Parental mental health problems are identified in a significant proportion of families coming into contact with child protection services. A number of innovative responses have been developed to facilitate collaboration between the mental health and child welfare sectors and to enhance the skills of individual practitioners to be able to work across mental health and child protection issues. This paper looks in detail at one such initiative—the Mental Health Liaison Project—to examine the factors that help and hinder such an intersectoral approach. It includes the perspectives of practitioners and clients of the service. The findings are used to provide direction for future work involving the intersection of child-focused and adult-focused services.

KEYWORDS
Mental health, child protection, interagency collaboration

PARENTAL MENTAL HEALTH PROBLEMS AND CHILD WELLBEING
The Australian 2007 National Survey of Mental Health and Wellbeing estimates that, in the preceding 12 months, one adult in one-fifth of two-parent families and just over one-third of sole parents had a mental disorder (Australian Bureau of Statistics, 2009). It further estimated that almost half of Australians aged 16 to 85 have experienced a mental disorder at some time in their lives (Australian Bureau of Statistics, 2009). The vast majority of adults with a mental health disorder are able to parent very effectively (Royal College of Psychiatrists, 2002; Tunnard, 2004), but, for a number of reasons, some children in families in which a parent has a mental health disorder may be vulnerable.
The association between parental mental illness and child development and wellbeing has been well documented (Centre for Community Child Health, 2004; Cleaver, Unell & Aldgate, 1999; Cowling, 1999; Oyserman, Mowbray, Meares & Fiminger, 2000). Mental health disorders that are more persistent and severe are likely to have a greater impact on children through the disorder’s impact on parenting behaviour and the contexts in which children live. (See Tunnard, 2004, and Royal College of Psychiatrists, 2002, for more details on the impacts of parental mental illness on children.)

The symptoms of a mental health disorder can affect a parent’s ability to demonstrate adaptability in their parenting (i.e., to be flexible, responsive and perceptive). By the same token, parenting difficulties and the stress associated with them can impact on the mental wellbeing of parents (Centre for Community Child Health, 2004; Royal College of Psychiatrists, 2002). These effects are particularly exacerbated when parents have comorbid disorders (e.g., the presence of depression and a personality disorder) or are in stressful life circumstances (e.g., when they have been hospitalised, when there are financial pressures or when they do not have adequate support from partners, friends and family members (Lovejoy, Graczyk, O’Hare & Neuman, 2000; Zahn-Waxler, Duggal & Gruber, 2002). Some mental health disorders (e.g., schizophrenia) can also markedly disrupt thoughts, feelings, perceptions and communication abilities, which can also impact on parenting and, subsequently, child development (Royal College of Psychiatrists, 2002; Zahn-Waxler, Duggal & Gruber, 2002). However, as stated in a review of the literature examining the determinants of parenting behaviour (Centre for Community Child Health, 2004:29):

…the general rule that applies to the issue of mental illness in parents is that the quality of parenting has been found more important than the [parent’s] diagnostic status in determining the children’s intellectual and social functioning. However, the evidence is clear—especially concerning depression and psychotic disorders—that early intervention is warranted with this group. Specifically, interventions should be targeted at [parents]

presenting multiple risk factors, such as depression and economic disadvantage.

The reality of the impact of parental mental health on child wellbeing is identifiable for the increasing proportion of children assessed in child protection investigations where the mental health status of a parent is often a key factor impeding the parent’s ability to care safely for their child/ren (Hollingsworth, 2004). Victorian data from 2000-01 show that 19% of substantiated cases of child abuse and neglect and 31% of child placements in care involved a parent with a psychiatric disability (Department of Human Services, 2002, 2003). Many of these parents also had problems with drug and alcohol misuse or domestic violence. Similarly, a more recent examination in South Australia of the records of children who had been placed in care identified that, in 70% of cases, drug and alcohol misuse was identified. In these cases, 65% of families also had a parent with mental health problems (Jeffreys, Hirte, Rogers & Wilson, 2009). These proportions are likely to be underestimates because the mental health status of a parent may not be known to child protection services.

