what they have got to do and so I will just bugger off out of their life.
>
> **CP/JJ respondent**

Clearly having a child placed on a statutory order is a stressful experience for parents and likely to elicit fear and resentment. If parents are experiencing mental illness, their cognitive abilities can also be compromised, diminishing their capacity to understand and retain information. Complex legal language and documentation may further contribute to tensions and misunderstandings between CP staff and clients, and increase the perception of parents that they are not being treated fairly.

Child health and wellbeing

While people with mental illness and mental health problems can and do parent well, many studies have found higher rates of adverse outcomes for children in these families (Rutter & Quinton, 1984; Keller, Beardslee, Doser et al., 1986; Weissman, Warner, Wickramarante et al., 1997). All parents who were involved in the evaluation reported difficulties in their children's behaviour and functioning and some also noted physical health problems. Three of the four families had been involved with CAMHS

and children also had difficulties with peers, some had few friends and others were involved with an anti-social peer group. School problems were common to all families involved in the evaluation, and they reported either school refusal or significant learning difficulties. For some children, their problems with school fluctuated depending upon their parents' mental health, while others experienced long-standing learning difficulties.

Parents did not talk positively about their interactions with the education system, feeling that schools had been insensitive to their families' needs and did not adequately support their children. Mary described the difficulties her son experienced and the limited support she felt was offered by the school:

> …he had teachers that weren't really understanding because he was a bit different, because he had experienced things, and so I think they just treated him differently. In prep, he had a lot of trouble getting his ABCs and reading … he is still having a lot trouble now in Grade Five…He gets picked on a bit because of his size… his social behaviour,…His teacher this year, I find it really difficult to speak to him …I just feel that they have let him down a lot.

Parents also spoke about children's physical health problems. In three of the four families interviewed, at least one child had one or more health problems. Parents felt these health problems were related directly to their own illness or treatment (i.e. effects of medication taken during pregnancy) or due to their impaired ability to care for their children.

Impact of Parenting on Mental Health

> I do everything for my kids, I hate it when they are away from home, I worry about them, and I try and look after them. I just feel that somewhere along the line we have done something wrong. I can't figure out where it is, or how to fix it. Family affects everything, everything about how you are feeling.
>
> **Lucy, Mother**
>
> I don't think I have done anything good [as a mother]. When he is waiting I have let him down, his inactivity… Last year, I was really, really bad, a psychotic episode, I told him lots of stuff that wasn't true, and yeah, I behaved badly, so all that worries me how that has been affecting him.
>
> **Mary, mother**

While mental health problems have important implications for parenting, the demands of parenting can also adversely affect the mental wellbeing of parents (Devlin & O'brien, 1999). Parents reported that managing the difficult behaviours of children increased their stress levels and in some instances contributed to a relapse of their illness. Staff also noted that negotiating a child's different developmental phases could be very demanding for parents affected by mental illness, as they may have limited skills and knowledge to assist them in adjusting to the subtly changing needs of infants, toddlers, children and adolescents(Hutchison, 2003).

Limited social support

Parents affected by mental illness, parents of young offenders and those involved in CP tended to have a shared experience of limited social support. Staff reported that parents involved in the CP system had often experienced maladaptive interactions in their own family-of-origin and had limited positive parenting role modelling. In addition, social networks in low-income neighbourhoods where this group of families frequently lived, could promote unhealthy approaches to parenting.

> Where you have got parents who aren't coping with life very well, they are pretty isolated. They might have good neighbourhood networks, but they are not necessarily helpful in lots of ways… they don't have the contacts that can support their parenting.
>
> **CP/JJ respondent**

Parents described how mental health problems could undermine their capacity to sustain friendships and positive relationships with family members. During times of crisis or the chronic stress that can accompany parenting with a mental illness, parents had limited respite, encouragement or assistance. Within this context of limited support, families could rely heavily on one two friends or family members. The loss of this support due to illness, death, moving away or simply burnout could have a profound impact. Lucy describes the experiences of her family:

> It was fine until Mum and Dad died and then it sort of all went in a heap. It was like there is no person up there to respect anymore… Mum and Dad died two years ago…. That just blew us away.

Limited social support also impacted upon children. Not only could parents become more stressed, but there were fewer adults available to undertake caring roles when a

parent was unwell, leaving children to shoulder greater responsibilities within the family

Life stressors

All families who participated in the evaluation reported experiences of violence and/or trauma. Domestic violence was a common theme and most mothers had been victims of this form of abuse. Traumatic experiences related to mental illness, treatment and childbirth were also frequently mentioned. Serious and chronic physical health problems were also common among families.

Socio-economic disadvantage

Those involved in the CP, juvenile justice (Weatherburn & Lind, 2001) or mental health systems (Rogler, 1996) tend to be poor. As Weatherburn and Lind (1997) argue, economic stress in the context of limited social support is a potent predictor of child maltreatment. Staff made particular note of the impact of inter-generational poverty and the adverse impact this had on the capacity of families to negotiate daily demands such as cooking, basic hygiene and budgeting. With limited access to formal education, parents' literacy was often poor. This created further challenges in adhering to treatment regimes or court orders. Living on low incomes also meant that housing choices could be limited to neighbourhoods where anti-social behaviour is normalised, adding to both parents' stress and difficulties in providing safe and stable environment for their children. It also exposed adolescents to anti-social and criminal behaviour

Young Offenders

Clients involved in the juvenile justice system include a diverse group of young people. However there are a number of recognised antecedents of juvenile offending as shown in **Table One.**

Level	Risk Factors
Child	Poor problem solving; Beliefs about aggression; Attributions; Poor social skills; Low self esteem; Lack of empathy; Alienation; Hyperactivity/disruptive behaviour; Impulsivity; Prematurity; Low birth weight; Disability; Prenatal brain damage; Birth injury; Low intelligence; Difficult temperament; Chronic illness; Insecure attachment.

Family	Psychiatric disorder, especially depression; Substance abuse; Criminality; Antisocial models; Family violence and disharmony; Marital discord; Disorganised negative interaction/social isolation; Parenting style; Poor supervision and monitoring of the child; Discipline style (harsh or inconsistent); Rejection of the child; Abuse; Lack of warmth and affection; Low involvement in child's activities; Neglect; Teenage mothers; Single parents; Large family size; Father absence; Long-term parental unemployment.
School	School failure; Normative beliefs about aggression; Deviant peer group; Bullying; Peer rejection; Poor attachment to school; Inadequate behaviour management.
Life events	Divorce and family break-up; Death of a family member
Community and social factors	Socio-economic disadvantage; Population density and housing conditions; Urban area; Neighbourhood violence and crime; Cultural norms concerning violence as acceptable response to frustration; Media portrayal of violence; Lack of support services.

Table 1: Risk factors for juvenile offending based on Homel et al (1999)

Discussions with juvenile justice staff provided insights into the experiences of this group of young people are experiencing. Parental mental health issues, parental or family trauma, and family break-up and discord were common.

Consistent with previous research substance abuse (Prichard & Payne, 2005) and mental health issues (Allerton, Champion, Butler et al., 2003) were also common among this group of young people. Discussions with both juvenile justice staff and the Victorian Youth Parole Board highlighted that despite the high level of need among this group; their entry into mental health care was often limited, complicated by their substance use and other lifestyle issues, their age and the nature of the service system.

> Often the worker is the only one that kid will work with. Sometimes, that is appropriate on an ongoing basis, and sometimes because you have got to start somewhere and you might need to get the relationship, and get the kid ready to refer them into a specialist service. …There are also a group of kids they wouldn't t get entry into the adult mental health system; you may be looking at the early stages of things [such as psychotic illness]. There is also that transition from CAMHS to adult, and the access into CAMHS is a different group of kids to the adult system.
>
> **CP/JJ respondent**

Access to services was increasingly difficult with distance from the major centres as the number of providers of care for high-needs young people diminished. In some

instance the absence of appropriate mental health support resulted in young people spending longer periods in detention.

Summary

The issues identified in this project are consistent with previous research in this area. It is also important to note that individual stressors tend to interact and compound the effects of other challenges. Interview participants provided vivid descriptions of the 'pile-up' of how mental illness, socio-economic disadvantage and social isolation coalesce to demoralise parents and undermine the health promoting capacity of families. Despite these challenges parents remained strongly committed to their roles and to their families.

Implementation of the Collaborative Practice Project;

The following section details the implementation of the Collaborative Family Practice Project. The CFPP consists of two positions, supported by a multi-disciplinary, inter-agency working party. The two positions that are funded through the CFPP are both managed by the AMHS. While both roles were designed to promote families' mental health each position had a distinct focus. The Child Protection (CP) and Juvenile Justice (JJ) consultant is a mental health clinician with experience in adult psychiatry. The key aims of the position are 1) to provide support and enhance the skills and knowledge of CP and JJ staff in working with clients' mental health issues and 2) to enhance collaboration between the AMHS and CP. The key responsibilities for this position included:

- Secondary and tertiary consultation on mental health issues to CP and JJ staff;
- Development and maintenance of collaborative working links with adult psychiatry;
- Primary consultation for CP and JJ and adult services' clients or parents of clients.
- Contribute to the formation, implementation, monitoring and evaluation of case plans;
- Assist in the development, implementation and review of protocols between adult psychiatric services and CP and JJ that enhance appropriate access to adult psychiatric services for parents who are clients or whose children are CP or JJ clients;
- Assess need, plan, implement and evaluate education and training programs for staff in both sectors;
- Work with relevant consultancy positions for example the Spiritual and Emotional and Wellbeing (indigenous mental health) worker for Psychiatric Services; and
- Refer or consult with Psychiatric Services staff and other professionals on specialist matters as required.

The purpose of the CAMHS consultant position is to provide consultation to adult psychiatry staff on issues related to parenting skills, and the wellbeing of dependent

children of adult psychiatry clients. The position also aimed to take a prime role in the development and maintenance of a collaborative relationship between adult mental health services and CAMHS, CP and JJ. The key responsibilities of this position are:

- To identify adult psychiatry clients with dependent children who are: experiencing parenting problems, including those who are involved with CP and JJ;
- To assist in assessing the impact of adult mental health problems on dependent children;
- To conduct assessments, including risk of harm for dependent children of adult psychiatry clients where indicated and to contribute to care plans to address these problems;
- To develop and maintain collaborative working links between adult psychiatric services, CAMHS, CP and JJ;
- To work collaboratively with other CAMHS consultancy positions; and,
- To provide professional education for adult psychiatry staff regarding the initial assessment of dependent children and their mental health needs.

Activities of the Consultants

Both consultants recorded their activities for a three-month period, which are shown in **Table Two**. As the data shows, the activities of the consultants consistent with the aims of the positions, with the majority of work being secondary consultations to staff

Type of Contact	MH Consultant	CCP &JJ Consultant
Direct Service	18%	0%
Primary Consultancy	5%	4%
Secondary Consultancy	51%	64%
Tertiary Consultancy	15%	17%
Administration	8%	13%
Education	3%	2%

Table 2: Activities undertaken by consultants

Need for the consultants

The need for the consultants was assessed by examining four issues, the policy context for the delivery of mental health, juvenile justice and CP, current skills and knowledge of staff, the prevalence of parental mental health problems and the impact of mental health problems on parenting.

Policy Context

There is a clear policy impetus for addressing family and parental mental health issues among families affected by parental mental illness, including those involved in the juvenile justice and CP systems. The *National Practice Standards for the Mental Health Workforce* (Mental Health & Special Programs Branch, 2006) states that children of parents with a mental illness have a right to "information, care and protection"(Mental Health & Special Programs Branch, p.2) and that mental health care providers have an obligation to recognise the needs of clients' family members. The *National Mental Health Plan* 2003-2008 (Australian Health Ministers, 2003) echoes these sentiments promoting a holistic approach to treatment and recovery that includes consideration of clients' goals and their roles and aspirations. The National Mental Health Promotion Plan (Commonwealth Department of Health and Aged Care, 2000) also identifies children of parents with a mental illness as a specific group at risk of mental health problems. The plan recommends that strategies to address these issues be developed across a range of settings including home, workplaces, health clinics and child and family welfare services (Commonwealth Department of Health and Aged Care, 2000).

Child protection policy in Victoria also recognises that families affected by parental mental illness represent a substantial and growing proportion of clients (Office for Children, 2005). Over 70% of children involved with CP come from families affected by mental health problems, substance abuse, intellectual disability or family violence. Between 1995 and 2001 the proportion of parents involved with CP who experienced one or more of these issues grew by 40% (Community Care Division, 2004). While there is an urgent need to link families with appropriate care, it has been acknowledged that historically there has been poor coordination of these services. In order to address the current failings a more integrated approach to the delivery of services for vulnerable families, including those with mental health problems, has been suggested, as *Protecting children: ten priorities for children's wellbeing and safety in Victoria* (Community Care Division, 2004) recommends, "A more coordinated approach, focused on earlier intervention, will help prevent the problems that a family might experience from worsening and impeding the healthy development of children." (Community Care Division, 2004 p.12). The importance of

sharing information and developing a set of common goals among agencies working with affected families was also noted.

A similar approach to service delivery can be found in Victoria's Juvenile Justice Policy. This policy highlights that involvement in the CP system and the experience of mental health problems are significant issues for many young offenders. Mental health problems are experienced by 25 % of young people on remand (Youth Parole Board and Youth Residential Board, 2006), and 20% of young people involved in the juvenile justice system were previously, or still are, under the responsibility of the child and adolescent protection services of the Department of Human Services due to abuse or neglect (Campbell, 2000).

In response to these issues, the approach to juvenile offenders in Victoria aims to address the underlying drivers of offending.

> The Juvenile Justice system must provide an adequate response to young people's complex behaviours and needs. Many young offenders act impulsively, have chaotic, substance-abusing lifestyles and all too often their family relationships and community links have been fractured (Campbell, 2000, p.6).

Unlike the adult corrections system the aim of sentencing is not punishment but rehabilitation and current Victorian policy promotes community based orders, rather than custodial sentences. In order to comply with recommendations that strong partnerships and multi-agency approaches need to be adopted. In addition, current policy notes the importance of well qualified and supported juvenile justice workforce, which includes mechanism for ongoing improvement of skills.

All policy documents acknowledge the relationship between mental health problems and involvement in the CP and juvenile justice systems. These policies highlight the importance of initiatives that focus on these client needs and promote better integration of services.

AMHS Worker Skill and Knowledge

While there is a strong policy emphasis on family focused practice, there is currently limited knowledge of adult mental health workers' skills in this specialist area. As shown in **Figure One**, most workers reported their levels of skills and confidence in

working with family, parent and child mental health issues were *satisfactory*, yet very few workers recorded that their skills were *very good* or *excellent*.

