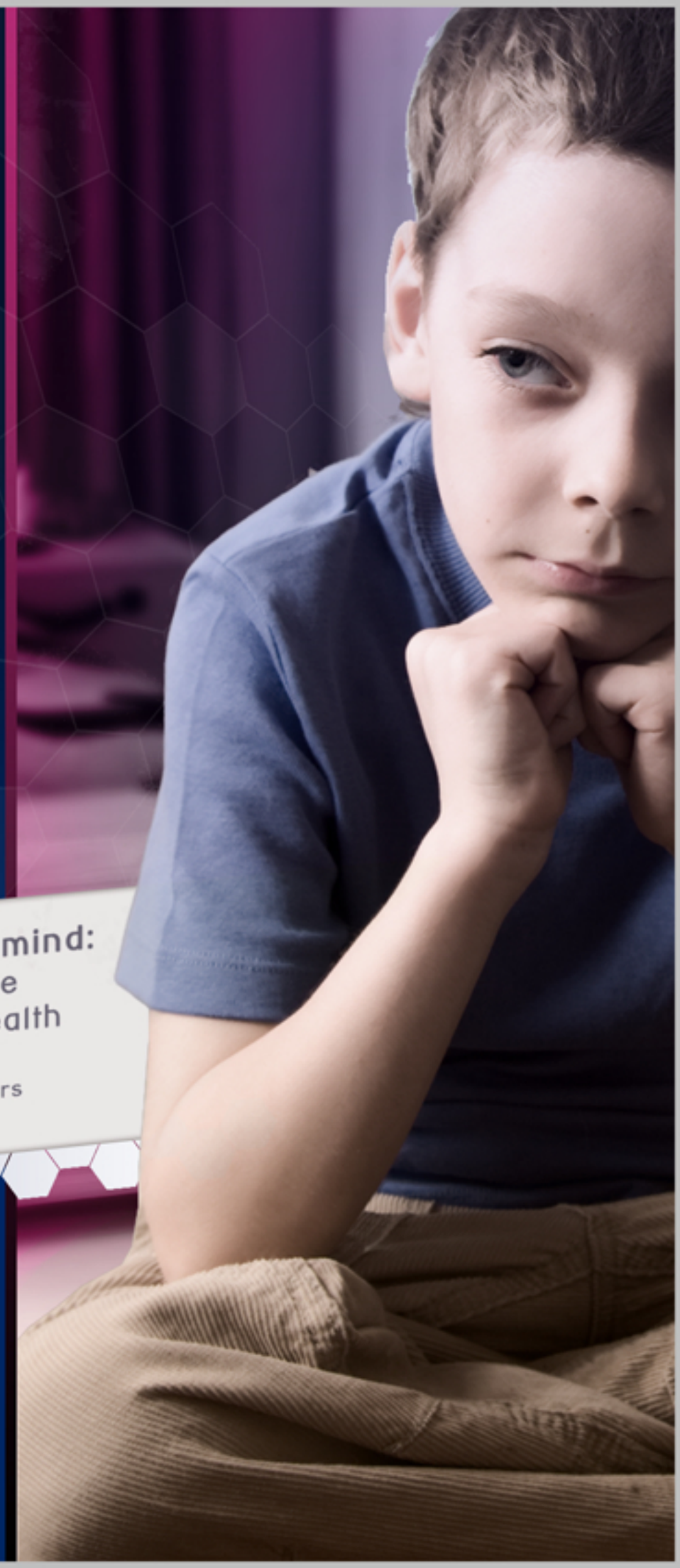
# Keeping the child in mind: child protection practice and parental mental health

Dr Helen Jeffreys, Nancy Rogers and Craig Hirte

Government of South Australia

Department for Families and Communities



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# Contents

# 1 Introduction

The association between adult mental health disorders and child abuse and neglect has been well documented. To date, however, there have been few studies that examine the prevalence of parental mental health disorders in child protection matters, including the types of mental health disorders associated with protective concerns for children. Similarly, little is known about how child protection workers identify parental mental health disorders, what they classify as such, and how this impacts upon their decision-making.

This project was conducted in response to this gap in knowledge. It seeks to identify the numbers of substantiated child abuse and neglect cases in South Australia where parental mental health difficulties have been identified as a significant risk factor. It should be emphasised that the study was designed to capture broad understandings of emotional and/or mental health difficulties rather than focus more specifically and narrowly on clinically diagnosed mental disorders (for example, major depression or schizophrenia). We believed that there is probably a larger group of parents who either do not meet clinical (DSM-IV) criteria (e.g. those with 'borderline traits'), or who have not come to the attention of mental health services, but who still have significant difficulties and problems in parenting. That is, many parents come to the attention of child protection agencies because of child abuse and neglect issues and are later found, or believed to have, a mental health disorder or problem.

In this study, we sought to identify cases where parenting difficulties are (perhaps loosely) assessed by child protection workers as constituting a 'parental mental health problem' and what criteria child protection workers use to assess these cases as such. We suspected that there would be cases where child protection practitioners assess parents as having a 'mental health problem' because parents present with challenging behaviours – a catch-all phrase to describe parents who are difficult and demanding for practitioners. We thought that child protection workers might experience difficulties assessing parenting capacity because they have limited training regarding mental disorders and there has been little research to guide workers in providing services in that context. We were also interested in examining how assessment guided intervention and the outcome of these decisions for children and their families, as well as the dilemmas for practice that parents with a 'mental health problem' may present.