**INTERSECTORAL COLLABORATION BETWEEN MENTAL HEALTH AND CHILD WELFARE SERVICES**

There are a number of new and different challenges facing workers in child protection. In the past, poverty was a major factor contributing to children coming into state care. More is now known about other issues and social vulnerabilities affecting parents and children, such as persistent severe mental illness, alcohol and substance abuse, domestic and family violence, parental experiences of being in state care, unemployment, homelessness and social isolation (Hollingsworth, 2004; Jeffreys, Hirte, Rogers & Wilson, 2009; Leek, Seneque & Ward, 2004; Thorpe & Thomson, 2003). These factors influence the wellbeing of children and other family members and negatively influence clients’ ability to engage with services and take steps towards recovery (Hinton, 2008).

Robinson, Rodgers and Butterworth (2008) identify three approaches to responding to adult mental
health problems in the context of family relationship services: (1) increasing the skills and knowledge of service providers to provide family or couple relationship counselling or therapies for mental health problems of a less serious nature; (2) referral to specialist care for clients with more severe mental health concerns; and (3) collaborative approaches between family relationship services and mental health services that have a strong interface at the local level. Similarly, there has been an increasing demand for adult-focused and child-focused services to improve skills, knowledge and processes to be able to collaborate more effectively for the benefit of children at risk of child abuse and neglect. This is in response to recognition that multidisciplinary, intersectoral approaches to working with clients presenting with complex case histories can produce benefits not only economically but also in terms of improved service flexibility and effectiveness and enhanced communication and trust between practitioners from different agencies (Considine, 2005; Darlington & Feeney, 2008; Darlington, Feeney & Rixon, 2005a).

Partnerships can exist in the relationship between professionals and service users, between different organisations (as in multiagency teams, when one worker is seconded from another agency) and between different professionals, such as in multidisciplinary teams (Frost, 2005). Frost (2005) identifies a continuum of partnerships that can apply to intersectoral work commencing with no partnership through to cooperation (sporadic, informal working together but no shared goal); collaboration (shared goals exists, can lead to the extension of agency goals, as in joint assessments, joint planning to address gaps and overlap); coordination (planned, systematic working towards shared and agreed goals); and, finally, merger/integration (different services become one service).

While both policymakers and practitioners have positive attitudes towards intersectoral collaboration in general, a number of systemic and professional barriers have been identified that prevent collaboration between child protection and mental health services (Darlington, Feeney, & Rixon 2005a, 2005b; Maybery & Reupert, 2006; Tunnard, 2004). These barriers include issues to do with communication between practitioners in different sectors; knowledge, skills and confidence around mental health and parenting problems; role conflict and problems with role clarity for common clients; resource issues, including a lack of time; a lack of supportive structures and policies to facilitate intersectoral collaboration; confidentiality; and statutory requirements (Darlington & Feeney, 2008; Darlington, Feeney & Rixon, 2005b; Maybery & Reupert, 2006; Scott, 2005). A lack of a preventative focus in child protection and mental health services also means that problems have usually emerged before anything is able to be done from the service perspective. While clients might be eligible for a response from one service, they may not be seen as eligible for the other service (Maybery & Reupert, 2006).

Anderson, McIntyre, Rotto & Robertson (2002) discuss three types of barriers to collaboration—personal, systemic and environmental. Personal barriers include an individual’s attachment to a professional identity that causes friction in shared decision-making processes. Systemic barriers include limitations as a result of a lack of resources, staff turnover and constraints on internal and external communication in social services. Finally, environmental barriers exist in communities and at the state and national level, such as competing political rivalries or definitions of social problems (Anderson, McIntyre, Rotto & Robertson, 2002).