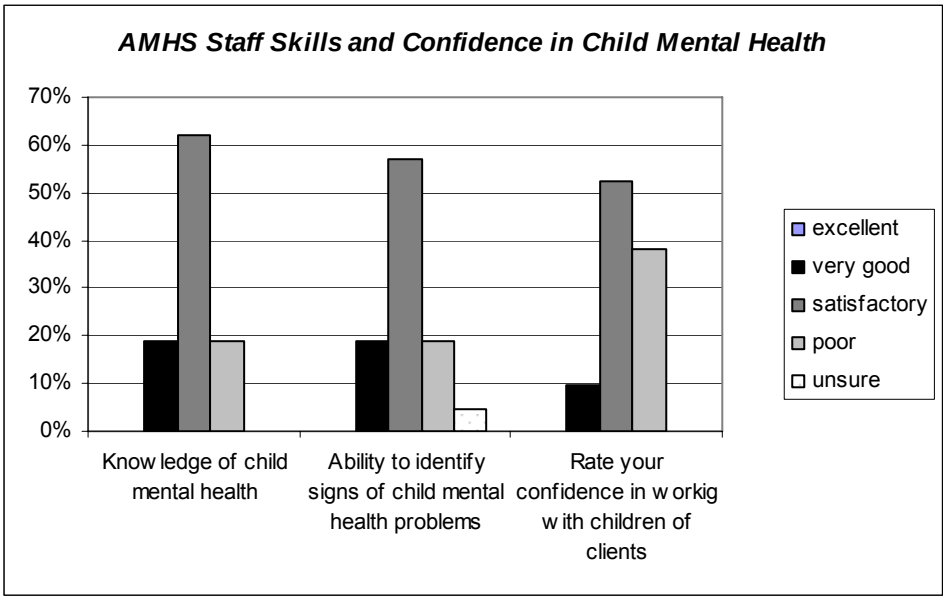

Figure 1: AMHS self reported staff skills and confidence in child mental health

While most mental health staff felt that their knowledge of child mental health and ability to identify children's mental health problems was satisfactory, almost forty percent of AMHS staff reported that their confidence in working with clients' children was poor.

CPU and JJ Worker Skill and Knowledge

As with AMHS staff most CP and JJ workers reported that their knowledge of adult and child mental health was satisfactory or better. Of concern however was that over one quarter of respondents reported that their knowledge of general parental mental health issues was poor. A similar proportion of respondent also reported that their confidence in working with families affected by mental illness was poor. This is of particular concern given the high rates of mental illness among CP clients.

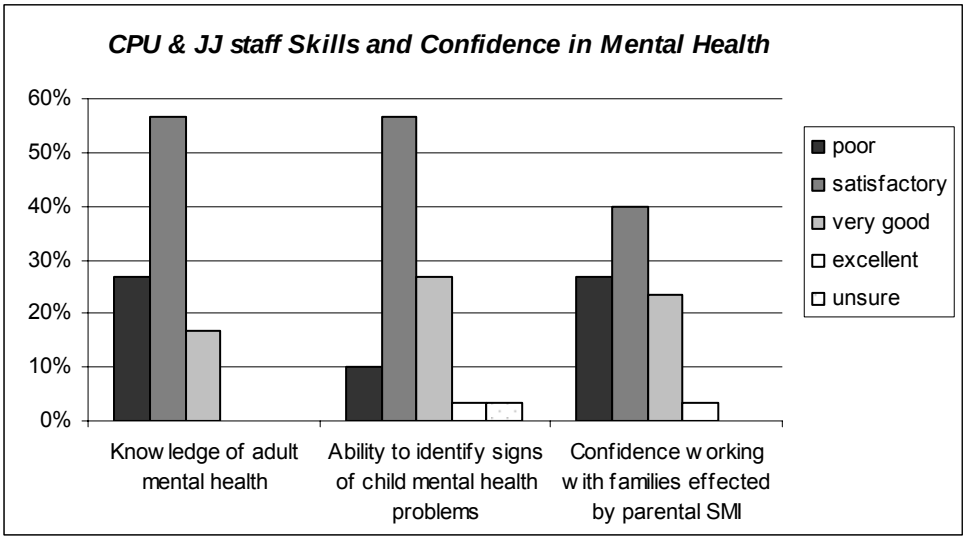

Figure 2 CP and JJ self –reported staff skills and confidence in mental health

The qualitative interviews highlighted that knowledge of mental health services was often very limited. Prior to the introduction of the CFPP, interactions between mental health and CP agencies has been characterised by tension. There was a limited understanding of the roles and parameters of mental health services and this contributed to inappropriate referrals and inadequate information about sharing clients.

Parental mental health problems among child protection and juvenile justice caseloads

Data from both the surveys and interviews indicated that parental mental health problems were commonly encountered by staff from CP and JJ. **Figure Three** shows the proportion of workers' caseloads that involve families affected by mental illness.

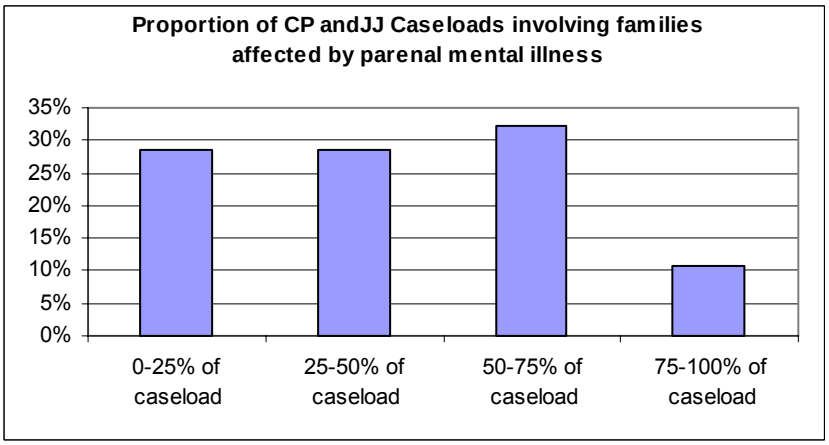

Figure 3: Proportion of CP & JJ caseloads involving families affected by parental mental illness

While approximately a third of workers reported that one quarter of their caseloads, or less, included families affected by parental mental illness, for the remaining three quarter of workers, dealing with these issues was a common occurrence. This findings, highlights the importance of a solid understanding of mental health issues and services for these workers.

Parenting responsibilities among AMHS clients

Primary carers of children were common among the caseloads of AMHS case managers, as shown in **Figure Four**. Interviews with staff also indicated that the workload associated with clients who were parents could be substantially higher and more complex than those associated with non-parenting clients.

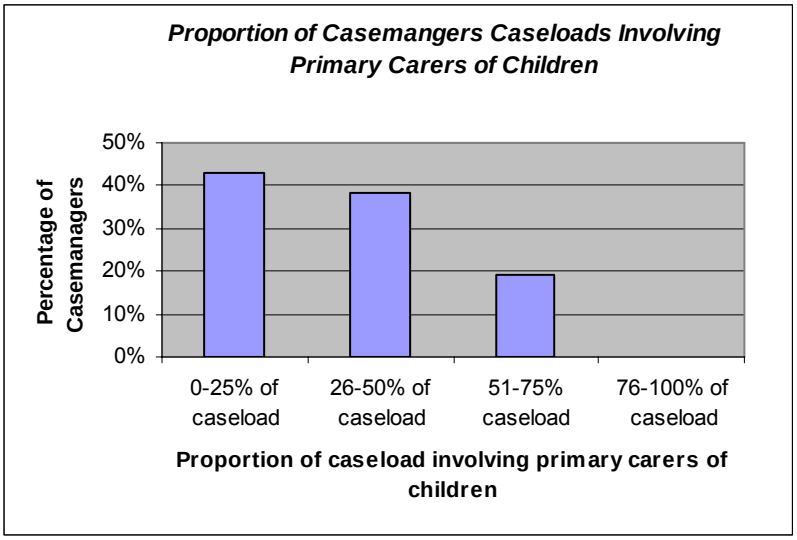

Figure 4: Proportion of Case-managers caseloads involving primary carers of children.

Impact of mental health problems on parenting

The survey and interviews also explored workers' perceptions of the impact of parental mental health problems on young people and families.

CPU & JJ staff					
	no impact	little impact	moderate impact	significant impact	major impact
Impact of mental health issues on parenting skills	0%	10%	20%	40%	30%
Impact of parental mental health issues on children	0%	0%	20%	47%	33%
AMHS Staff					
Impact parental mental health issues impact children	0%	0%	0%	52%	48%

Table 3: Perceived impact of mental health problems on children and families

Table Three indicates that the majority of JJ and CPU staff (70 %) and all AMHS staff (100%t) perceive parental mental health problems and disorders to have a significant impact or major impact on parenting skills. JJ and CPU staff also reported that parental mental health problems have adverse consequences for children, with 80% reporting significant or major impact on children.

Summary

The evaluation found that there was a considerable need for the work of the consultants. This finding was based on the State and Federal policy emphasis on well coordinated, family-focused approaches to service delivery, workers current levels of skills and confidence, and the prevalence and impact of mental health and parenting issues on clients and families. Mental health and parenting issues frequently occur in these areas of work, and are recognised by both clinicians and researchers to have profound impacts on families and young people, yet the majority of workers did not rate their skills in these areas highly. Without adequate support and training workers are more likely to be limited in their scope to effect useful changes for clients and their families

Strengths and limitations in the delivery of CFPP

Three key strengths and one weakness in the delivery of the intervention were identified through the evaluation. The strengths included 1) co-location of consultants, 2) flexibility, and 3) skill level of consultants. Limited time of the consultants was identified as the major weakness of the project.

Co-location

> You have got to be in here to understand the chaos that we actually have to work in at times.
>
> **CP/JJ respondent**

The co-location of both consultants with the agencies they were providing support to was consistently identified throughout the evaluation as centrally important to the success of the intervention. Co-location enabled the consultants to develop an in-depth understanding of the parameters of each service and the constraints under which

staff were working. Co-location also provided easy access for staff, which was identified as an important consideration given the time constraints and unpredictable nature of juvenile justice, child protection and mental health service delivery. 'Hallway' secondary consultation – which occurred informally and without the need for prior planning, was noted by both staff and the consultants as an important opportunity for workers to quickly access advice or information, as the quotes below indicates:

> You probably wouldn't have time to sit down ring someone about this stuff, or even know who to ring, so it is great just having the consultant here.
>
> **CP/JJ respondent**
>
> Without this position gaining information and accessing knowledge, consultation and services have been atrocious. A major plus is the co-location, ease of access and knowledge of each other's work areas.
>
> **CP/JJ respondent**

The regular presence of the consultants and their participation in staff or team meetings also raised awareness with workers about their roles and the importance of family and mental health issues.

Flexibility

The scope for the CFPP consultants to provide different levels of consultation and different services (i.e. information, assessment, etc) was an aspect of the intervention that was strongly endorsed through the evaluation. Staff reported that the flexibility within the positions allowed the consultants to respond to client and workers' needs. The consultants could also respond to workers' understanding and awareness of mental health and/or family issues, which cannot be achieved through written materials or didactic presentations.

> It is great for me because it confirms some of my thinking and there is not a lot of people around who I feel do not have the understanding that I am talking about. So the consultant is great like that. On the other hand I have heard her speak with other people and she is flagging some of the things that they might go and have a look at the next time they go out to do. So the consultant is very good at managing all levels.
>
> **CP/JJ respondent**

The capacity for the consultants to undertake primary consultations and maintain a role in certain cases was also seen as an important. For particularly complex cases this

included ongoing involvement with both clients and workers. This had direct benefits for families and also enhanced the skill of workers in managing these issues.

Skill Level of the Consultants

The consultants' high levels of skills in child, parent and family mental health issues was seen as essential by both staff and families. Families in particular noted the value of the specialised child and adolescent skills of the consultants.

> The consultant has just has got a way with children, my daughter is not one to speak with strangers, but she took to (the consultant) straight away, she was always concerned about the day he was coming, she could talk to him really easily.
>
> **Lydia, mother**
>
> I can't really imagine my case manager working with my son, he had had a little bit of contact with him, but he just doesn't have that feel for kids. He doesn't have any kids of his own and you know he is just not specialised in working with children… it is good to have someone to look at the family stuff.
>
> **Mary, mother**

Staff also reported that the consultants' high level of knowledge about both mental health and family issues and the service system was invaluable. This allowed staff to gain important clinical insights and knowledge of the appropriate referrals and services available to families and clients.

Resource limitations

The major limitation of the CFPP identified through the evaluation was the number of hours attached to each position. Families and staff reported that expanding the number of hours worked by each consultant would be valuable. Staff indicated that more home visits, primary consultations and formal education sessions would be useful adjuncts to the program. The long-standing and chronic problems experienced by families also indicated that more intensive and longer-term direct or indirect support would be useful in resolving these issues.

Summary

Based on the reports of staff and families, the CFPP was found to be a well-delivered, highly utilised and valued program. The structure and content of the project suited the

needs of both staff and families. Expansion of the program to include more direct contact with clients and greater capacity for staff education was identified as the key change required enhancing the Collaborative Family Practice Project.

Impact of the intervention on staff and clients

Changes to staff attitudes and knowledge

A key aim of the evaluation was to understand the impact of the work of the consultants. As shown in **Figure Five** and **Figure Six**, workers perceive that the CFPP has increased both their skills and confidence. The data also indicates that the project has enhanced the functioning of the service system through ensuring more appropriate referrals, increasing knowledge of resources and enhanced interagency relations.

