CONFERENCE REPORT

Working Together for Children at Risk

Monash University

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We would like to acknowledge the speakers at the Conference:
Professor LeGrand, Dean of Arts, Monash University; Miss Elizabeth Lewis, Chair, Child Maltreatment Committee, Monash Medical Centre; Judge Jennifer Coate, President, Children's Court, Victoria; Professor Peter Birleson, Maroondah CAMHS; Professor Bruce Tongue, Child Psychiatry, Monash Medical Centre; Dr Cathy McAdam, Community Paediatrician, Southern Health Care Region; Anne Houlihan, Maternal and Child Health Nurse, Bayside, Melbourne; Brendan O' Hanlon, Bouverie Family Services; Angela Obradovic, Waratah Area Mental Health Service; Ric Pawsey, Working Together Project, Department of Human Services (DHS), Victoria; Dr Jenny Ouliaris, General Practitioner; and speakers from the Child Protection Service, Southern and Northern Regions, DHS; Victoria Police, SOCA Unit; the Mother's Support Programme, Prahran Mission; the Maroondah Area Mental Health Service, Parents' Project; Canterbury Family Centre; Oz Child Foster Care; CAMHS, Austin and Repatriation Medical Centre.

The Conference was organised by Glenda Bawden, Co-ordinator of Social Work (Acute Care), Southern Health Care Network; Dr. Rosemary Sheehan, Dept of Social Work, Monash University; Maria Rigopoulos, Allied Health Director, Mental Health Program, SHCN; Pauline Turner, Senior Social Worker, Adult Mental Health, Dandenong, SHCN; Marianne Townshend, Counsellor/Advocate, SECASA, SHCN; Valerie Wilson, Educator, Children's Program, SHCN.

Monash University's Dean of Arts Fund and the Southern Health Care Network came together to sponsor this two day conference, led by Dr Danya Glaser, Department of Psychological Medicine, Great Ormond Street Hospital for Children, London, and Professor Christine Hallett, Vice-Principal, University of Stirling, Scotland. The conference included presentations by a number of Victorian professionals with an interest in children at risk of harm and in how adult mental health agencies and child welfare services work together.

The conference had two specific aims: Day 1 focused on identifying and intervening with children at risk of emotional harm; Day 2 focused on the theme of 'working together' and developing a shared discourse about children in families with parental mental health problems. Professor Christine Hallet spoke about why emotional harm matters, informed by her significant research into inter-agency collaboration in child protection, child protection policy, child welfare and the law, and her role as Associate Editor of *Child Abuse Review*. Dr Danya Glaser has paid particular attention, in clinical work and in research, to the impact of emotional abuse and neglect on children, and to the treatment of children who have been sexually abused or who are the victims of factitious disorder by proxy.

The significance of such a conference, and the debates within it, is confirmed by the reality that cases involving the grounds of emotional and psychological harm and jeopardy to the child's development were the basis of one-third of child protection applications completed in the Children's Court of Victoria during 1993. In 1998/9, emotional harm was the basis of concern in 25.7% of child protection matters completed in the Family Division of the Children's Court of Victoria. After physical abuse, emotional harm is listed in Children's Court figures as the most prevalent reason for seeking a child protection order, although it is often conjoined with the grounds of physical or sexual abuse (Department of Justice, 1998/9:25).

Studies undertaken in the Melbourne Children's Court (Sheehan 1997, 1999) found that the children of parents with mental health problems were frequently presented at Court. Just under 30% of all new child protection applications

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brought to the Court and referred to alternative dispute resolution during the first half of 1998 involved parents whose mental health problems were the basis of, or a significant factor in, the child protection concerns presented to the Court.

What was common to both groups of cases was the lack of inter-agency cooperation between adult mental health and child protection services, differences of view about what constituted risk factors for children in the care of parents with a mental illness, or over which parents manage well in spite of their mental illness. The different professional functions of adult mental health and child protection contributed to this. These findings also emerged in the Icarus Project (Sheehan et al 2000), a cross-national project that compared the views and responses of mental health professionals and child welfare professionals to the dependent children of mentally ill parents, when there were child protection concerns. Professionals did not share common views about what constituted a risk situation for such families, what factors created resilience in such families or what interventions achieved positive results for such families.