A recent study that examined adult mental health nurses’ beliefs and practices in working with people with a mental illness who were also parents found that a quarter of the nurses reported barriers to discussing parenting issues with their clients (Thompson & Fudge, 2005). More than one-third of the nurses had not made a mandatory child protection notification to child protection services even though they believed there were significant child protection concerns. The main reason given was a lack of confidence in the response of child protection services. There has been a call for increased mental health education and resources for practitioners working in the child protection sector to address some of these barriers as well as for greater knowledge of children’s needs by adult mental health practitioners.
The lack of intersectoral collaboration also has an impact on families beyond the initial child protection assessment and investigation. Sheehan (2004) found that low involvement by mental health workers in child protection cases precluded the Children’s Court in Victoria from taking into account aspects of the children’s or parents’ emotional wellbeing and their mental health needs. In the United States (US), Nicholson, Biebel, Hinden, Henry & Steir (2001) found that adults with a mental illness, especially those who are parents, are disadvantaged in the legal system due to the denial of some basic civil rights for people with a mental illness; the stigma of having a mental illness; the lack of information and knowledge about the parenting capacity of particular parents with a mental illness; and limited mental health assessments and evaluation methods, which can introduce biased assumptions and decisions regarding mental illness and parenting into court proceedings.

INITIATIVES TO ENHANCE COLLABORATIVE EFFORTS BETWEEN MENTAL HEALTH AND CHILD WELFARE SERVICES

Darlington and Feeney (2008) present practitioner-identified components of best practice in collaborations between mental health and child protection services. These include:

- effective communication strategies at the level of the organisation (e.g., protocols for collaboration regarding confidentiality and information sharing) and the practitioner (building and maintaining interprofessional relationships)
- obtaining and retaining procedural and substantive knowledge
- adequate resources, including staffing, facilities and service components.

Bloom also argues that:

...when faced with complexity it is important to have some kind of cohesive framework that helps structure the formulation of an action plan for change. In a therapeutic situation, it is essential that the client and the helper get on the same page so that their goals and strategies for achieving those goals are aligned. Similarly, in an organisational setting it is critical that staff members, administrators, and when relevant, board members agree on basic assumptions and beliefs about their shared mission, desired outcomes, and methods for achieving their goals (Bloom, 2005:5).

In looking more broadly at the need for a cohesive framework, it is apparent that Australian mental health services and child protection services fall within different government departments and are subject to different governance arrangements by the national government and each state government. A 1992 report from a national inquiry into the welfare of people with a psychiatric disability identified for the first time that children in families where a parent has a mental illness, and the families as a group, need support (Fudge & Robinson, 2009). Subsequent national mental health plans responded by approaching the area of mental illness with a broader approach. These policy developments led, in 2001, to the Australian government providing funding to establish the National Children of Parents with a Mental Illness (COPMI) initiative (Fudge & Robinson 2009). COPMI’s overall aim is to “promote better mental health outcomes for children (0-18 years) of parents with a mental health problem or disorder” (COPMI, 2010). In addressing the perceived gaps in the field, the current COPMI objectives for 2008–10 include the promotion of training and education resources for relevant workforces, children and families (Fudge & Robinson, 2009) and improving good practice principles for work with children of parents with a mental illness.

Across Australia there has been variable progress in initiatives to address issues for children in families where a parent has a mental illness (Owen, 2008). In addition to national and state-wide initiatives in this area (e.g., Victoria has developed state-wide strategies, guidance and capacity building positions in the area of families where a parent has a mental illness), there are also smaller scale, localised projects to improve outcomes for children of parents with a mental illness. Until recently, there has been little research into these specific initiatives (rather than naturally occurring practices) designed to increase...
intersectoral collaboration between child protection and mental health services. This paper reports on the results of an action research project designed around the Mental Health Liaison Project. It will be used as a case study to highlight potential approaches and barriers to multidisciplinary and multiagency collaboration in this field.