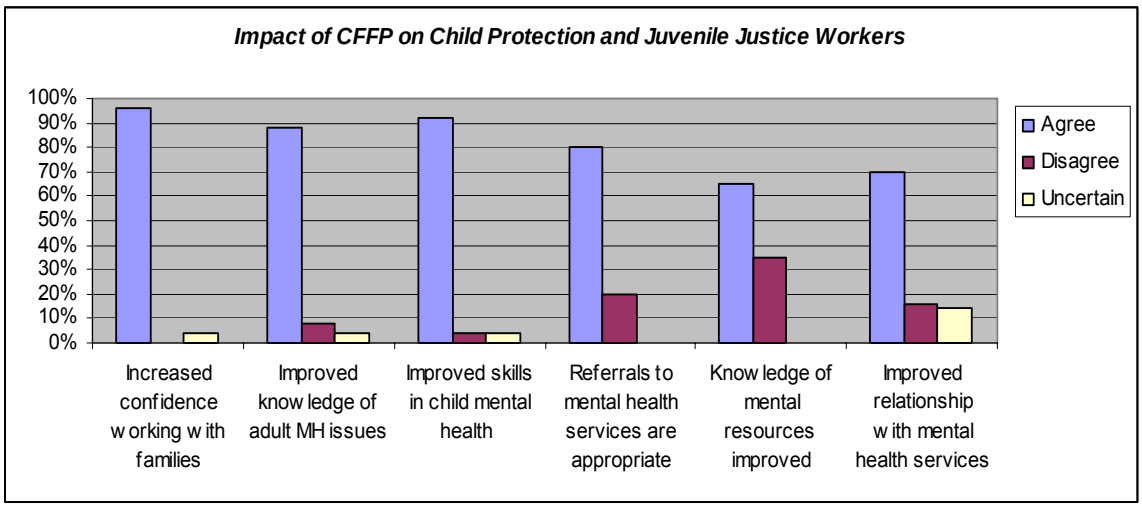

Figure 5 Perceived impact of CFPP on Child Protection and Juvenile Justice Workers

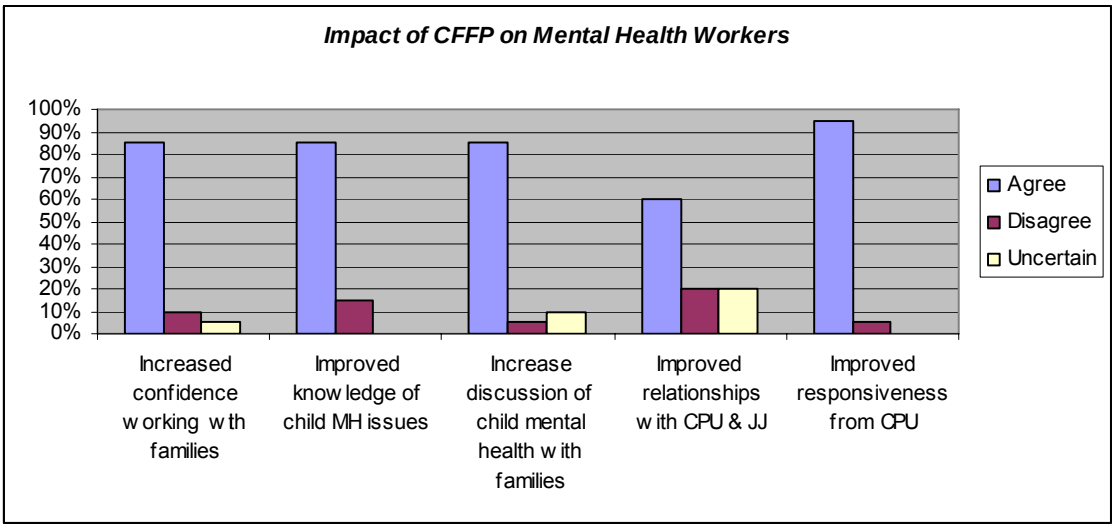

Figure 6 Perceived impact of CFPP on AMHS workers

Some of the key benefits staff identified included increased clinical awareness and greater knowledge of the service system:

Clinical Knowledge

- The development of better insights into the complex behaviours of parents, young people and families involved in the child protection system
- An understanding of how mental health problems could impair parenting capacity
- Increased knowledge and awareness of child and adolescent mental health and welfare issues

Service System Issues

- Knowledge of the roles and limitations of child, adolescent and family health and welfare agencies
- Types of information required by each agency
- Appropriate referral pathways

The activities of the consultants that staff found most helpful are detailed in **Tables Four and Five**

	CP and JJ staff	
	% staff accessing service	% staff found service useful
Consultation regarding client	80%	70%
Formal education	47%	47%
Assessment of children	37%	33%
Provision of information	33%	23%
Ongoing monitoring & follow-up	27%	17%
Written information	27%	27%

Table 4 Type and utility of CFPP services accessed by CP and JJ staff

As the table above indicates, consultations regarding clients were the most commonly used and useful aspect of the consultants' work. Among child protection and juvenile justice workers, formal education sessions, followed by assessments were the most frequently used services of the consultant.

	AMHS Staff	
	% staff accessing service	% staff found service useful
Consultation regarding client	71%	71%
Provision of information	67%	67%
Ongoing monitoring & follow-up	57%	57%
Assessment of children	57%	62%
Written information	24%	24%
Formal education	19%	19%

Table 5: Type and utility of CFPP services accessed by AMHS Staff

AMHS staff reported that consultation, assessment, provision of information and ongoing follow-up were the most valued aspects of the consultants' work. Written information was judged as being among the least useful service provided by the consultants, highlighting the importance of verbal information and feedback for this group.

Interviews with staff provided further insights into how these services had increased confidence and competence in work with families. The additional support provided by the consultants also encouraged staff to deal with complex areas of practice that they had previously been likely to refer to other agencies.

> Access with mental health can be difficult having the consultants on hand makes a response quick to questions and adds to me being confident to address mental health issues appropriately.
>
> **CP/JJ respondent**

Supporting the finding of the surveys, the interview data indicated that written information or single sessions are of limited utility, and ongoing support is required. The process of consultation with the CFPP workers was an important opportunity for providing this type of skill development.

> There needs to be more hours for this position. Case managers need ongoing support education and training and the consultants' job/position is excellent in providing this. Case managers have so many clients to cover and we find that this position is really helpful.
>
> **AMHS respondent**
>
> It is important to have someone you can actually throw ideas onto and they will come back with their expertise, which the consultant has got, and is knowledgeable about the

> services available, with that mental health in mind. Sometimes it was just because she would say, "Yes this is a complex one, and it will have to be handled delicately, and I will help you explore the mental health issues a little bit further." Then she provided ways of addressing it and offering some information about the hypothesis.
>
> **CP/JJ respondent**

The validation that the consultants provided was also central to increasing confidence among workers. Due to the tendency for crisis-driven service delivery, workers could find themselves trying to make important decisions about clients 'on-the-run'. Having an opportunity to reflect upon and discuss these issues with skilled practitioners was both valued and often not readily available from other staff.

> The really critical bit is that secondary consultation, and supporting the worker, and often the worker is the only person that the kid will work with, so helping the worker get through that process to, and helping them feel confident about what they are doing, because sometimes you are making incredibly big decisions and you might not have a lot of time to make them. We had one particularly complicated client and the consultant held that worker together through that process in a way that none of us could, because she could validate his work, as well as give him other strategies and be of practical assistance.
>
> **CP/JJ respondent**

Change to practice

In addition to improving knowledge and confidence, the evaluation also indicated that the work of the CFPP consultants has changed practice in three important ways 1) increased focus on family mental health issues 2) improved response to the needs of clients' families, and young people and 3) improved interagency communication and collaboration.

Increased focus of family and mental health issues

> The CFPP consultant has proved an invaluable resource. In conjunction with the Kids with Confidence program it has provided broader scope for treating people with families and has assisted in taking a holistic view to case managing clients.
>
> **AMHS respondent**

> Dealing with the family is pretty big, because in terms of the dynamics you are also getting a lot ventilation from the partners about their needs being addressed, so it is quite a big workload, huge… some of the interactions become quite difficult in that people have gotten quite angry when you need to be gently confronting about the parameters of our service… it is good to have that sort of back-up.
>
> **AMHS respondent**

Staff across the three services spoke about the high and complex demands of their work. While workers were mindful of family issues, they also spoke about the volume of cases limiting their capacity to only the 'bare-bones' of clients' needs: immediate risk issues, medication, housing and finances.

> I think it is naïve of a worker to say that they can do everything, because once upon a time they tried to do that, but our psych funding has gone to the community to all sorts of other services now, and for a case manager to think that they can do all that, maybe they have got the ability but its not how we are being directed.
>
> **AMHS survey respondent**

With the establishment of the consultants' roles staff reported being more likely to address these issues as they knew that support and back-up were available if required.

Improved responsiveness to mental health issues for parents, children and families.

In addition to a greater awareness of family issues, workers also believed they could tailor more appropriate responses to families due to their contact with the consultants. Through an increased clinical knowledge, workers described adopting strategies with families that produced more useful outcomes, as the quote below indicates.

> There was one in particular client which I worked with the consultant on; one woman who we didn't realise had a personality disorder. Then we went to a meeting, and we had like eleven services, and I was thinking, "Has anyone ever thought about personality disorder with this particular woman?" Then I sat down with the consultant and told her what was going on and she was fantastic… really, really, vital for what we were doing and it really changed the whole way that we dealt with this woman.
>
> **CP/JJ respondent**

Workers reported that through developing more appropriate responses, better outcomes were achieved for clients and their own efficiency improved. Workers could

resolve issues with clients more expediently and without creating a demand for an additional service, as the extract below highlights.

> We are not burdening that [AMHS] service, it is a real option to have a talk with the consultant first and see if there are some other options and often there are, if you recognise it and you work in with the person… Maybe give them information or understanding about what might be happening for this person, and offer them options and clarity.
>
> **CP/JJ respondent**

In this way, the CFPP not only assisted individual workers to operate more efficiently but enabled the service system to function more effectively, by limiting the inappropriate or unnecessary intervention of different agencies.

Debriefing and discussing cases was also valued. Staff welcomed the opportunity to discuss particularly stressful or challenging issues with the consultants. Staff perceived the consultants were knowledgeable about the difficulties of the nature of their work and work environment without involvement in team or organisational dynamics. In the following extract a worker discusses how this has helped with a particularly challenging case:

> [Debriefing with the consultant] is fantastic for me- I can put stuff out there and get information back. It was wonderful, it was clear … when I was told by my team leader that a case had become a personal thing and I was taken off it, I have gone back to the consultant and said I have become really frustrated. The consultant's sense of it was that you have hit the wall with it and you are struggling, and it gives off that aura. I don't know if it helped the case but it helped me put the situation into perspective.

The sense of resolution this worker felt about a potentially demoralising experience has clear implications for the morale and retention of staff in these demanding areas of practice. Through a simple intervention the consultant was able to increase the workers' sense of self-efficacy and reduce stress, both factors that reduce rates of burnout and fatigue among staff in human services organisations (Conrad & Kellar-Guenther, 2006).

Improved interagency communication and collaboration

Previous studies have identified that communication and collaboration between mental health services, child protection and juvenile justice services can be tense and infrequent. Workers can find phone calls unanswered or requests for information or advice met with inappropriate responses (O'Connor, 2002). Through the CFPP important steps were taken toward addressing these issues.

In the interviews, workers described a greater understanding of the pathways, language and criteria of each service. This enabled more efficient and effective use of time and the development of goodwill, as summarised in the comments below:

> I attend state-wide meetings … I listened to their stories and difficulties in accessing services and understanding the protocols of those services, and the lack of partnership and coordination. And we just resolve things so much quicker, and without animosity anymore because the consultant's position allows people to understand where the adult mental health service are coming from ….So in terms of trying to coordinate case-management so the consultant bridged that gap both ways.
>
> **CP/JJ respondent**

Workers developed a better understanding of the constraints and parameters within which agencies were working and this led to more appropriate requests and realistic expectations of the services available.

Impacts of the intervention on clients and families

As highlighted previously, families involved in the child protection, juvenile justice and mental health systems typically experience a range of stressors. Both staff and families reported that the consultants had been able to address a number of these issues. Families and young people had benefited from four main areas of activity 1) provision of a family focused service; 2) a focus on children's health and wellbeing, 3) supporting parental mental health; and 4) promoting better outcomes for young offenders.

Family-focused service delivery

Families affected by parental mental illness can experience both disruptions and disharmony. While mental health services can effectively address parents' mental

health problems, dealing with the effects of chronic or acute mental illness on family functioning may be beyond the scope of workers due to time and skill constraints. In this context the work of CFPP consultant has been demonstrated to be a highly effective adjunct to case management, allowing case managers to focus upon the needs of the client, while family issues are also addressed.

> Well there is a family, a complicated family where there is significant health issues for both parents, and there has also been some concerns regarding domestic violence. There are difficult behaviours between the client and their spouse … it's quite helpful to have the consultant involved and really to have someone to look at the family holistically. There is a message here that there is someone here that the rest of the family can use as a support. It has also meant that they have a positive view… There are a lot of problems here but we have got someone who has got a bit a team approach.
>
> **AMHS respondent**

> You need something to help with parenting … some way to tie the two together, mental health and child rearing. Because it sort of rips your whole life around, my son has suffered now, because I was struggling to look after him... I felt all alone… So it has been good to have the consultant, it has been good for my son too, just to get the issues out there and discuss them, instead of sweeping them under the rug.
>
> **Mary, mother**

Meeting the needs of both families and clients simultaneously has important benefits that addressing these issues consecutively cannot achieve; reduced family tensions promotes better mental health, and improvements in parental mental health allow individuals to address relationship and child welfare issues. Through working with families, the consultants could also identify issues that had important clinical implications for the management of clients.

> It is really good, you feel the load is shared, and you are not being totally responsible for the significant others, and sometimes they go in, and they go in at a different time, and feedback something totally different to what you have seen, like do you know that your client is counting things all over the place. So then you know you have to go back, so it is helpful in our way of looking after mum as well as just discussing the issues of the case and encompassing the case a little better.
>
> **AMHS respondent**

A key issue for parents was changes that can occur in family dynamics after episodes of their illness. The CFPP provided a key mechanism for these relationships issues to be addressed.

> The kids used to play my illness against me, I can't be bothered arguing. The consultant has just been really good, he just comes and talks things out with us, gives us ideas about strategies that we can use that really work. We were having marriage difficulties, but now we have sort of been able to work as a team, with the consultant help, been able to work out ways of dealing with all the different kids' moods and temperaments and sorts of things, so that the whole house seems to work really well. Now the kids are generally helpful and cooperative.
>
> **Georgia, mother**

Focus on Children's Issues

The CFPP consultant improved outcomes for families by focusing specifically on children's mental health issues and their concerns regarding a parent's mental illness. Children were provided with information about mental illness in a format that was age and developmentally appropriate, they were given the opportunity to discuss fears, concerns or difficult experiences and also provided with some brief counselling. For some young people this intervention averted the need for them to engage formally with child and adolescent mental health services and for others it greatly enhanced their relationships with their parents and their general functioning. The following quote from Lydia highlights the changes in her daughter:

> She was top of her class in everything and then she went right down [after her mother's acute episode of illness and extended separation], and that really worried me … I went to the teacher-parent interviews, and they weren't very nice about it. They said her work was untidy, losing everything all the time, not concentrating on the set tasks, not following through and it broke my heart…She doesn't read as much as she did, but she is starting to apply herself and they have said she is getting back on track.

Other parents also reported improvements in their children's mood, behaviour, schooling and parent-child interactions after their involvement in the CFPP.

Supporting Parents' Mental Health

The CFPP directly enhanced family outcomes through the identification and management of mental health issues among child protection clients. In some instances the CFPP consultant identified previously undiagnosed mental health issues, and in

other cases provided clarification regarding a diagnosis or management plan. The consultant was also able to provide advice to workers around engaging with challenging clients (who did meet the criteria for a mental illness) and assisted in providing mental health expertise in workers general interactions with clients.

The consultant also provided preliminary mental health assessment of clients in a manner that was less threatening and more acceptable to families compared with a formal assessment process by an AMHS clinician. This clarified the mental health needs of parents and ensured that requests for further follow-up by the AMHS, if required, were appropriate. Child protection staff reported that the early detection and appropriate management of mental health issues had in some instances resulted in fewer out-of home placements for children.

Promoting better outcomes for young offenders

Through secondary consultations with juvenile justice staff the CFPP was able to promote better outcomes for young offenders through the identification of mental health problems and advice regarding the management of these issues. For this group of young people, who typically have difficulty in accessing mainstream mental health services, this link to mental health expertise was essential. Staff reported that there had been some instances where this level of intensive support had enabled young people to remain on community based, rather than custodial sentences.