CHILDREN AT RISK OF EMOTIONAL HARM

Dr Glaser reminded the conference that emotional harm is a common factor that binds together all forms of child maltreatment. Yet, despite the available knowledge about the necessary conditions for healthy child development, there is a culture of diffidence (Stevenson 1996) about intervention in cases of emotional abuse and child neglect. Judge Coate reminded the conference that the Children's Court does not shy away from making child protection orders when there is clear evidence of emotional harm or child neglect. However, child protection representatives said it was difficult to translate factors that are emotional abuse concerns into legally acceptable evidence of harm or neglect. The community paediatrician and the maternal and child health nurse said they were increasingly seeing in their work a worrying group of children who were at risk of emotional harm and neglect. Yet they had difficulty persuading child protection professionals of the destructive consequences of emotional abuse and thus of the need for intervention.

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What became clear was that the lack of shared frameworks for determining what constitutes emotional abuse and the lack of legal criteria available to guide decision-making, hinder the identification of and response to emotional abuse. Agreed frameworks such as those for characterising physical or sexual abuse are notably absent in this debate. Dr Glaser commented that children who are emotionally abused often do not have needs that qualify them for child protection. The child protection system is triggered when it is perceived that the threshold of significant harm has been crossed (Ayre 1998). Emotional harm is contextually based, unlike physical and sexual abuse which may be single incident based; it is ongoing in nature and does not precipitate a crisis, and a response, in the same way as other categories of child abuse.

Thus the community, including professionals, are unclear about what parental behaviours require sanctioned or mandated interventions. Children who are emotionally harmed have become a group who are marginalised in terms of services and by the failure of legislation to enshrine notions of parental responsibilities (Scotland) or threshold criteria (England). Services have been increasingly constructed in our system to favour short-term crisis interventions to respond to the long-term chronic child abuse situations typical of emotional abuse. Yet, as reflected in the figures mentioned above, the emotional abuse of children is a problem that dominates the child protection landscape. Conference participants urged the legal and welfare systems to be less selective and more inclusive in their concerns about parental behaviours that are known to be harmful to children

WORKING WITH CHILDREN AND ADULTS WHERE THERE ARE PARENTAL MENTAL HEALTH PROBLEMS

Day 2 of the conference focused on developing a shared discourse about children in families with parental mental health problems. Dr Glaser invited debate about whether children are at risk when their parents have mental health problems. Representatives from adult mental health services, from the Department of Human Services (DHS), from non-government services working with families and children where there is parental mental illness, from child psychiatry and from general medical practice, agreed that there is a problem in meeting the needs of children of mentally ill parents. However, they wanted it understood by child welfare agencies that it was often difficult enough for adult mental health agencies to engage and work with vulnerable adults without also needing to work with their parenting issues. This debate included comment about the problems that services encounter when working in this area, most particularly in terms of inter-agency cooperation. Programs that offer practice solutions to these problems, and focus on the needs of such families, were described by the Mother's Support Program, Prahran Mission; the Maroondah Area Mental Health Service Parent Project; Canterbury Family Centre; and the Oz Child Foster Care Program.

Meeting the needs of children in families with parental mental illness is a recognised and increasing problem. Developments in the mental health field have meant that more people with mental illness are being managed in the community. Moreover, national policy emphasises that people with mental illness should be maintained in their community and that those who are parents should be better

supported to retain their children in their care. Parents with mental illness who have dependent children need considerable support and are therefore likely to be involved with a range of professionals and services. The precarious nature of mental illness can bring these families to the attention of child welfare services when the parent's mental illness interferes with their capacity to care appropriately for their children. The difficulties such families encounter challenge not only the families themselves but also the professionals who work with them. As the various services that work with such families will have differing professional functions, they will often have a different view about what constitutes a problem in the life of these families. Certainly these difficulties were encountered by the Icarus Project, a cross-national study undertaken in different countries within the European Union and in Australia (Melbourne), which examined professional interventions with mentally ill parents and their children (Sheehan et al 2000).