THE MENTAL HEALTH LIAISON PROJECT

In 2004, staff from the then Child, Youth and Family Services (now Families SA) district office at Aberfoyle Park in South Australia made a submission for funding to incorporate an experienced mental health nurse (the project officer) within their child protection intake and assessment team. The funding submission was developed in response to a number of barriers workers had identified regarding their clients’ access to mental health services, including: long waiting lists; strict criteria for service eligibility; clients’ reluctance to follow up mental health assessments voluntarily or their inability to access services due to their geographical location; client denial of mental health issues; and the focus of child protection services on the child rather than the parents. It was anticipated that the multidisciplinary approach outlined in the proposal would improve collaboration between the mental health and child protection sectors, assist with the assessment of parents and fast-track referral for parents experiencing mental health difficulties to help them maintain the safe care of their children.

The funding submission was successful and, in April 2005, the Mental Health Liaison Project was established. Broadly, the goals of the Mental Health Liaison Project are to improve outcomes for adults and children, such as preventing or reducing child removals; to improve communication across mental health and child protection services; and to develop collaborative processes and understanding across the service systems working with this client group.

Collaborative activities have included setting up an interagency workshop to discuss information sharing; developing companion agency meetings; providing education for Families SA staff on mental health issues; developing a consultation and linking role for community mental health services on child services; helping in the development of training material for COPMI; contributing to the development of the SA Information Sharing Protocol between health and child protection services; and contributing to strategy meetings between the South Australian Mental Health Unit and Families SA.

At the end of 2005, the Australian Centre for Child Protection conducted a qualitative action research project to explore stakeholder (former and current clients of child protection services, child protection staff and mental health practitioners) views of the Mental Health Liaison project (Arney, Lange & Zufferey, in press; Zufferey, Arney & Lange, 2006). These views were used to develop recommendations for changes to the program (and for the continuation of key features). The views of stakeholders were sought again in response to the changes made to the Mental Health Liaison Project on the basis of these recommendations. Table 1 outlines the action research evaluation, the recommendations made and the changes made in response.

Semistructured interviews and focus groups were conducted with 25 workers (19 child protection staff and 6 mental health workers). There were telephone interviews with 8 parents (5 were clients of the Mental Health Liaison Project and 3 were clients of child protection services before the program began). Parental mental health problems included depression and other mood disorders; schizophrenia; self-harming behaviour, including suicidal ideation; anxiety disorders; and personality disorders. Clients also had other social issues, including domestic violence, poverty, single parenthood, drug and alcohol misuse, special learning needs, a physical disability, grief and loss and trauma.

All interviewees were asked what worked well and what could be done differently when including a mental health worker in child protection services. There was a specific focus on what helps and what hinders intersectoral collaboration. Approval for the research was obtained from the University of South Australia Human Research Ethics Committee and from the South Australian Department for Families and Communities Research Development Committee.
The following section briefly describes staff and worker perceptions of the Mental Health Liaison Project. It highlights the ways in which the project was different from traditional, “silied” ways of working. The barriers that still exist to intersectoral collaboration between mental health and child protection are also discussed, and there is a specific focus on systemic constraints and the complexity of clients’ lives.