Future Directions

While the evaluation found that the CFPP had addressed many areas and needs of clients and their families, the focus of the intervention has been primarily on mental health and welfare issues. While this has been both appropriate and necessary given the scope of the intervention, a number of issues for families and clients require further investigation and support. These activities should not necessarily be undertaken primarily by the consultants rather, the CFPP may raise awareness of these issues with other relevant agencies.

Education issues for children of parents with mental illness: the findings of the intervention identified that problems with schooling were common among children affected by parental mental illness. While previous studies have identified that

children of parents with mental illness tend to have poor academic outcomes (Oyserman et al., 2005) this issue is often overlooked by programs designed for this group of young people and their families (Fraser, James, Anderson et al., 2006). As school attachment and academic achievement are such an important factors for children's academic and social development, further work to enhance the performance of children in this domain needs to be undertaken. Clearly partnerships with the Department of Education and Training are central to this activity.

Physical Health Needs of clients and families: The physical health status of people with mental illness is often poor, and the quality of their medical care frequently unsatisfactory (Mitchell & Malone, 2006). Less is known about the health status of families; however it is likely that they are also exposed to lifestyle factors (such as smoking, poor nutrition, poor dental hygiene) that exacerbate physical health problems among clients. The barriers to care experienced by clients that include lack of recognition by providers and difficulties in negotiating health care systems (Muir-Cochrane, 2006), are likely to be shared, if not more severe for dependent children. Thus, professionals who come into contact with these young people either through specialist mental health services or child protection need to be aware of potential physical health problems.

Social support: Lack of social support was an issue common to all families. While it is challenging for specialist providers to directly address these issues linking families into services such as Mothers Support (St Luke's) or the Compeer Program (St Vincent de Paul) may assist in promoting enriched social networks.

Limitations

This evaluation had a number of limitations which need to be considered in interpreting the findings. First, the evaluation relied on self-report measures to assess workers levels of skills, confidence, and changes to their practice since the implementation of the CFPP. No objective measures of these variables were obtained. Second, the prevalence of parenting among mental health clients and mental health problems among child protection and juvenile justice clients was based on the assessment of clinicians. While it is reasonable that AMHS case-managers would be able to provide accurate estimates of the parenting responsibilities of their clients, a review of case files would have been a more accurate method for obtaining this data. However, the ethical complexities associated with gaining this type of personal information from vulnerable people without consent precluded its use in this study.

The estimates of parental mental health problems by child protection and juvenile justice workers are likely to be less accurate. While these workers have expertise in child, adolescent and family welfare, their knowledge of mental health issues may be limited, leading to imprecise estimations of mental health problems among clients. Epidemiological studies indicate that one in five Australians experiences a diagnosable mental disorder at some time in their life (Andrews et al., 1999) and a that rate increases significantly for those who are on low incomes (Butterworth, 2006). The finding in this study that almost 30 % of child protection workers perceived that 25 % or less of their clients experience mental health problems suggests a considerable *under*-estimation of mental illness among CPU and JJ clients by some workers.

A further limitation of the study was the absence of objective outcome measures for clients involved in the CFPP. The scope and resources of the evaluation did not permit this information to be obtained.

Conclusion

This evaluation has found that the Collaborative Family Practice Project addresses a significant gap in the provision of services to clients involved in juvenile justice, child protection and mental health services, and their families. Data collected throughout the project suggests that need in this area will continue to grow and services and governments need to develop more effective and efficient strategies for promoting the health and welfare of these families. Failure to do so will not only diminish individual wellbeing but create significant costs to the community through the health, welfare and criminal justice systems.

The Collaborative Practice Project represents a significant move toward successfully dealing with these mounting challenges. The project is entirely consistent with current policy in these areas, promoting collaboration, skill development and enhanced service provision. The CFPP has demonstrated both need and utility among staff and families, and its continuation and expansion can further improve individual and systems level outcomes.

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Appendix One: Project Budget

Salaries	
CAMHS consultant to Adult Mental Health 0.8EFT	$66,672
Mental health consultant to Child Protection and Juvenile Justice 0.8 EFT	$66,672
Combined salary costs	$133,344
Administration Charges	$38,963
Total Project Budget	$172,307

Appendix Two: Child Protection and Juvenile Justice Staff Survey

Please tick the appropriate box unless otherwise indicated. The questionnaire can be returned either by post using the addressed internal mail envelope attached. PLEASE DO NOT INCLUDE YOUR NAME ANYWHERE ON THIS QUESTIONNAIRE

1. Could you estimate the percentage of parents you work with who you believe have mental health problems?

0-25%	☐		26-50%	☐	
51-75%	☐	76-1	00%	☐	

2. How would you rate your knowledge of adult mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

3. How would you rate your ability to detect signs of adult mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

4. How would you rate your confidence in working with families where a parent has a mental health issue?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

5. How easy or difficult is it to obtain advice to assist you when working with families where a parent has mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
extremely easy	very easy	satisfactory	very difficult	unsure

6. Do you discuss mental health issues with parents you work with?

1	2	3	4	5
☐	☐	☐	☐	☐
never	sometimes	often	very often	always

7. Do you consider that parental mental health issues have an impact on parenting skills?

1	2	3	4	5
☐	☐	☐	☐	☐
never	sometimes	often	very often	always

8. How much impact do you think that parental mental health issues have on children?

1	2	3	4	5
☐	☐	☐	☐	☐
no impact	Little impact	Moderate impact	significant	major impact

9. (a) Have you had contact with the Collaborative Practice Project consultants?

☐ Yes ☞**please complete Qs 9, 10, 11&12**

☐ No ☞ **please go to Q.12**.

☐ Never heard of the consultants ☞ **please go to Q.12**.

10. What type of contact have you had with the consultants? (tick as many as apply)

☐ Ongoing monitoring and follow-up

☐ Formal education sessions

☐ Written Information

☐ Consultation regarding client

☐ Assessment of clients' parents/carers

☐ Provision of information and education for clients and families

☐ Other (please specify)_____

11. What have you found useful? (tick as many as apply)

☐ Ongoing monitoring and follow-up

☐ Formal education sessions

☐ Written Information

☐ Consultation regarding client

☐ Assessment of clients' parents/carers

☐ Provision of information and education for clients and families

☐ Other (please specify)_____

12. How strongly do you agree or disagree with the following statement on the impact of the consultant's's work?

	strongly agree	**agree**	disagree	strongly disagree	uncertain
I am more confident in working with families where there are mental health issues	❑	❑	❑	❑	❑
My knowledge of adult mental health issues has not changed.	❑	❑	❑	❑	❑
My skills in child mental health have improved	❑	❑	❑	❑	❑
Most of the time my referrals to mental health services are appropriate	❑	❑	❑	❑	❑
My knowledge of mental health resources has not changed	❑	❑	❑	❑	❑
I have a good working relationship with the Mental Health Service	❑	❑	❑	❑	❑

13. Is there anything else you would like to add?

Thank you for your assistance

Appendix Three :Area Mental Health Service Staff Survey

Please tick the appropriate box unless otherwise indicated. The questionnaire can be returned using the addressed internal mail envelope attached. PLEASE DO NOT INCLUDE YOUR NAME ANYWHERE ON THIS QUESTIONNAIRE

14. Please estimate the percentage of your clients who are the primary carers of their children?

0-25% ☐ 26-50% ☐

51-75% ☐ 76-1 00% ☐

15. How would you rate your knowledge of child mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

16. How would you rate your ability to detect signs of child mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

17. How would you rate your confidence in working with children of clients?

1	2	3	4	5
☐	☐	☐	☐	☐
excellent	very good	satisfactory	poor	unsure

18. How easy or difficult is it to obtain advice to assist you when working with families where a parent has mental health issues?

1	2	3	4	5
☐	☐	☐	☐	☐
extremely easy	very easy	satisfactory	very difficult	unsure

19. Do you discuss child mental and wellbeing health issues with parents you work with?

1	2	3	4	5
☐	☐	☐	☐	☐
never	sometimes	often	very often	always

20. Do you consider that parental mental health issues have an impact on parenting skills?

1	2	3	4	5
☐	☐	☐	☐	☐
never	sometimes	often	very often	always

21. How much impact do you think that parental mental health issues have on children?

1	2	3	4	5
☐	☐	☐	☐	☐
no impact	little impact	moderate impact	significant impact	major impact

22. (a) Have you had contact with the Collaborative Family Practice Project consultants?

☐ Yes ☞**please complete Qs 9, 10, 11&12**

☐ No ☞ **please go to Q.12**.

☐ Never heard of the consultants ☞ **please go to Q.12**.

10. What type of contact have you had with the consultants? (tick as many as apply)

☐ Ongoing family intervention

☐ Formal education sessions

☐ Written Information

☐ Consultation regarding client

☐ Assessment of clients' children

☐ Provision of information and education for clients and families

☐ Other (please specify)_____

11. What have you found useful? (tick as many as apply)

☐ Ongoing family intervention

☐ Formal education sessions

☐ Written Information

☐ Consultation regarding client

☐ Assessment of clients' children

☐ Provision of information and education for clients and families

☐ Other (please specify)_____

12. How strongly do you agree or disagree with the following statement on the impact of the consultant's' work?

	strongly agree	**agree**	disagree	strongly disagree	uncertain
I am more confident in working with families where there are mental health issues	❑	❑	❑	❑	❑
My knowledge of child mental health issues has not changed.	❑	❑	❑	❑	❑
I routinely discuss child mental health & wellbeing issues with clients who are parents	❑	❑	❑	❑	❑
I have a good working relationship with Protective Services	❑	❑	❑	❑	❑
My knowledge of resources for children of clients has not changed	❑	❑	❑	❑	❑
I still can't get answers to queries about child mental health issues	❑	❑	❑	❑	❑

13. Is there anything else you would like to add?

Thank you for your assistance

Appendix Four: Staff Interview Schedule

General family situation	1. Are there any characteristics that you can identify as common among parents who have mental health problems and who are involved with child protection?
Parenting Skills	2. What do you see as some of the key strengths among the target group of parents? 3. What are some of the key areas of need in parenting skills among the target group?
Challenges in parenting	4. What are some of the challenges these parents face in providing safe and stable environment for children? 5. What are some of the resources parents have to draw on in parenting (i.e. social support, role models etc)?
Services	6. What are some of the ways in which your service supports parents? 7. What are the current gaps/limitations in current service provision?
Collaborative Practice	8. Could you tell me about your involvement with the Collaborative Practice Project? 9. In what ways has the CCP changed your practice? 10. What impacts has this had on families you work with? 11. What do you see as the key strengths of the program? 12. What are the weaknesses? 13. What existing areas need further development? 14. Do you have any suggestions for new strategies that could lead to improvements in service delivery?
Future	15. What are some of the hopes you have for improving the system to support families affected by parental mental illness?
	16. Further comments
	17. Would you like to us to mail a summary of the project's findings?

Appendix Five: Parent Interview Schedule

General family situation	18. To begin with, could you tell us about your family situation? (i.e. number and age of children) 19. How long have you lived here? 20. Do you have family and friends close by? 21. What sort of support have you received from family and friends in bringing up your children?
Parenting Skills	22. What do you feel are some of the things that you feel you are good at as parent? 23. What do like about being a parent?
Challenges in parenting	24. What are some of the challenges you have found in being a parent? 25. In coping/dealing with these things what have been some of the things you have found useful i.e. talking to a friend, getting some time out, getting practical support etc
Service Use	26. How long have you been a client with AMHS/ CP? 27. Could you please describe some of the aspects of the support/care that you have received from this service that has been helpful to you in promoting your mental health? 28. Could you please describe some of the aspects of the support/care that you have received from the service that has been helpful in supporting you as a parent? 29. Have there been any aspects of the services you have received that have not been good for your mental health? 30. Have there been any aspects of the services you have received that have not been good for you as a parent?
Collaborative Practice	31. Could you tell me about your involvement with the consultant? 32. What impact did seeing the consultant have on you and your family? 33. What did you find most helpful about seeing the consultant? 34. What did you find unhelpful about the consultant? 35. What are some of the things that could be done to improve the service? 36. Since your involvement with the consultant have you found any differences in the support you receive from child protection/AMHS?
Future	37. What are some of the hopes you have for you and your children in the future? 38. What would be the signs that would tell you a service was making things easier for you and your family?
	39. Further comments?
	40. Would you like to us to mail a summary of the project's findings?

Collaborative Practice Project

Department of Human Services Child Protection and Juvenile Justice and Bendigo Health Care Group Psychiatric Services

Interim Report
May 2005

Centre for Rural Mental Health

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Tables and Diagrams

The Department of Human Services Loddon Mallee Region have funded this project and their support is gratefully acknowledged.

Collaborative Practice Project Working Party

Implementation of the project has been guided by a working party with representatives from agencies providing services to families affected by mental health issues

Katy Curtis	CAMHS Consultant to Protective Services and Juvenile Justice
Sue Ellen Radford	Kids with Confidence worker Centre for Rural Mental Health
Sue Jeavons	La Trobe University
Kevin Gerber	Continuing Care Team Adult Psychiatric Services Bendigo Health Care Group
Vic Tripp	Continuing Care Team Adult Psychiatric Services Bendigo Health Care Group
Natalie Storti	PCATT/Triage Adult Psychiatric Services Bendigo Health Care Group
Justin Clarke	PCATT/Triage Adult Psychiatric Services Bendigo Health Care Group
Lisa Harrington	Child Protection Department of Human Services
Robin Smythe	Child Protection Department of Human Services
Wendy Price	Mental Health Program Department of Human Services
Jenny Singe	Child and Adolescent Mental Health Services Bendigo Health Care Group
Dirk Lynzaat	Alexander Bayne Centre Psychiatric Services Bendigo Health Care Group
Jenni Fox	Mother's Connect Program St. Luke's
Chris Jacksen	Mother's Connect Program St. Luke's
Simon Reeve	Placement and Support Services St. Luke's
Patrick Byrne	Child and Adolescent Mental Health Services consultant to Adult Psychiatry Bendigo Health Care Group
Gail Clarke	Adult Mental Health consultant to Protective Services and Juvenile Justice

1. Executive Summary

We are dealing with a new generation of long term clients with kids. Fathers have issues such as substance abuse and anger management. The kids have the potential to develop a mental illness. Having the consultant involved provided kids with the opportunity not to be traumatized by their environment… I have a sense of optimism for the kids. There is now something there to pick them up earlier rather than later.

This quote from a clinician indicates the Collaborative Practice Project has given staff a sense of hope in working with families affected by mental illness who are also involved with protective services. The evaluation of this project found that the interventions used were effective in developing a more coordinated response to the needs of these vulnerable families.

The Collaborative Practice Project is a joint initiative of the Department of Human Services Child Protection and Juvenile Justice and Bendigo Health Care Group Psychiatric Services. Limited project resources meant that project work was concentrated in Greater Bendigo. The initiative for this project came from those working in the field and commenced with the study *Child Maltreatment and Parental Mental Health Problems*. This 2002 study found that:

- A more coordinated response was required for families affected by mental illness who are also involved with protective services.
- There was a lack of understanding amongst organizations and a level of mistrust between services that prevented coordinated services being delivered.