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DEVELOPING A SHARED DISCOURSE ABOUT CHILDREN IN FAMILIES WITH PARENTAL MENTAL HEALTH PROBLEMS

The significance of developing services that will work together in a system that shares knowledge frameworks, and that has a structure for interdisciplinary discourse around sharing responsibility for children at risk who have parents with mental health problems, was emphasised by Professor Peter Birleson, Director, Maroondah Child and Adolescent Mental Health Service (CAMHS). The Department of Human Services, Victoria (1998), in the Working Together protocol, emphasises the importance of such shared knowledge and skill frameworks when working with people who have a mental illness and have children who have been or may be at risk of harm.

Professor Birleson reminded us that 15% of the normal child population lives in families where a parent has a mental illness (Hammen 1991), and that community studies in the UK (Iddamalagoda & Naish 1993) have shown that around 60% of women with serious chronic illness have children under the age of 16 years. A recent survey of inpatients at Maroondah Hospital Area Mental Health Service (1998) confirmed this figure with women inpatients. Thus there is a significant population of parents and children who may need help from a range of services associated with mental health, family support and child welfare. If these services are to be effective, they will need to work co-operatively with each other. Professor Birleson reminded the conference of the vulnerability of children in families where there is significant parental mental illness. Schizophrenia research indicates that 12% of children who have one parent with schizophrenia will develop this disorder, whilst 40% of children with two parents with this disorder will develop a schizophrenia spectrum disorder. Constance Hammen (1991) found in her US study that there is a significantly higher risk of psychiatric disorder among the children of parents with unipolar and bipolar depression compared to the children of parents with a chronic medical disorder and parents who do not have a recognised psychological disorder. Professionals who work in this area must not only be alert to this biological vulnerability but to other potential and associated difficulties that include: parental personality disorder or substance abuse, impaired parenting (irritability or parental unavailability), adult relationship role strains and conflict, socio-economic disadvantage, family adversity and illness-related stress separations, isolation and other psycho-social stressors. All these risk factors increase the risk of childhood developmental difficulties, especially in language, attachment disorders and social isolation.

THE VICTORIAN SERVICE SYSTEM

Services which recognise and support parent competencies, emphasise resilience factors for children (eg, consistency of care and a context of caring relationships), support child-parent attachments, and which apply well designed preventive programs, do achieve success (Durlack & Wells 1997). Victorian programs have focussed on universal prevention (eg, strengthening parent-child bonds), targeted prevention and early intervention aimed at symptom reduction and coping skills (for example, the Parent Project, Maroondah Adult Mental Health Service; the Mothers Support Program, Prahran Mission; *Keeping Kidz in Mind* and *Hidden Children Hard Words* (MHRI, 1997)).

This group of parents needs services that help them cope with mental illness and its impact upon them and other family members, and this includes important identification of their parent status by adult mental health services. Mental health care plans must consider the parenting role, the children and their strengths and vulnerabilities. This calls on professionals to always identify clients who are also parents, and to consider the impact of parental illness on family, to reliably identify high risk children and develop pathways of care, and to be involved in area networks for supporting people with mental illness and their children. The onus is also on child welfare professionals to be educated about mental illness and drug abuse and its effects, and to develop better local links with adult mental health and child mental health services, with primary health and welfare services. Professor Birleson emphasised that the children of a parent with mental illness must be noticed and heard, their strengths and vulnerabilities must be considered, and they must have available family community supports or other necessary pathways of care. Overwhelmingly children want to know about their parent's mental illness and have explanations for what is happening.

The Victorian service system does have in place a range of services that may have contact with such families, and these services need to be alert to the needs of this population.

Clearly child and adolescent and adult mental health services, the child protection service, and maternal and child health nurses see many of this client group, So too do drug and alcohol services, youth and family services, schools, GPs, and the juvenile justice system. These agencies need to work collaboratively to identify and meet the needs of this group. But, Professor Birleson reminded us that in practice often there is still little inter-professional communication, workers in different systems disagree about what services are needed or could be offered, and clients can fall between service systems. Despite policy statements that specify the need for more collaborative care, developing effective collaboration in practice has proved difficult. Even communicating with each other is difficult. So services to children of parents with mental illness have developed in an ad hoc manner, if they have developed at all.