**Table 1**

Action research process for the Mental Health Liaison Project

<table>
<thead>
<tr>
<th>Period</th>
<th>Stage</th>
<th>Description</th>
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<tbody>
<tr>
<td>April 2005</td>
<td>MHL commencement</td>
<td>Partnership between mental health and child protection services</td>
</tr>
<tr>
<td>April 2005-December 2005</td>
<td>Development and implementation</td>
<td>Reference committee&lt;br&gt;Advancing agency sharing forum&lt;br&gt;Identifying mental health resources and education&lt;br&gt;Joint assessments and mental health consultation&lt;br&gt;Case conferences and linkages with Drug and Alcohol Services, and Community Women’s Health&lt;br&gt;High Risk Infant Program Subcommittee&lt;br&gt;External evaluation&lt;br&gt;Marion Families SA and DASSA Partnership Project</td>
</tr>
<tr>
<td>December 2005-February 2006</td>
<td>Evaluation</td>
<td>8 interviews and 3 focus groups with 9 child protection and 5 mental health staff. Interviews with 3 parent clients of the MHLP and 2 parent clients of child protection services before the MHLP began</td>
</tr>
<tr>
<td>January 2006-February 2006</td>
<td>Analysis and reporting</td>
<td>Content analysis. 100% of interviews assessed for inter-rater reliability Interim report with recommendations</td>
</tr>
<tr>
<td>March 2006</td>
<td>Refinement</td>
<td>Recommendations from interim report</td>
</tr>
<tr>
<td>March 2006-June 2006</td>
<td>Implementation</td>
<td>Changes based on recommendations:&lt;br&gt;Additional information and resources at team meetings&lt;br&gt;Development of a mental health resource board for the child protection office&lt;br&gt;Development of mental health checklists or referral tools&lt;br&gt;Joint training initiatives undertaken such as Families in Mind Training Mental Health First Aid training,&lt;br&gt;Additional referrals to the MHLP&lt;br&gt;Changes not based on recommendations:&lt;br&gt;Project Officer working part time to extend the life of the project</td>
</tr>
<tr>
<td>June 2006-July 2006</td>
<td>Re-evaluation</td>
<td>3 interviews and 2 focus groups with 10 child protection and 1 mental health staff members. Interviews with 3 parent clients of the MHLP following changes recommended in the interim report</td>
</tr>
<tr>
<td>July 2006-August 2006</td>
<td>Analysis</td>
<td>Content analysis. 100% of interviews assessed for inter-rater reliability Final report with recommendations</td>
</tr>
<tr>
<td>August 2006-present</td>
<td>Refinement</td>
<td>Recommendations from final report to be implemented</td>
</tr>
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</table>

**THE MENTAL HEALTH LIAISON PROJECT: BUILDING BRIDGES AND BUILDING CAPACITY**

Workers and parents commented that the Mental Health Liaison Project was an innovative project that positively facilitated intersectoral collaboration. The results from interviews with parents and child protection and mental health workers showed overwhelming support for the project and for the
innovative idea of a mental health nurse working in child protection services. All involved with the Mental Health Liaison Project recommended its continuation and expansion. One child protection worker said:

In almost 5 years now, it has been the one truly innovative project that I have seen that has worked. This is one of the best projects that I have actually seen in the department in terms of being viable, being accepted, being useful and working at a ground roots level…it has been a wonderful project.

One mental health worker stated:

It is important to be able to continue to have someone involved in that type of position who can be vigilant in maintaining contact with mental health services and child protection services...raising issues from both sides—child issues and mental health issues—and keeping them prominent so they are not being overlooked.

Many benefits of the project were reported. The Mental Health Liaison Project was seen to enable client access to mental health services, a mental health assessment and new counselling, psychological and psychiatric resources. By improving collaboration between child protection and mental health services, workers reported that the Mental Health Liaison Project enabled clients to have a better understanding of the roles of different agencies; improved networking across services; provided ongoing advocacy and support for parents with a mental illness within the child protection system; and made for more efficient services. It also reinforced case plans for clients; offered a multidisciplinary mix of ideologies; enabled mental health and child protection workers to have fewer conversations that focused on child removal; enabled conversations between services to be more client-focused; and allowed joint assessments and interventions which resulted in different pathways for families.

Workers reported that the Mental Health Liaison Project improved communication, information sharing and knowledge across both services and assisted in developing a shared emphasis on parents and children. Broad support for the project at policy levels and local support from workers ensured that many individuals were committed to the issue of supporting parents with a mental illness and to agency partnerships. The multidisciplinary and cross-agency reference committee for the project and matrix of support and supervision to the mental health nurse also assisted the cross-fertilisation of ideas.