In response to these findings the Collaborative Practice Project was funded by the Department of Human Services to develop a model of practice that would address these issues. The project commenced in July 2004. The model involved:

- Placing an adult mental health (AMH) clinician with protective services staff to provide support in their work with families affected by parental mental illness;

liaise between protective services and psychiatric services; and provide education on adult mental health issues to protective services staff.

- Placing a child and adolescent mental health services (CAMHS) clinician with adult psychiatric services to provide assessments for children of clients of adult psychiatry; family therapy interventions; and education to adult clinicians on child and adolescent mental health.

One of the project strengths was the location of the consultants with the services they provided support to. The adult mental health AMH clinician was based with protective services and the CAMHS consultant was based with Greater Bendigo Adult Community Mental Health Services. This enabled liaison and collaboration to occur in the course of day to day work, and was vitally important in building trusting relationships in this area of complex work. As a result, the two positions now reflect the culture and needs of the services that they operate in. The AMH consultant to protective services provides education, liaison, secondary consultation and direct clinical care when necessary. The CAMHS consultant to adult psychiatric services has provided primarily clinical services with some education and liaison. This flexible response to the needs of the agencies involved in the project has also been a major factor in the success of this project.

2. Collaborative Practice Project Findings

The following findings describe the work of the project undertaken in this first phase of project development. These findings are presented in descriptive terms. In the 2005/06 phase of the project it is planned to collect quantitative data on project findings.

a) Data Collection

Currently RAPID, the psychiatric services data base does not collect data that could be used to estimate the number of case managed clients who have dependent children. Therefore anecdotal data was collected by the CAMHS consultant to adult.

- Twenty five percent of case managed clients of Greater Bendigo Adult Community Mental Health Team have dependent children (120 children)
- Data was collected on 65 children of case managed clients. Twenty eight percent (28%) of these children have had or have ongoing involvement with protective services and 11% have a history of ongoing involvement with both Child and Adolescent Mental Health Services (CAMHS) and protective services.

The above findings indicate that a substantial proportion of case managed clients of adult psychiatry in Bendigo are parents. These people have to manage the demands of both parenting and mental illness. A proportion of these families are involved with both psychiatric services and protective services.

b) Coordinated Service Delivery

The number of families involved with both psychiatric services and protective services demonstrates the need for coordinated delivery of care. Project findings on the delivery of care were that:

- Staff from both services reported that the work of project consultants improved access to the respective services
- Consultants have streamlined referral processes between protective services, adult psychiatry and CAMHS
- Staff reported improved understanding of service processes and the information required by the respective services.
- Protective Services reported fewer inappropriate referrals to the psychiatric services Regional Triage Service and a higher rate of acceptance of referrals by this service.

c) Clinical Work

Clinical work undertaken by project consultants supported increased collaboration between services by providing a resource for undertaking work with families involved with both services. The following are examples of clinical work undertaken by project consultants:

- Children of clients of adult psychiatry received timely and age appropriate education on mental illness.
- The majority of adult psychiatric service clients accepted support, either through assessments for children, psycho-education for children, family sessions or consultations to support clients in their role as a parent.
- Support to adult psychiatry staff in using the Family Support Plan[1] resulting in increased use of this tool in working with families
- Protective service staff reported that psycho-education and joint work in the development of strategies to support families affected by mental illness increased their skills in working with these families.
- The access of protective services staff to clinical support in working with families affected by mental illness was improved through the capacity to undertake joint assessments and to access mentoring and debriefing.
- Co-location provided the opportunity for staff to directly discuss clinical concerns with consultants

d) Education and Professional Development

The access by protective services staff to mental health education tailored to the specific requirements of service delivery was improved through delivery of the following education activities:

- One formal presentation on mental health at protective services planning day

[1] The Family Support Plan documents information relevant to the care of dependent children in Psychiatric Services Comprehensive Assessment and Service Plan.

-Five sessions on early psychosis delivered for CP and JJ staff

e) Policy Development

Policy development to support the work of the Collaborative Practice Project has commenced with the development of policies and procedures for access visits to the Alexander Bayne Centre.

The above project findings are evidence of the effectiveness the work of the Collaborative Practice Project in addressing barriers to enhancing service delivery to families involved with both protective services and psychiatric services. These findings demonstrate the project has provided a resource to support collaborative work between services; the project has provided early intervention for children of protective services clients with mental health issues; and support to families of clients of adult psychiatry has been enhanced.

While the gains to date from the Collaborative Practice Project are significant this work is still in the early stages of development. The following section makes recommendations to consolidate the work to date and for further project development.

3. Recommendations for Project Development

The evaluation of the first phase of this project found that the following areas must be addressed if service delivery to these vulnerable families is to be further enhanced.

a) Model development

This project has demonstrated that a small resource can enhance service delivery to these families. However, the model needs to be consolidated and extended if the needs of these vulnerable families are to be adequately met.

It is recommended that the following areas should be addressed in the next phases of the project:

- Consolidation of positions within both services.
- Strengthening of linkages between the two positions and CAMHS consultancy to protective services and St. Luke's Mental Health Youth Intensive Support positions.
- Strengthening of the relationships with relevant programs such as the Kids with Confidence project, the Spiritual and Emotional Wellbeing project and Psychiatric Services Dual Diagnosis position.
- Increased capacity for the project to undertake further interventions to meet the needs of families.

b) Increased Capacity for Collaborative work

Whilst collaboration amongst agencies has been significantly enhanced as a result of the project, it continues to be hampered by the different focus of each organisation and policies resulting in changes to service delivery. Discharge planning is an example of this. There have been cases where protective services were concerned about the effects on children of a parent being discharged home following inpatient psychiatric treatment. Decisions in these cases are not easy, as they involve balancing the mental health needs of the parent against the needs of the child for a safe and stable environment. While staff from both services acknowledged progress has been made as a result of the project there is still scope for improvement.

The following recommendations are made to strengthen and support collaborative work in meeting the needs of families.

- That the Collaborative Practice Project consultants have the time and resources to support joint planning in cases involving both services.

- That the consultants have the time to work with staff from both services to develop solutions that meet the needs of both parents and children at key points in service delivery such as discharge from inpatient services.

c) Increased capacity for the Collaborative Practice Project

While the Collaborative Practice Project has made significant progress in addressing barriers to more co-ordinated delivery of care for families it must be acknowledged that the current time fraction (.4EFT for both positions) is not sufficient to achieve this goal. The capacity of both positions should be increased in recognition of the fact that both services have a regional brief. The capacity to undertake more clinical work is a particularly important area when risk factors often faced by these children such as parental mental illness, substance abuse and lack of stability are considered.

Two additional issues require further attention; firstly, assistance with education to foster carers regarding parental mental illness. These carers must negotiate complex emotional territory in respecting the rights of parents and ensuring the wellbeing of children. Specialist mental health education would enhance their capacity to achieve this. Secondly, legislative changes in juvenile justice have taken the maximum Children's Court age from 17 to 18. This will mean a 20% increase in clients across the region for Juvenile Justice and a significant increase in contact with adult psychiatry as this group of young people have a number of risk factors. This increased workload needs to be reflected in increased resources provided to this area if an appropriate service response is to be provided.

It is recommended that the time fraction for both positions be increased to full time to achieve the following objectives:

- To allow the AMH clinician to undertake therapeutic work for protective service's clients.

- To allow the AMH clinician to respond to the likely increased demands on adult psychiatry resulting from legislative change in juvenile justice.

- To increase clinical work with families of clients of adult psychiatry undertaken by the CAMHS consultant.

- To increase family therapy work with families of clients of adult psychiatry by the CAMHS consultant.

- To provide support to other workers such as foster carers in their work with these families.

- To broaden the reach of both positions to the region beyond Greater Bendigo

d) Education and training

Project development to date has demonstrated the effectiveness of increased skills and knowledge for workers in both psychiatry and protective services.

It is recommended that the following areas of skill development in working with children and families for protective services staff and adult mental health service clinicians are focussed on in further project development:

- Detection and referral skills in child mental health.
- Improved communication skills for talking about parental mental illness with children.
- Improving the skills of protective services workers in communicating and engaging with parents who have mental illness.
- Opportunities for protective services staff to increase knowledge of adult mental disorders.

- Opportunities for adult mental health service staff to increase knowledge of child mental health.

f) Prevention and early intervention

The collaborative approach used in this project has enabled early intervention and prevention work to be undertaken with families.

It is recommended that this approach should be extended with the following initiatives:

i) Adult Mental Health Consultant to CAMHS

The work of the CAMHS consultant to adult psychiatry should be complemented by an Adult Mental Health consultant to CAMHS. An Adult Mental Health consultant to CAMHS could provide clinical support to parents with mental health issues and whose children are CAMHS clients. This worker would provide education and training in adult mental health to CAMHS staff paralleling the education provided by the CAMHS consultant to adult psychiatry.

ii) Extension of the Collaborative Approach to other Agencies

The collaborative approach to service delivery should be extended to include the key areas of education, maternal and child health nurses, community health, school nurses to maximise the alliance of all service providers around the needs of these children and their families.

f) Research Opportunities

Two extensive literature reviews have been undertaken in this area[2] and these reviews show that research into the impact of parental mental health issues on families is still in the early stages.
It is recommended that in the next phase of the project the following research activities are undertaken:

- Investigate research opportunities and initiate discussions with relevant research institutions.

g) Project Evaluation

Evaluation of projects such as this is essential if an evidence base is to be developed for interventions in this area. Process evaluation has been used to trace development of this project to date. This evaluation has identified underlying project assumptions and described project components.

It is recommended that outcome evaluation is undertaken in the next phase of the project. The following strategies will assist in achieving this goal:

- Outcome measures are developed for client satisfaction.
- Outcome measures are developed for changes in practice.
- RAPID[3] data is investigated for usefulness in measuring project outcomes.

[2] See the literature review in O'Connor, R. Child Maltreatment and Parental Mental Health Problems and Fraser, C. and James, E. A Systematic Review of Interventions for Families Affected by Parental Mental Illness (unpublished manuscript)
[3] RAPID is the Psychiatric Services client data base

4. The Collaborative Practice Project

New Directions for Victoria's Mental Health Services states that "significant benefits can be derived from implementing integrated approaches to meeting the special needs of young people, including the development of comprehensive responses to the growing complexity of problems, evident in this age group.[4] The Collaborative Practice Project is an example of the development of an integrated approach to meeting the needs of families affected by mental illness who are also involved with protective services.

The report documents the process evaluation of the initial phase of the Collaborative Practice Project. As such it describes the implementation of two clinical positions to support adult psychiatry in working with families of psychiatric services' clients and to enhance liaison, collaboration and integration between mental health and protective services for families affected by mental illness. This report describes progress made in providing a more coordinated response to these vulnerable families.

The initiative for the Collaborative Practice Project came from those working in the field. In 1998 workers concerned that the mental health issues of these families required further investigation formed a working party and funding was obtained for a study into the mental health issues of parents of children on statutory orders. The report from this study *Child Maltreatment and Parental Mental Health Problem*s examined existing frameworks for service delivery and provided the groundwork for a more coordinated response to the often complex needs of these families.

The report identified a number of issues affecting service delivery to these families. The study found that Psychiatric Services and Protective Services "were not collaborating to the extent needed to meet the interests" of these families.

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[4] Victorian Government Department of Human Services 2002 New Directions for Victoria's Mental Health Services: The Next Five Years Melbourne Victoria Australia p.18

The agencies were found to be poorly co-ordinated and distrustful. This resulted from resource constraints and the emphasis placed by Psychiatric Services on the parent as primary client, and misconceptions held by both agencies about the roles and statutory obligations of the other. However both agencies recognised the need for improvement.[5]

The report recommended four initiatives to address parental mental health issues and to reduce the incidence of child maltreatment

1. A new emphasis in Psychiatry on considering the role and interdependence of families;
2. enhanced liaison, collaboration, and integration between mental health and protective services;
3. a primary prevention community based home visiting program by health professionals to areas containing large numbers of at-risk families (while this intervention is outside the brief of both psychiatric services and protective services, it would fit well with community agencies such as community health or local government); and
4. A mechanism for coordinating and integrating the broad range of services concerned with child abuse and neglect, including the proposed primary prevention program.[6]

A pilot project, the Collaborative Practice Project commenced in June 2004 to address the first two initiatives. This project consists of two interventions to enhance service delivery to these families. These are:

- Child and Adolescent Mental Health Services consultant to Adult Psychiatry Bendigo Health Care Group
- Adult Psychiatry consultant to Protective Services and Juvenile Justice

[5]O'Connor, R. 2002 *Child Maltreatment and Parental Mental Health Problems: an investigation into the mental health issues of parents of children on statutory orders* Bendigo Health Care Group, p.6

[6]O'Connor, R. 2002 *Child Maltreatment and Parental Mental Health Problems:* p.55

Both positions are .4EFT and are based in the respective services they work with. That is the AMH consultant is located with protective services and the CAMHS consultant is located with the Greater Bendigo Adult Community Mental Health Team. Senior and experienced clinicians hold both positions.

5. Project Background

The Collaborative Practice Project is targeted at improving service delivery to families where mental health issues are linked with other significant issues such as poverty, homelessness and substance abuse and can result in children becoming at risk. Before going further it is important to note that many parents who have a mental illness are good parents and their children's development is normal. Smith writes,

That there are statistical associations relating to populations, and although children of mentally ill parents are at significantly increased risk in terms of their cognitive, emotional and social development, many parents with mental health problems continue to parent their children well and many children with parents who are mentally ill do not suffer any adverse effects.[7]

Nicholson, Biebel, Hinden et al in their study of families affected by mental illness write "Mental illness by itself does not guarantee poor outcomes. Instead mental illness in parents interacts with, or is associated with many variables and processes that can enhance resilience or confer risk upon children.[8] When parental mental illness interacts with a number of other variables and processes such as substance abuse, unstable accommodation, lack of family supports and poverty, children can be placed at increased risk of negative outcomes. Outcomes can include mental health issues and ongoing involvement with the health and welfare system and for some the criminal justice system.[9]

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[7] Smith, M. 2004 Parental Mental Health: disruptions to parenting and outcomes for children *Child and Family Social Work* 9 pp3-11, p. .3

[8] Nicholson, J., Biebel, K., Hinden, B. Henry, A., Stier, L., 2001 Critical Issues for Parents with Mental Illness and their Families Center for Mental Health Services Research Department of Psychiatry University of Massachusetts Medical School p. 18

[9] For a comprehensive review of the literature in this area see the literature review in O'Connor, R. Child Maltreatment and Parental Mental Health Problems and Fraser, C. and James, E. A Systematic Review of Interventions for Families Affected by Parental Mental Illness (unpublished manuscript)

When the prevalence of mental illness is considered, the impact of this risk factor can be appreciated. It is estimated that more than one million Australians have mental disorders and that almost half of these have a long term condition.[10] Depression is estimated to occur in about 8% of women of child bearing age and schizophrenia has an estimated point prevalence of 0.4%.[11] When combined with other risk factors for child abuse the prevalence of mental illness makes this factor a "widespread and significant issue"[12] It would appear that some mental disorders are more commonly associated with child maltreatment than others. Smith found that the disorders most commonly associated with child maltreatment are personality disorders (especially anti-social personality disorder) and major depression. Smith goes on to add that "alcohol and/or substance abuse have also shown strong associations with child abuse especially when these factors are co morbid with serious mental illness".[13]

Mental illness is a risk factor for child maltreatment when it affects the ability to parent. This can result in a lack of security and safety for the child. Other affects of parental mental illness, while more subtle can have a lasting affect on the child. For example, mental illnesses such as depression can result in a lack of interaction between mother and infant that the research indicates can have a significant effect on the child's cognitive development. In their study of the cognitive development of five year old children of mothers with postnatal depression Murray, Hipwell and Hooper found that where maternal interactions have been significantly impaired by post natal depression, "not only is the infant likely to have poor cognitive outcome at 18 months, but the infant's subsequent developmental trajectory up to five years is markedly constrained by their cognitive functioning in late infancy".[14] In reviewing the research on the link between parental mental illness and child development Smith writes that "children may show

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[10] Commonwealth Department of Health and Aged Care 2000 *Promotion, Prevention and Early Intervention for Mental Health- A Monograph, Mental Health and Special Programs Branch*, Commonwealth Department of Health and Aged Care, Canberra p.4

[11] Smith, M. Parental Mental Health, p. 5.