The Way Forward

Professor Birleson suggested the organisational literature gives clues as to why practice change has been so hard to achieve for our organisations and our staff. This literature explores the general restraints that operate in all organisations and between organisations to maintain homeostasis, delay change, and increase obstacles to what seem like sensible ideas. Restraints range from ignorance of the issues that require changes (Galer & van der Heijden 1992), to using outdated frames of reference or 'mental models' (Vaill 1991), a lack of motivation for change and inadequate investment in change (Conner 1992). Other issues that emerge include the self-interest and competitive dynamics between services and service units that override organisational or client interests (eg, Tjosvold 1988), the barriers to communication between structural levels (Senge 1990) and the defensive interpersonal routines that develop within everyday organisational life (Argyris 1993), such as blame-shifting, buck-passing, scapegoating, avoidance and denial, placating and self-deception.

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Investment in change must come from policy makers as well as practitioners, to implement structural changes that are client-centred rather than professional role-centred. Children must be included in the core business of adult mental health services, and considered in the assessment, intervention and service plans for the adult client. Adult mental health services must be willing to maintain protocols and training with child protection services. Mental health and child welfare professionals need to give this priority not only because consumer pressure requires this, but also because action groups such as the Families and Mental Health Network in Victoria have lobbied for it. National mental health policy is committed to prevention and early intervention in mental health problems, but this is predicated on services being able to work together and giving a commitment to quality practice.

What do at risk children and families need?

Professor Birleson postulated what might motivate each of these players to try to change the situation. He suggested that Department of Human Services' regional offices could take a greater interest in how this client group is being served. However, given that regional offices are busy with many different client groups, they may not choose to give this group priority until the Mental Health Branch and Child Protection Branch of the Department of Human Services both drive strategic directions for parenting

A 'bottom up' approach has been adopted in the Northern Region of DHS where the CAMHS and the Child Protection Service have developed a protocol to work collaboratively in this area. This approach can be initiated by client organisations or by staff in local mental health services. Another example of this is the Southern Partnerships Project in Melbourne, which is a coalition of a variety of welfare and health service organisations. This coalition aims to build local service networks for collaboration in the interests of this population of parents and children. Regional service providers and staff in this coalition in the area mental health service worked collaboratively to share information and case consultation about families in need. Local area activity should include establishing an advisory group of key stakeholders that can identify both the scope of needs of the community and what possibilities there are to meet them, and develop work plans and agree on shared operations and support. At the same time regional policies must be in place to operationalise the Working Together Strategy (DHS 1998) and ensure there are structural links and policies that include training of service providers.

Campbell (1999) emphasised that the best place for solving problems is the community where they occur, that local needs, resources and potential should be assessed, and that local ownership of issues, processes and outcomes is required. These are complex problems, requiring action by multiple agencies. Professor Birleson suggested that health and welfare senior management could look to auditing services to ensure that those who work with parents are in fact identifying children's needs and assisting the parent to also do this, and that they have in place as a matter of policy targeted prevention and early intervention for children, as well as psycho-education for parents, families and children. They also need funding arrangements that will act as drivers to reward desired action.

WHO NEEDS TO ACT?

These issues will not receive priority unless attention is paid to the following pivotal issues:

1. knowledge of the risks for emotionally abused or stressed children must be shared between all services and providers;
2. adult mental health services must put more emphasis on the parenting responsibilities of their clients with dependent children and have stronger links with family support and child welfare services;
3. mental health must be accepted as everybody's business although there must also be a realistic acknowledgement of the opportunity and restraints on all.

A shared systems interactional 'mental model' will see the whole complex picture where multiple needs are required to be addressed through 'joined up' services. Child protection and welfare service managers need to review their practice and their training and change their organisations where necessary. These changes must be driven by social policies that are not just welfare and health based, but include attention to child welfare legislation.

CONCLUSION

What was clear across the conference was that the development of inter-agency co-operation and inter-professional confidence is essential if families are to receive the support they need. For this to happen, shared principles and strategies must be developed around the identification of, and intervention in, child welfare and adult mental health problems, and around the expectations each profession has about the others involved in the care of mentally ill parents and their children. Finally, no matter how co-ordinated the professional systems manage to become, unless we pay heed to the experiences of children whose lives, like that of Icarus, are subordinated to the needs of their mentally ill parents, then we are not acting in the best interests of vulnerable families, and the problems we have addressed in this report will continue to exist. ☐

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