At a broader level, the project was able to improve the knowledge of staff in both services. Capacity building education and training activities, such as information sharing forums involving a range of services, were initiated; reference or resource materials were disseminated; and training courses open to a range of services and staff involved with the client group were organised and facilitated. In mental health services, the project worker aimed to increase staff awareness about the importance of assessing client parenting responsibilities when conducting risk assessments. In child protection services, the project officer aimed to improve parenting assessments by developing the mental health knowledge of social workers working in child protection services. This would enable them to provide an improved response to parental mental health issues. The intervention of the project officer had varied outcomes. Different outcomes were deemed positive by workers depending on the client situation. In one situation, a child protection worker felt that the project prevented children being removed from their parents:

The project officer was very good at coordinating everyone, [she] put her foot down and really escalated through mental health services. We would have got to the point where we would have had to remove [the children]...I think for me we probably would have removed long ago because I would have got to the point where I would not have known where to go. She has been a great asset.

In another situation a better assessment of the client’s mental health meant that the child was removed, which was also deemed a positive arrangement:

Mum and dad both have a mental health issue
and a newborn… the assessment we got from 3 weeks [admission in a residential mental health service for parents and babies facilitated by the project worker] really made us understand that these parents are really sick; they can’t care for their child. So, as a result, the child was a lot safer, because we weren’t going to put the child back into the parents’ care as we once planned. In a way, it is a good outcome because the child is safe.

In summary, while the project did not always prevent children being taken into care, it did provide early intervention and improved assessment. Another participant said:

One goal for when the project was set up was that it would reduce the numbers of children we were taking into care. This is not the case, but it did improve early and better intake and assessment and enabled us to focus intervention, as a result of the Mental Health Liaison Project.

Working at the individual level, joint assessments (where opportunities were available) and mental health nurse involvement in family case conferences were reported to be effective at improving information sharing between mental health and child protection services. Key influences on perceived outcomes included the project officer’s characteristics and the client’s characteristics.

**PRACTITIONER CHARACTERISTICS**

The personality, skills and experience of the worker employed in a partnership project and his or her ability to develop relationships with workers in diverse settings were seen as key issues that enabled successful cross-agency collaboration and engagement with parents. The availability and accessibility of the project officer were also important to the success of the project. Personal and professional expertise was deemed important and included:

- good mental health knowledge
- the skills, knowledge and the ability to be supportive
- being able to take a pragmatic approach
- being receptive to new ideas
- having an intersectoral mindset
- believing in a collaborative approach.

The project assisted with mediating between child protection and mental health services, particularly because of the project officer’s networks, previous experience and credibility in the local mental health services. She referred parents to a range of diverse services, including mental health services, and acknowledged client expertise about previous experience with services. This positive relationship and experience of the Mental Health Liaison Project led to hopefulness and high expectations of services being able to assist. One staff member said:

I value her both as a colleague for her professional skills and for her support for all the workers and her expertise on these cases and the way that she has been improving collaboration with a whole range of mental health services. And that has been enormously helpful in the way we deal with our cases [resulting in] a much better outcome, a much better outcome.

In reflecting on access to a mental health nurse in Families SA, one parent participant said:

…it sometimes people need it and sometimes they don’t. But it is up to them if they needed one. And, if they needed one, a mental health nurse would be available.

Parents stated that they wanted to be, and believed in being, good parents. As one participant said, “I do what I can to the best of my ability”. The Mental Health Liaison Project would assist them to work towards being the best parents they can be and, because it was voluntary, they would more readily consider becoming involved with the project if required.

Parents reported positive effects of being able to talk about problems and being listened to respectfully.
by the project officer. This made them feel that their concerns were important. The project officer enabled access to a number of resources, which the parents appreciated; she was able to offer helpful practical assistance to both the parents and the children as well as refer parents to services that enabled them to have respite from parenting responsibilities and support for themselves. Participants stated that contact with the project assisted them to parent more effectively and helped them with their thought processes:

It is good to have a mental health nurse in [child protection services] for people like me, to help me “keep my mind straight” so I don’t lose control at the children.