[12] Smith, M. Parental Mental Health, p.3.

13 Smith M. Parental Mental Health, p. 4.

[14] Murray, L. Hipwell, A. Hooper, R. The Cognitive Development of 5-Year-Old Children of Postnatally Depressed Mothers *Journal of Child Psychological Psychiatry*. Vol 37, No.8. pp 927-935

developmental delays, lower academic confidence, and difficulty with social relationships." [15]

Not only can mental illness affect the ability to parent but it is a risk factor for the development of mental illness in offspring. Leverton writes that "the children of psychiatrically ill parents are substantially more likely to develop a psychiatric disorder during childhood."[16] Nicholson, Biebel, Hinden et al also note "that rates of child psychiatric diagnosis among offspring range from 30% to 50% compared with an estimated 20% among the general child population. Both the effects of mental illness on parenting and the increased risk of offspring developing a mental illness themselves highlights the importance of developing effective interventions to support these families.

This support is particularly important for families where there is involvement with protective services as the risk of difficulties with social development, delays in cognitive development and child and adolescent mental health problems are higher. The Stargate Project, a Melbourne based early intervention program for children and young people in out of home care found that nearly 90% of adolescents in the program who completed the assessment sufficiently for diagnostic purposes met criteria for a major psychiatric diagnosis, 26% met the criteria for a second diagnosis and 3% met criteria for a third.[17]

As discussed above, parental mental illness is often one of a number of risk factors for child maltreatment in these families. Work with these families therefore, can involve a number of service systems and this requires a good level of collaborative work to achieve successful outcomes. However, there have been a number of barriers to collaborative work in this area. One barrier has been the assumption that parents with mental illness do not want further intrusions into their lives through additional services for their children. The Stargate Project commented on this belief thus "originally it was assumed that parents would not want to be engaged as they were in an adversarial situation with CPS.

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[15] Nicholson, Biebel, Hinden, et al Critical Issues for Parents with Mental Illness and their Families p.

[16] Leverton, T.(2003) Parental Psychiatric Illness: the Implications for Children *Current Opinion Psychiatry* 16:395-4002 p.400

[17] Royal Children's Hospital Mental Health Service 2004*Protected and Respected: Addressing the needs of the child in out of home care* p.41

In fact parents overwhelmingly welcomed the opportunity to speak with specialist staff about their children and their concerns."[18]

Lack of trust between agencies can be a significant obstacle to collaborative work. Robinson believes that this lack of trust is in part due to the difficult and often emotionally demanding situation helping professionals work with.[19] Robinson is convinced that collaborative work in this area demands the existence of professional good will and respect between helpers. This creates an environment which makes therapeutic outcomes more likely. If "workers are able to sit together in an atmosphere of trust and a willingness to collaborate, then the potential for creative and therapeutic outcomes are more likely to be realised.[20] Developing trusting relationships addresses other barriers to collaborative work such as "scepticism about the capabilities of workers from other agencies."[21]

Another barrier to undertaking collaborative work has been the view that parents in these situations do not always act in the best interests of the child. The placement of a child in out of home care can be viewed as resulting from parents not acting in the best interests of the children. Nicholson, Biebel, Hinden et al state that parents with mental health issues face an increased likelihood of losing custody of their children. They go on to point out that "to fail as parents can be quite traumatic."[22] Not only is this traumatic for the parents but this disruption can have a critical impact on children. The Stargate Project made the important observation that "Placement in care did not indicate that parents were not acting in the best interests of the child. Many parents had voluntarily placed their children in care as a last resort because they had been unable to manage a range of difficulties in other ways."[23] This last comment indicates the desire of parents to

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18 *Protected and Respected: Addressing the needs of the child in out of home care* p.43

19 Robinson, M. (2004) Therapeutic Collaboration: Bridging the gap between Statutory and Therapeutic Work *Australian Social Work* vol: 57, No.4 pp. 374-381, p.377

20 Robinson, M. Therapeutic collaboration p.379

21 Blanch, A.K., Nicholson, J., Purcell J. 1994 Parents with Severe Mental Illness: the need for human services integration in *The Journal of Mental Health Administration* pp 388-397 p.389

22 Nicholson, Biebel, Hinden, et al Critical Issues for Parents with Mental Illness and their Families p.10

23 *Protected and Respected: Addressing the Needs of the Child in Out of Homecare* Melbourne p.43

act in the best interests of the child even at a traumatic moment such as the placement of their child in care.

The above studies indicate that a number of beliefs about collaborative work in this area that have hampered the development of this type of work may be incorrect. However, this collaborative work must be well targeted at the needs of these families and then it can be very beneficial. A finding from the Stargate project was that "successful collaboration between key services has significantly enhanced case planning across all domains at the entry point into care." This project found that "enhanced case planning has led to cost efficiencies through stabilization of placement, reduced placement duration and reduced outsourcing to private services to provide specialist assessments."[24] Blanch, Nicholson and Purcell in describing the outcomes from a task force established to promote service collaboration in working with families affected by mental illness commented that "the provision of duplicate services is counter productive for clients and unnecessarily costly for the public."[25]

The studies examined for this report show the need for collaborative work with families affected by mental illness who are also involved with protective services. The studies also highlight the importance of effective interventions for these families to promote positive outcomes. Families can have the best interests of their children at heart and they can welcome interventions that will support their children. Agencies can work together in a trusting way to deliver care to these families. In fact these studies indicate that collaborative interagency approaches result in more effective interventions. The Collaborative Practice Project is based on similar perspectives to those described in these studies.

[24] *Protected and Respected: Addressing the needs of the child in out of home care* p. 8

[25] Blanch,*et al* Parents with Severe Mental Illness p.389

6. Implementation of the Collaborative Practice Project

Implementation of this project commenced with the appointment of the two consultants in 2004. The positions were and still are located with the services that they provide consultation to. The AMH consultant is located with CP and JJ and the CAMHS consultant is located with the Greater Bendigo Adult Community Mental Health Team. The AMH consultant reports to the Manager, Continuing Care and Mobile Intensive Support Team (MST) Bendigo Health Care Group Psychiatric Services. The CAMHS consultant reports to the CAMHS Regional Manager. Project development was advised by a working party representing the key players in the area.

6.1. The Collaborative Practice Project Working Party

Project development was advised by a working party with representation from the key agencies involved in services delivery to families affected by mental health issues. (See appendix 1: Working Party Review for a complete description of the working party) The role of the working party in project development is summarized in the Terms of Reference. (See appendix 2) The working party commenced meetings to guide the development of the pilot project in February 2004. There were seven working party meetings between project commencement and this report. An analysis of attendance at the seven working party meetings held shows that attendance represented the key stakeholders in the project:

Department of Human Services Mental Health Program 86%
CAMHS 100%
Centre for Rural Mental Health (CRMH) 86%
St. Luke's 43%
Department of Human Services Protective Services 71%
Adult Mental Health Services[26] 86%

[26]Representation from Psychiatric Services included PCATT/Triage, Continuing Care/MST and Inpatient services

Working party meetings enhanced collaboration and interagency linkages. For example, at the September working party meeting a discussion occurred on the merits of face to face planning meetings vs. the development of joint documentation. The working party preference was for joint face to face meetings at least as a starting point for collaborative work. Education and training needs were regularly discussed at these meetings. The working party provided valuable feedback on the evaluation design and findings. Most importantly, a venue was provided for the two workers to discuss progress and any issues they may have had in a supportive environment. One member of the working party commented, "I am intimately aware of the problems facing these families and workers working with them."

6.2. Adult Mental Health Consultant to Child Protection and Juvenile Justice

The purpose of this position is to provide high quality consultation services to CP and JJ. The position aimed to take a prime role in the development of and maintenance of a collaborative relationship between adult mental health services and these services. The key responsibilities for this position are:

- Provide secondary and tertiary consultation on mental health issues to CP and JJ staff.
- To develop and maintain collaborative working links with adult psychiatry.
- Undertake primary consultation of CP and JJ and adult services' clients or parents of clients and contribute to the formation, implementation, monitoring and evaluation of case plans.
- Assist in the development implementation and review of protocols between adult psychiatric services and CP and JJ that enhance appropriate access to adult psychiatric services of parents who are clients or whose children are CP or JJ clients.
- To assess need, plan, implement and evaluate education and training programs for staff in both sectors.
- To work with relevant consultancy positions for example the Spiritual and Emotional Wellbeing worker for Psychiatric Services.

- And; refer or consult with Psychiatric Services staff and other professionals on specialist matters.

CP has statutory authority and responsibility for investigating notifications of abuse and neglect. They retain case planning responsibilities for children who are subject to protection orders made by the Children's Court. However, CP believes that no one agency can provide for all the needs of children at risk and their families and relies on a range of agencies to provide support to these children and families. Therefore this agency has both a direct role in service provision and must work through a broad continuum of other services.

Table 1: Collaborative Practice Project work with Child Protection

The key issues addressed in this part of the project are described in the following table.

Issues	Strategies
Position Promotion to increase awareness of the support it can offer to CP staff	• Attendance at CP meetings • Briefing staff on the position
CP staff knowledge of adult mental disorders	• Formal education sessions • Informal case related education
Communication difficulties with Psychiatric Services staff	• Strategies to communicate concerns in a meaningful way to adult psychiatric services
Prioritising parent and child needs	• Understanding Psychiatric Services concerns about the mental health of the parent • Strategies to communicate Child Protection concerns about the child
Lack of appropriate areas for access visit in the Alexander Bayne Centre	• Joint meeting between ABC manager and CP to discuss the requirements for an area that would meet the needs of parents and children • Development of a joint protocol between CP and Psychiatric Services for access visits in the ABC.
Coordinated planning between agencies	• Initiated and attended case conferences
Limited resources for supporting these families	• Co-operative arrangements negotiated to ensure support to the family
CP staff uncertain about whether a referral to Psychiatric Services is required	• Consultation on adult mental health to determine the need for referral • Joint assessment with CP workers • Collate relevant information
Confidentiality issues in exchange of information between services	• Information provided on a "needs to know basis" by AMH consultant to adult psychiatric services

Much of the work of this position involved education not only on adult mental health but the delivery of psychiatric services. Liaison and inter service consultation were also a

significant part of the work of the position. Although joint assessments and home visits were an important activity, clinical work was a smaller component of this position.

The aim of JJ is to reduce the risk of re-offending. This service works with the client and family to normalise the situation and encourage appropriate development in areas such as health, education and recreation. Their involvement is time limited and involves setting up longer term support systems for clients and families.

The following table describes the mental health issues for JJ clients and the joint work undertaken by these workers and the AMH consultant. In contrast to the work undertaken with CP, the majority of contacts were regarding JJ clients rather than the parents of clients.

Table 2: Collaborative Practice Project work with Juvenile Justice

Issues	Strategies
Communication with mental health professionals in both private and public sector	• Working with JJ worker to identify the information required by mental health professionals and appropriate language for communicating concerns. • Clarifying expectations about Psychiatric Services' interventions • More appropriate referrals to Psychiatric Services
Substance abuse issues	• Referral to YSAS and Psychiatric Services Dual Diagnosis services
Unstable accommodation	• Information on/referral to Psychiatric Disability Support and Rehabilitation programs such as St. Luke's Whirakee Housing program
Compliance with medication	• Liaison with Psychiatric Services Continuing Care/MST team
Lack of meaningful recreation and employment opportunities	• Investigation of recreation opportunities
Parental mental illness	• Education for juvenile justice workers in adult mental health • Consultation for JJ workers on effective strategies for working with parents who have mental health issues
On court orders	• Interventions for mental health issues to prevent likely breaches of parole conditions • Representation of mental health issues at Parole Board hearings
Emotionally volatile/mental health issues	• Consultation on: -Mental Health resources private and public -Early intervention -Anger management strategies • Joint risk assessment for mental health issues
Refusal of psychiatric services assistance	• Information on private mental health services • AMH consultant up skilled workers in management strategies

The above table shows that vulnerable young people require a range of interventions of which mental health is a key component. The AMH consultant has worked with staff to resolve mental health issues before they resulted in difficult behaviours or placed the young person at risk.

6.3. Child and Adolescent Mental Health Consultant to Adult Psychiatry

The purpose of this position is to provide high quality consultation services to adult psychiatry staff on the mental health wellbeing and issues related to this such as parenting skills, of dependent children of adult psychiatry clients. The position aims to take a prime role in the development and maintenance of a collaborative relationship between adult mental health services and CAMHS, CP and JJ. The key responsibilities of this position are:

- To identify adult psychiatry clients with dependent children who are experiencing parenting problems, including those who are involved with CP and JJ.
- To assist in assessing the impact of adult mental health problems on dependent children.
- To conduct assessments, including risk of harm for dependent children of adult psychiatry clients where indicated and to contribute to care plans to address these problems.
- To develop and maintain collaborative working links between adult psychiatric services, CAMHS, CP and JJ.
- To work collaboratively with other CAMHS consultancy positions.
- To provide professional education for adult psychiatry staff regarding the initial assessment of dependent children and their mental health needs.

A finding of the report *Child Maltreatment and Parental Mental Health Problems* was that adult psychiatry was willing to address the issues for client's families but lacked skills in child mental health and resources. The CAMHS consultant to adult psychiatry had a much stronger focus on clinical work. Clinical staff reported that families

welcomed the opportunity to discuss their children's wellbeing with the CAMHS consultant in contrast to the prevailing notion that families would see this as intrusive. This position provided the resources to undertake such work with these families.

The following table outlines the issues for these families and strategies used by the CAMHS consultant to adult mental health services to address these issues.