Overall, all parents said it was helpful and worthwhile “having a mental health nurse in [child protection services] to assist parents with mental health issues”. In the words of one parent, it was “like having two appointments in one” and this prevented having to report the same negative story “over and over again”. Another parent felt that the project was a “great idea” and that more people should be able to access it.

PROJECT CONSTRAINTS

The complexities of social issues facing parents and their children were barriers to their accessing appropriate services. These complex social issues were mentioned by several parent participants. These interrelated issues, in addition to child protection and mental health concerns, included domestic violence, disability, trauma and substance abuse. One parent said:

Mental health is one issue...child is another issue...issues bounce back and clash each other... [Families SA] need to take mental illness seriously, serious things could happen, [Families SA] need to be more active in connecting people to services, get people’s mental health stable because the concern is for the children. [Families SA] need to take more steps to help families [in this situation].

The parents indicated that they had previously had negative experiences accessing mental health and child protection services. From their perspective, the improvements needed in both services were related to the lack of communication with service users and, in the case of child protection services, unannounced visits; staff turnover; access to appropriate services; limited support; the ability and capacity to follow up referrals; parent relationships with workers; how appointments were managed; and the limited effectiveness of interventions or available services to improve parenting skills. The following quotes reflect some of the negative comments:

It is like surveillance without the security camera. They can visit, ring, “spot check” at any time...Every kid I have I am going to have welfare on my doorstep. I’m always looking over my shoulder. I can’t have a happy life.

The social worker went to another job and I’ve never heard from anyone since. Nearly one year has passed and I have not met the new social worker or case manager. Don’t know who it is and who the right person to talk to is.

When asked what the Mental Health Liaison Project could do differently, parents commented on what they needed more help with—personal barriers in their ability to follow up referrals. One parent named the issue of confidentiality. Participants also suggested a number of things they could be assisted with, such as accessing a psychiatrist and medication that suits them and they are happy with; practical assistance to help them care for their children; help with attending medical appointments; transport; and assistance with the Family Court. One parent said:

I should have kept following her up. I’ve been thinking about her a lot lately. I might ring her to talk to her. She was good... If I was able to follow up suggestions, it may have worked better.

The complexity of cases that the project and services deal with was also mentioned by workers as a barrier to interagency collaboration. As one worker noted, both services were holding the other service accountable to help fix the problem or find a solution:

Interagency or interprofessional conflict is
worse in bad cases. What happens is you see
the other person as having the solution. You
can’t fix it, so you imagine they can fix it. So
you blame them for not fixing it and then get
angry… I could see that all over the place.

Workers identified a number of barriers to
collaboration that impacted on the Mental Health
Liaison Project. These included bureaucratic
administrative processes that delayed the start of
the project; the need for an ongoing commitment
dollars and resources; the need for bipartisan
support (advocating for joint child protection and
mental health funding); and the need for political
will to enable the project to continue. Systemic
constraints, such as having the resources to work on
collaboration, were key concerns because workers
reported a lack of time to build collaborative
relationships, high staff turnover and a high volume
of work. Three key barriers to collaboration were
the “us and them” culture, limited knowledge and
understanding across services and the complexity
of cases.

The need for a systemic approach to the issues was
highlighted by one child protection worker:

In the time she has been with us, certainly
done a lot of work for us. In my opinion, there
still is a lot of work that needs to be done [in]
broader systems. But also bringing on board
the mental health field, to understand our role
and somehow figure out how we can actually
work together. We are slowly getting there.
She is only one person, and that one person is
certainly getting her voice heard, but I think
we need time to establish and get something
running.

Most participants commented that more time and
resources would be needed for the full benefit of
this project to be experienced at a systemic level. It
was noted that one person is not enough to change
the “us and them” culture systemically. This is
compounded by different concerns about who the
client is. For child protection services, the client is
the child; for mental health services, the client is the
adult. The different legal responsibilities of each
service (e.g., the youth court compared with the
guardianship board) were also identified as barriers
to systemic collaboration. Confidentiality issues for
both services also need to be resolved.