Table 3: Collaborative Practice Project work with Bendigo Community Mental Health Services Adult Team

Issues	Strategies
The number of dependent children of case managed clients	• Collection of anecdotal data on the number of dependent children of case managed clients
Assessing the impact of adult mental health issues on children	• Primary consultations for dependent children • CAMHS assessment for children identified as in need of a more ongoing service • Secondary consultation for case managers and PCATT/Triage staff
Support to client families	• Family therapy session/s • Reassurance to parents that the children are coping or referral made if required
Maintaining links between CAMHS, adult psychiatry and protective services	• Collaborative work between AMH consultant and CAMHS consultant
Adult psychiatry staff knowledge of child mental health	• Feedback to case managers • Secondary consultations

6.4. Linkages with other positions

The Collaborative Practice Project made linkages with other positions currently working in this area. These are the CAMHS consultant to CP and JJ and the CAMHS Mental Health Intensive Youth Service. The project also linked with the Dual Diagnosis worker (substance misuse and mental illness), the Kids with Confidence Project[27] and the Spiritual and Emotional Wellbeing project.[28]

[27] The Kids with Confidence Project is aimed at children in families affected by mental illness.
[28] The Spiritual and Emotional Wellbeing Project aims to improve psychiatric service delivery to Koori communities.

7. Project Evaluation

The positions have developed quite differently and in response to the needs of the services in which they were based. The AMH consultant took much more of a liaison, networking and education role. Direct clinical work was undertaken in partnership with CP and JJ staff. e.g. joint assessments. The CAMHS consultant to adult position took on a more clinical role. This worker undertook family assessments for Crisis Assessment Treatment Team (CATT) clients and assessments of children in families affected by mental illness. The development of this position reflected the clinical nature of the service. Adult psychiatry needed clinical expertise in child and family mental health. The innovative nature of this work made it important that project evaluation was undertaken.

7.1. Evaluation Method

This project is in the early stages of development. Therefore it was decided that process evaluation would best achieve the goal of describing the project and exploring the contribution of the various project elements to shaping the project. This commenced with the use of the principles of program logic to explore the underlying assumptions and clearly outline program structure. This identified the key elements of the project including consultation to the agencies involved in the project, clinical work with families, the development of protocols to enhance service delivery and professional education. Evaluation indicators were developed for each of these areas. (See Appendix: 3 Program Objectives and Evaluation Measures)

When the project had been in operation for six months a series of qualitative interviews were conducted with staff from all services involved in the project. Staff members were selected for interview on the basis that they worked at key points in the service delivery system or at the interface between Psychiatric Services and CP and JJ. Altogether six staff from CP and JJ and eight Psychiatric Services staff were interviewed.

Data was collected on the following:

- Number and type of contacts
- Activities currently being undertaken
- Intervention outcomes
- Any issues that had emerged

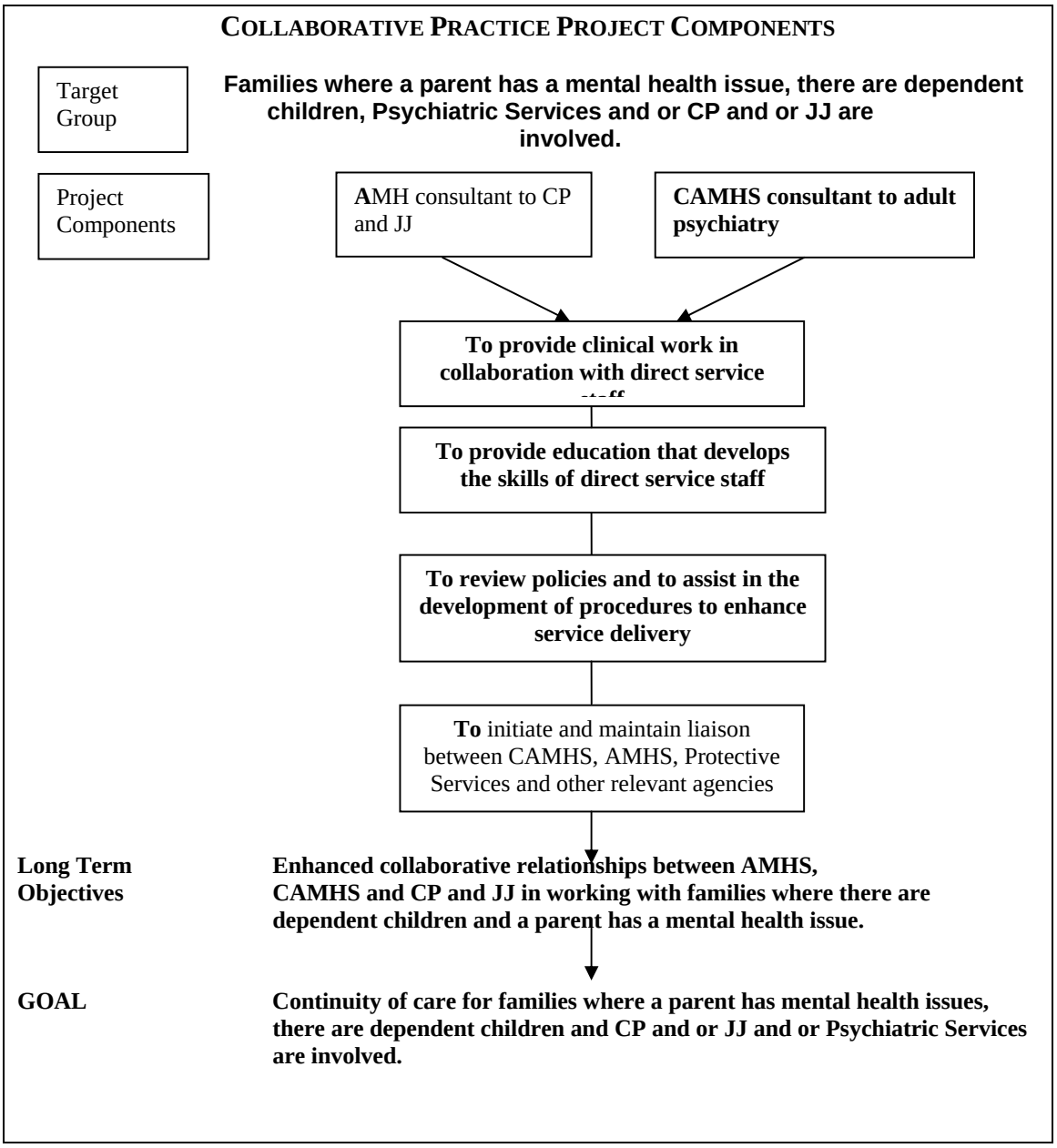
(See appendix 3: Interview Questions)

7.2. Project Key Components

This section describes project outcomes in terms of the main components as described in the following diagram. This is not an exhaustive description of all project outcomes. Rather data has been selected that illustrates the nature of the work undertaken. While data has been analysed in terms of the key components of the model clearly there is considerable overlap between components and some data may actually reflect several project components.

The following table describes project components and linkages.

Diagram 1: The Collaborative Practice Project Components



7.2.1. Clinical Work

The first project component to be described was the provision of clinical work in collaboration with staff in the services the project consultants were based with. The following examples provide a description of this work.

- A adult psychiatric services case manager concerned about risks to a child contacted the AMH consultant. The consultant facilitated a case conference with CP staff and a number of supports were put in place for the family. This included an assessment for the child and a psycho-education session. The case manager commented that, "while the interventions would have been more helpful earlier, "Nothing would have happened but for these workers."

- The consultants also took on both directly and indirectly the very important role of explaining parental mental illness to children of adult psychiatry clients. This is a skilled area that requires not only a good understanding of adult mental health but also an understanding of communicating complex information to children. A case manager gave an example of the CAMHS consultant explaining a parent's mental illness to a child in a way that alleviated the child's fear that they had somehow caused this illness. The consultant then worked with the adult psychiatry staff to identify appropriate supports for this child.

- Psychiatric Services Regional Triage Service has offered the option of talking to the CAMHS consultant to clients with mental illness concerned that their child may have mental health issues. At the time this data was collected only one client refused this offer.

- The CAMHS consultant to adult mental health was able to undertake assessments of children in families of adult clients when there were concerns. Parents reported

that they found this service reassuring and this offer was only occasionally refused. An adult psychiatry staff member commented that this service, "Acknowledged that parents care for their children, they have concerns for their children and here is something that could be used to check it out."

- There is a gap in services for children who are stressed and finding it difficult to cope with parental mental illness but who do not fit the criteria for CAMHS. In one case involving parental mental illness and distressed children, the CAMHS consultant linked the children into school counselling services and a private psychologist for ongoing support.

- CP had concerns about possible mental health issues for a very isolated parent. The AMH consultant assisted by clarifying the information that CP needed from adult psychiatry in order to assess the level of risk to the child. The parent was assessed as not needing psychiatric services ongoing interventions. The AMH consultant was able to explain the case outcome to CP staff and make recommendations about areas they needed to consider in providing services to the parent and children. The consultant contacted the CAMHS consultant to adult psychiatry for an assessment for the children. The parent was happy with the recommendations made and thankful for the support offered. CP was able to close the case.

- CAMHS consultant to adult psychiatry provided a family assessment that resulted in a child at risk of a mental disorder being referred to CAMHS for specialist interventions.

- Some adult psychiatry staff had been reluctant to use the Family Support Plan (FSP).[29] They did not understand the rationale for the plan and were not confident

[29] The FSP is a part of Psychiatric Services Comprehensive Assessment and Service Plan (CASP) documentation

using it. The CAMHS consultant provided a clear rationale for using the plan to adult psychiatry staff.

- AMH consultant accompanied a CP worker on a home visit initiated in response to concerns about the effect of parent's challenging behaviour on the children. The consultant observed at the home visit and then discussed strategies for engaging the parent and coping with the parent's behaviours. Previously working with a family with these issues would have involved a home visit; a call to Triage for assistance; a second home visit to verify concerns; and then work would have commenced on management strategies.

- CP and JJ can talk to the AMH consultant about clients who they suspect may have a mental health issue. The consultant assists workers to clarify the issues and provides clinical expertise when needed. This results in clients being linked into services that "they need rather than what we think they need."

- The AMH consultant has provided support to JJ staff working intensively with clients who have complex issues. The consultant has "partnered staff members in working with clients and provided debriefing and mentoring." This is "very valuable and frustration levels for staff are significantly lower."

- Issues in assessing the degree of risk from suicide ideation have decreased since the two consultants (CAMHS and AMH) can assist with joint assessments with JJ.

7.2.2 Education and Professional Development

Education and professional development activities were an important component of this project. The aim of these activities in protective services was to increase the knowledge and skills of protective services workers in working with families affected by mental illness. The CAMHS consultant to adult mental health aimed to increase understanding of child mental health and the possible effects of parental mental health issues on children.

- AMH consultant attended CP meetings to not only promote the position but to discuss any concerns that staff had about parent behaviours.
- Formal presentation was made at a joint CP and JJ Adolescent planning day by CAMHS and AMH consultant.
- Five sessions on Early Psychosis were coordinated for CP and JJ staff.

7.2.3 Review of Policies and Procedures

A third component of the project was the development of policies and procedures to support and consolidate the direct service work of the project. CP staff bringing children into the Alexander Bayne Centre for access visits with parents was the first area for policy and procedure development in this project. Issues around access visits at the Alexander Bayne Centre were raised at working party meetings. The AMH consultant arranged these joint meetings between adult psychiatry and CP to discuss possible solutions to these issues. A plan has been developed to maintain the safety of both CP staff and children and an area for access visits has been found. While more work is required this represents a start to resolving issues around access visits in the ward.

7.2.4 Liaison and Collaboration

The final project component was to encourage liaison and collaboration between services. The following outcomes illustrate improved communication between all services involved in the project.

- Adult psychiatry workers reported that collaborative work between services had been enhanced by the consultants. They reported that work with joint clients had been streamlined by the consultants. "We know how processes work and how intake works and what needs to happen before CP become involved." Another worker commented that "We have improved access to CP through the AMH consultant. She clarifies whether we should be accessing CP".

- Consultants (CAMHS/AMH) provided communication strategies that assisted in approaching Psychiatric Services. The example was given of CP concern that a

parent was not well enough to care for the children. Adult psychiatry was concerned that removing the children would have a detrimental affect on the parent's mental health. The AMH consultant provided advice on communicating CP information in a way that was meaningful to adult psychiatry so that the services could work collaboratively on the situation.

- Prior to the project there was more "mystery" about protective services for adult psychiatry staff. New staff members were concerned that children would be removed if they contacted CP. "They can now get advice from someone who knows Protective Services and is part of Protective Services but who is a mental health clinician." The consultant can clarify for Psych staff whether they should be accessing CP and the likely outcome.

- More sharing of resources between services occurred. The example was given of a family situation involving parental mental illness that needed monitoring over the weekend. As CP can only provide a crisis response on weekends psychiatric services Mobile Intensive Support team visited the family on the weekend.

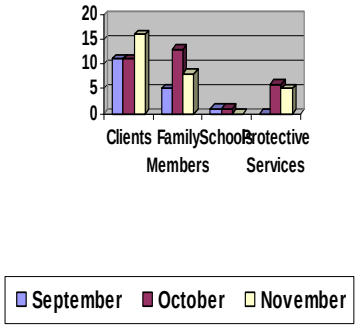
- AMH consultant "can explain why the expectations that we have of Psychiatric Services may not be delivered on. The consultant explains what psychiatry can and cannot do."

- JJ commented that their referrals to Triage were less likely to be inappropriate and the rate of acceptance of referrals was higher. It is clear that the referrals that "we do make will get over the line." "Less time is wasted on inappropriate referrals and disagreements." CP case management staff contact Triage less than they used to as they can access the consultant. The consultant also provided other referral options.

7.3. CAMHS Consultant to Adult Psychiatry Statistics

As discussed earlier this position had a much stronger clinical focus. The following graph shows that clients and families were the main service recipients. The figures indicate that contacts with protective services started to increase as the position became established indicating the strengthening of collaborative relationship between this position and Protective Services.[30]

Graph 1: CAMHS Consultant to Adult Psychiatry Contacts for September, October and November 2004



Research into the relationship between parental mental illness and child abuse is limited in several ways. Most studies are based on samples of parents who have been determined through the child welfare system or the courts to be abusive or who report themselves to be abusive. These studies do not tell us what percentage of parents with mental illness abuse their children, but rather tell us what percent of parents who abuse their children have mental illness. Currently it is not possible to collect data on the number of case managed clients who have dependent children from the Psychiatric Services' data base RAPID. It is also not possible to establish the number of clients who are also involved with protective services. Therefore the CAMHS consultant collected anecdotal data on both the number of registered case managed clients who have dependent children and the number of dependent children. These figures provide a snapshot of the situation at that point in time for case managed clients of the Greater

[30] Nicholson, J., Biebel, K., Hinden, B. HenryA., Stier, L., 2001 Critical Issues for Parents with Mental Illness and their Families Center for Mental Health Services Research Department of Psychiatry University of Massachusetts Medical School p. 35

Bendigo Adult Community Mental Health Services. Approximately 25% of case managed clients have dependent children. The total number of children is 120.

- Fifty seven percent of these children were in the custody of a client of adult psychiatry.
- The proportion of male and female children was approximately equal.

The following findings are from data on 65 of these children:

- Ten children are currently involved with CP and 23 have had past involvement with this service.
- Of the ten currently involved with CP five have ongoing involvement.
- Seven children have a history of ongoing involvement with both CP and CAMHS.

Taken together the graph and figures clearly demonstrate the need for services to take into account the needs of dependent children of adult psychiatry clients. Further the figures indicate that these children can have complex needs that require a high degree of service collaboration.

7.4. Adult Mental Health Consultant to Protective Services Contacts

Contacts for the AMH consultant for one month were reviewed. All contacts involved the provision of information. This information included role of the position, supervision,

psychiatric services criteria, and medication, parenting strategies, family issues and assistance with new referrals.

7.5. Progress in Achieving Project Objectives

This has been a small, time limited intervention in a complex area. While staff have been uniformly enthusiastic about the project, it should be noted that the project has just commenced work in this area. The positions are just beginning integration with the services they are based with and there is a need to consolidate both the positions and the work that they undertake. However, even in this short time real progress has been made in implementing project components resulting in the following:

- Increased early intervention for children in families affected by mental illness. These interventions ranged from explaining parental mental illness and providing reassurance to children about their parent's mental illness to referral to CAMHS for assessment. What is important is the assistance provided to these children was timely and appropriate to their needs.
- Parents were receptive to the advice and support offered in regard to their children. This knowledge that children were coping with the effects of family mental illness or could be referred on to appropriate services was reassuring to parents.
- Protective services staff were better informed about adult mental health and had more options in working with these families. Co-location of the project consultant with Protective Services was particularly important in this regard. The worker was accessible for consultation, joint visits and advice on referrals.
- The education provided was tailored to the needs of the respective services. Much of the education provided by the project consultants was case based and related to clinical issues. The project consultant to Protective Services provided more formal presentations in direct response to worker requests.
- The development of a policy and procedure for access visits to the Alexander Bayne Centre marks the commencement of work on policies and procedures that will enhance collaboration in service delivery.

8 Conclusion

This process evaluation of the Collaborative Practice Project demonstrates the effectiveness of a small time limited resource in working towards seamless delivery of care for vulnerable families. This type of intervention is very important given the trajectory from CP to JJ and adult problems and issues. Interventions that are preventative or early interventions are cost effective both in terms of the outcomes for families and children and in savings made when more complex work is avoided. When the number of children in families affected by mental health issues is taken into account this cost saving is even more pronounced.

The Collaborative Practice Project has raised the profile of families involved with both services and provided a resource in addressing the needs of these families. It has clearly established that a significant number of adult case managed clients do have dependent children. Through the work of this project it has been documented that a proportion of these children are currently involved with protective services. Project findings show that parents in these families, just like other parents, are concerned about their children and if support is offered they will take it up as it is in the best interests of the child. Findings show that staff from both services were committed to the best interests of the child and this project has given them hope. The following quote closes this report and shows the optimism that the project has brought.

We are dealing with a new generation of long term clients with kids. Fathers have issues such as substance abuse and anger management. The kids have the potential to develop a mental illness. Having the consultant involved provided kids with the opportunity not to be traumatized by their environment… I have a sense of optimism for the kids. There is now something there to pick them up earlier rather than later.

Terms and Abbreviations

ABC	Alexander Bayne Centre, regional adult inpatient unit
AMH consultant	Adult Mental Health consultant
CAMHS consultant	Child and Adolescent Mental Health Services consultant
CRMH	Centre for Rural Mental Health
CP	Child Protection
CASP	Comprehensive Assessment and Service Plan
FSP	Family Support Plan
JJ	Juvenile Justice
MST Team	Mobile Intensive Support Team, Psychiatric Services
MHIYS	Mental Health Intensive Youth Service
Protective Services	refers to both CP and JJ

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Appendices

Appendix 1

Mental Health Issues of Parents of Children on Statutory Orders

Proposal for ongoing role of the working party

Background

In 2000 a working party was established to explore the problems for parents with mental health issues who have children on statutory orders. The working party consisted of representatives from the Department of Human Services Loddon Mallee Region, Protective Services, Bendigo Health Care Group Psychiatric Services, La Trobe University and St. Luke's. This group successfully submitted in 2001 for funding to undertake an investigation of the issues for these families. The working party continued to advise the development of the resulting project "Mental Health Issues of Parents of Children on Statutory Orders. A report on project findings, *Child Maltreatment and Parental Mental Health Problems* was completed in 2002.

The findings and recommendations from this report provide the basis for the development of initiatives to enhance service delivery to these vulnerable families.

Working Party Review

The first step in undertaking further work in this area is to review the working party "Mental Health Issues of Parents of Children on Statutory Orders" and write new terms of reference that incorporate the following:

a) The suggestion that the Working Party is renamed "Collaborative Practice Protective and Psychiatric Services – Implementation Working Party"
b) A representative of CAMHS will chair the working party
c) CRMH will continue to have representation on this committee
d) The role of the working party will be to advise on the implementation of initiatives arising from report findings and recommendations

Roles for the committee will include:

The working party will be chaired by the CAMHS representative and administrative support to the committee will be provided by CAMHS

Assistance to those seeking funding to implement service delivery recommendations

The report recommendations relevant to service delivery include:

1. The establishment of a new CAMHS position (.5EFT) located in adult Psychiatric Services to:

-Identify which of their patients are experiencing parenting problems (including identifying if parents are involved with Protective Services) and assist in suggesting elements to add to care plans

-Conduct a risk assessment of the potential of the adult patient harming their child, including the possible effects of preoccupation, emotional blunting and limited lifestyles.

-Manage parenting issues of patients with mental health problems, possibly including planning regarding parenthood

2. The establishment of a new Adult Psychiatry position (.5EFT) located with Protective Services. This would complement the existing CAMHS liaison position with Protective Services. It is proposed that this position would:

   -Provide training to Protective Services workers in adult psychiatry
   -Provide advice at assessment for cases where it is believed that parental mental illness may be a factor
   -Advise Protective Services workers re: the need to involve Psychiatric Services
   -Develop service protocols to ensure continuity of care

3. Development of an evaluation model for the proposed positions to identify effectiveness in enhancing service delivery to these families and in reducing risk issues

These recommendations require new funding and part of the brief of the working party will be to work with Protective Services and relevant parts of Psychiatric Services to assist in the development of funding applications for these initiatives.

Provision of advice on further research to be undertaken in this area

The committee could provide advice to existing or planned projects that are in line with report recommendations. These include:

(a) Psychiatric Services clients who have dependent children study

A study to collect basic information on how many registered clients of Psychiatric

Services in the Loddon Southern Mallee Region have:

a) Dependent children
b) Dependent children and Protective Services involvement
c) Dependent children and substance abuse issues

This study will be undertaken by the Centre for Rural Mental Health Kids with Confidence to supply baseline data to:

a) Identify issues for these families
b) Development of specific interventions to meet the needs of these families
c) Inform the development of policies and procedures that enhance service delivery to these families

(b) Male Carers: A Needs Assessment

Funding has been received for the Centre for Rural Mental Health to undertake a needs assessment for male carers of people with a mental illness. This project has a focus on male carers who are providing care for a person with mental illness and dependent children

(c) Protective Services Project

A complementary study to that being undertaken by the Kids with Confidence Project, to be undertaken by Protective Services, to collect basic information on how many registered Protective Services clients in the Loddon Mallee Region have:

a) Dependent children

b) Dependent children and Psychiatric Services involvement

c) Dependent children and substance abuse issues

Provide advice to Psychiatric Services and Protective Services staff development programs on professional education activities designed to enhance knowledge and skills in this area

The report highlighted the need for ongoing education in this area for both Psychiatric Services and Protective Services workers. The working party with representation from both Protective Services and Psychiatric Services is well placed to provide advice on professional education for staff of Protective Services, Psychiatric Services and other relevant health and welfare agencies that will develop skills in working with families involved with Protective Services where the parents have mental health issues.

Future development of the working party role

While the immediate business of the working party will be addressing the strategies outlined earlier, the importance of early intervention and prevention for children and families is recognised. The working party will:

(a) Identify opportunities to implement population based interventions similar to the El Mira study[31] and develop funding submissions

(b) When report recommendations to enhance service delivery to families involved with Protective Services where the parents have mental health issues are established, broaden working party membership to include primary health agencies working with families in order to provide a focus for future work on early intervention and prevention

[31] Olds, DL, Henderson CR jr, Chamberlin R, Tatelbaum, R. Preventing Child Abuse and neglest: A randomised trial of nurse home visitation in **Pediatrics** 1995;95:365-72

Appendix 2: Collaborative Practice Protective and Psychiatric Services – Implementation Working Party

Bendigo Health Care Group

COMMITTEES / WORKING PARTIES / PROJECT TEAMS

TERMS OF REFERENCE

Note: These terms of reference must be seen and approved by the executive before a new committee commences.

TITLE: Collaborative Practice Protective and Psychiatric Services – Implementation Working Party

OBJECTIVES:

- To advise on the implementation of the "Child Maltreatment and Parental Mental Health Problems" report recommendations
- To provide advice on further research to be undertaken in this area along the lines recommended in the report
- To provide assistance to those seeking funding to implement service delivery recommendations
- To provide a forum where the workers in positions recommended in the report can raise issues pertinent to their position and seek advice from key stakeholders

- To provide advice to Psychiatric Services and Protective Services on staff development activities to enhance staff knowledge and skills in this area.

MEMBERSHIP: (Updated: 5 August'04)

Katy Curtis CAMHS' consultant to Protective Services and Juvenile Justice (LCSM) (chair)

Sue Ellen Radford Kids with Confidence Project Worker, BHCG

Anne Fahey Centre for Rural Mental Health, BHCG

Sue Jeavons La Trobe University, Bendigo Campus

Kev Gerber Continuing Care Team Adult Psychiatric Services, BHCG

Natalie Storti CAT/Triage Team Adult Psychiatric Services, BHCG

Justin Clarke CAT/Triage Team Adult Psychiatric Services, BHCG

Lisa Harrington Child Protection, Department of Human Services

Robin Smythe Child Protection, Department of Human Services

Wendy Price Mental Health Project, Department of Human Services

Jenny Singe CAMHS, Bendigo Health Care Group

Dirk Lynzaat Alexander Bayne Centre, Adult Psychiatric Services

Jenni Fox 'Mothers Connect' Program, St Lukes

Chris Jacksen 'Mothers Connect' Program, St Lukes

Simon Reeve Placement and Support Service, St Lukes

Patrick Byrne CAMHS consultant to Adult Psychiatry

Gail Clarke Adult Psychiatry consultant to Protective Services and

Juvenile Justice

DURATION OF MEETING: One hour

FREQUENCY OF MEETING: Monthly

QUORUM: six

DURATION OF COMMITTEE / PROJECT TEAM Two years

REPORTING TO: Dr. Sandra Radovini Clinical Director Bendigo Health Care Group Psychiatric Services CAMHS

Ms. Connie Forbes Manager Direct Care Department of Human Services Loddon Mallee region

REPORTING MECHANISM: Minutes forwarded to Clinical Director CAMHS and Manager Direct Care Department of Human Services Loddon Mallee region

APPROVED: ……..…
(Title)

COMMENCEMENT DATE: ……

ANNUAL REVIEW DUE: ……
(date)

Appendix 3: Program Objectives and Evaluation Measures

Program Objectives	Benefit to the Target Group	Evaluation Indicator and Target	Data Source	Who Responsible
To provide consultation from adult Psychiatric Services to Juvenile Justice and Child Protection. To provide consultation from Juvenile Justice and Child Protection to adult Psychiatric Services	Improved understanding of adult mental illness by DHS staff	Observable changes in practice with families where a parent has a mental illness • Number of consultations • Consultation topic • Changes in practice	• Worker interviews • Contact sheets	Project workers Evaluator
Consultation for clients or parents of clients who have mental health issues to Protective Services and Juvenile Justice and adult Psychiatric Services	• Case management strategies that effectively target the needs of these families	• Documented changes in case management for adult clients with dependent children • Documented changes in DHS practice where a parent has a mental illness • Number of primary consultations • Number of secondary consults	• Interviews with Child Protection JJ and adult Psychiatry staff • CASP/FSP • Worker contacts	Project workers Evaluator
To provide consultation from child and adolescent mental health services to adult mental health services. To provide consultation from adult Psychiatric Services to Child and Adolescent Mental Health Services	• Improved understanding of child mental health by adult psychiatric services staff • Improved understanding of the effects of parental mental illness on children by adult psychiatric services staff	Observable changes in practice with adult psychiatric services clients who have dependent children • Number of consultations • Consultation topic • Changes in practice	• Worker interviews	Evaluator
To assess the use of the Family Support Plan (FSP) CASP documentation	Enhanced planning for dependent children when a parent is admitted to an in-patient unit or case management	Completion of the FSP for clients who disclose that they have dependent children	▪ Audit of FSPs ▪ KPI on FSP completion	Women's Mental Heath Worker

Support the review and/or development of protocols between adult Psychiatric Services, Juvenile Justice and Child Protection Child and Adolescent Mental Health Services that enhance service delivery to families engaged Psychiatric Services and/or Protective Services and Juvenile Justice	Protocols consolidate changes to practice designed to enhance service delivery to these families	• Identification of areas where protocol development is required	• Bendigo Health Care Group policies and procedures • DHS JJ and CP policies and procedures	• Project workers Working party
Consultation with relevant professionals on specialist matters	Service delivery targeted at the specific needs of families	Documented changes in practice for families with needs requiring more specialised interventions • Documented changes in case plans for adult clients with dependent children	• Worker records	• Project workers
To deliver and evaluate education and training programs for staff in both sectors	Improved understanding of both service systems. Service delivery more responsive to the needs of these families	Observable changes in participants knowledge, skills and confidence • Number and type of education session run • Documented changes in knowledge, confidence and skills	• Session outline • Participant evaluation • Education materials • Number of participants • Agencies	• Evaluator

CAMHS consultant to Adult	
Adult consultation to CP and JJ	
Common activities	

Appendix 4: Interview Questions

1) What would be ideal practice for Protective Services and Psychiatric Services in working with families affected by mental illness?
2) Describe practice for Protective Services and Psychiatric Services in working with families affected by mental illness prior to worker appointment
3) Do workers make full use of the position in working with clients/ families with mental health issues?
4) How does the joint position assist in working with some of these issues?
5) Are there any areas of practice that this position is currently unable to address?
6) Is there a good understanding between Psychiatric Services and Protective services of the criteria for service delivery and service processes?

Probes

-understanding different definitions of risk
-dual diagnosis
-understanding – of terms, medication diagnosis
-understanding of mental illness
-determination of level of risk
-knowledge of relevant services