The attitude of professionals in both services and
their understanding of the role and function of child
protection and mental health services were seen
as key hurdles that need addressing. In order to
develop a collaborative partnership between child
protection and adult mental health services, staff
on the ground in both services were being asked to
broaden their horizons. Some enjoyed this and some
resisted. This was related to a range of not only
systemic factors, such as workloads, but also a lack
of communication and common language between
social workers in child protection and mental health
workers. As one child protection worker stated, the
education initiatives implemented by the Mental
Health Liaison Project were slowly working on
these attitudes, but changing them would take a
long time:

[The] attitudes…are so entrenched by lack
of information and understanding of our
respective roles. [In the cross agency forum, we]
had such incredibly good conversations—that
it is not our purpose. We want to see children in
their families too, but we have to work around
issues of their safety. Huge conversations, and
many more conversations needed will happen.
But it was an incredibly good start in trying to
break down barriers and fences that have been
put up over probably many, many years.

Furthermore, community perceptions and
understanding of both mental health and child
protection services are poor. Negative publicity
or public opinion further impacts on the divisions
among professionals.

DISCUSSION AND CONCLUSION

Working with families where a parent has a mental
illness and there are child protection concerns
requires strategies that are targeted at systems,
agencies, individual practitioners and clients. This
paper has examined one strategy that has focused on
increasing the level of collaboration between adult
mental health and child protection services. The
strategy has aimed to build the knowledge, skills and confidence of workers within these services by placing a mental health nurse with a child protection intake and assessment team. As Stanley and colleagues (Stanley, Penhale, Riordan, Barbour & Holden, 2003:217) have suggested, using dyads of workers from mental health and child protection services (and other joint working models) enhances client engagement and facilitates effective service provision:

Such a dyad would resolve the question of which service should take a lead by offering adult and children's workers a shared key worker role. Each professional could offer the other an insight into the procedures, legal provisions and interventions specific to their service. Within this dyad of workers, one professional might still assume the role of supportive confidante, while the other emphasised monitoring and the paramount importance of children's need. However, close collaboration between the two workers should have the effect of making such a division of roles more explicit for the families as well as for other professionals.

Participants in the action research presented in the current paper commented on the limitations to collaborative practice created by bunker, or silo, ways of thinking and working in mental health and child protection services. Similar barriers have been noted by a number of authors in Australia, the US and the United Kingdom (Anderson, McIntyre, Rotto & Robertson, 2002; Darlington, Feeney & Rixon, 2005b; Frost, 2005). This may be further compounded by workers from different professions (e.g., health, mental health, child protection and voluntary staff) believing that they are best positioned to assess and respond to potential harm to children (Stanley, Penhale, Riordan, Barbour & Holden, 2003), resulting in role confusion and conflict.

Anderson and colleagues (Anderson, McIntyre, Rotto & Robertson, 2002) have highlighted the need for service providers to move away from viewing themselves as experts who implement interventions to people but instead develop partnerships with all stakeholders, including parents. The Mental Health Liaison Project has been instrumental in improving client assessment and intervention. It has done this by working with parents and service providers and facilitating collaboration across a range of services, particularly between mental health and child protection services. Consistent with this, Tunnard (2004) has emphasised the need for workers to have a comprehensive understanding of mental health problems whilst sustaining a positive attitude towards families and understanding that parents want to be the best parents they can be.

A key consideration for locally developed program initiatives such as the Mental Health Liaison Project is to what degree they can be sustained and scaled up. Can such programs survive in the absence of key personnel (e.g., project staff and project champions)? While such projects might be extremely useful at a local level, to what extent can one person influence broader organisational and systemic change in both mental health and child protection services? Short-term funded partnership initiatives and projects are unable to improve collaboration between services in the long term because partnership projects require political will, permanent funding and a long-term resource commitment. Such programs need to be supported in a climate of intersectoral collaboration at all levels of the systems concerned and to focus on the needs of the family rather than the individual client/s.
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