## 1.1 Literature review

### 1.1.1 Definitions

Mental illness is a term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterised by alterations in thinking, mood, or behaviour (or some combination thereof) that are not expected as part of normal development or culture and are associated with distress and/or impaired functioning. There are currently two widely established systems that classify mental disorders - Chapter V of the International Classification of Diseases (ICD-10), produced by the World Health Organisation, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association. Both manuals list categories of disorder and provide standardised criteria for diagnosis and are broadly comparable, having deliberately merged their codes in recent years.

The term 'mental health problems' is used for signs and symptoms of insufficient intensity or duration to meet the diagnostic criteria for any mental disorder, for example, mental ill health temporarily experienced as a reaction to life stressors (DoCs 2008).

### 1.1.2 Types of mental health disorders

Mental disorders can be broadly separated into two main categories:

- *Depression and anxiety disorders* – for example, persistent feelings of depression and sadness; or tension and fears that are so disturbing they affect the person's ability to cope with day-to-day activities. Conditions that can cause these feelings include: anxiety disorders (for example, phobias and obsessive compulsive disorder), eating disorders and depression.
- *Psychotic illness* – for example, schizophrenia and bipolar disorder (previously called manic depressive illness). Psychosis affects the brain and causes changes in a person's thinking, emotions and behaviour. People who experience an acute psychotic episode lose contact with reality and may develop delusions or hallucinations.

The most common forms of mental disorders are:

- Depression – around 16% of adults are affected by depression at some point in their life
- Anxiety disorders – around 10% of adults are affected by anxiety disorders at some point in their life.

The remainder of people with mental disorders are affected by psychotic illnesses with 3% of adults severely affected. The more severely disabling 'low prevalence' mental disorders include:

- Schizophrenia – this disorder affects approximately 1% of Australians at some point in their life
- Bipolar disorder – this condition affects up to 2% of Australians at some time during their life
- Other forms of psychosis – for example, drug-induced psychosis
- Some chronic forms of depression.

Other 'low prevalence' disorders include conditions such as eating disorders, obsessive-compulsive disorder and severe personality disorder (Better Health Fact Sheet: Victorian Government 1999/2009).

### 1.1.3 Prevalence in general population

Mental health is one of Australia's National Health Priority Areas and is one of the more prevalent conditions affecting the Australian population. Around one in five (20%) Australians will experience a mental health problem at some time in their lives and 11% of respondents to the National Health Survey 2004-5 reported that they had a long-term mental or behavioural problem (ABS 2006). It is, however, difficult to estimate the proportion of adults with mental health problems who are parents. Many parents experiencing mental health problems are reluctant to seek help and data regarding the incidence of adult psychiatric patients who also have dependent children and responsibility for their care is not routinely collected (Cowling 1996:23).

Recent estimates by Maybery and colleagues (2009:22) suggest that almost a quarter of Australian children (23.3%) are living with a parent who has a (non-substance) mental disorder. Of these, just over 1% (or approximately 60,000 children) are estimated to have a parent with a severe mental disorder such as schizophrenia, bi-polar or clinical depression. Accordingly, these figures 'provide basic evidence to governments and mental health support agencies of a large number of children, many of whom could be considered to be living in a high-risk family environment' (ibid).

### 1.1.4 Prevalence in child protection matters

Parental mental illness or problems are a significant reason for reporting children to child protection services, yet data dealing with the relationship between mental illness and child abuse and neglect in the Australian population is limited. Available data often do not distinguish between different types of mental disorders or between different stages of child protection involvement. This makes it difficult to estimate the numbers of families affected, the implications for care and protection systems and complicates the interpretation of research results.

Available data suggest that:

- Parental mental illness is a concern in 10-42% of child protection cases across Europe, the United Kingdom, Australia, Canada and the United States (Darlington et al 2005:1086)
- Parental mental health concerns are present in around a quarter of new referrals to social services in the UK with higher proportions for children involved in protection enquiries or entering care (Tunnard 2004:10)
- Parents were experiencing psychiatric illness in 28% of cases where children were on care and protection orders in Western Australia (Farate 2001)
- Parental mental illness was a contributing factor in 31% of cases where children first entered out of home care in Victoria (The Victorian Department of Human Services 2003:10).

### 1.1.4 The impact of parental mental illness on children

The effect of parental mental illness on children is varied and unpredictable. Although parental mental illness may present biological, psychosocial and environmental risks for children, not all children will be negatively affected, or impacted in the same way. The influence on children can be broadly divided into three areas: (i) the impact upon parenting; (ii) direct effects on children and (iii) children who care for a mentally ill parent.

#### Impact upon parenting

Parental diagnosis of mental illness alone is not sufficient to cause problems for the child and family. Rather, it is how the illness affects the parent's behaviour and familial relationships that may cause risk to a child. The age of onset, severity and duration of the parents' mental illness, the degree of stress in the family resulting from the parents' illness, and most importantly, the extent to which the parents' symptoms interfere with positive parenting, such as their ability to show interest in their children, all influence the level of risk.

Groves (2008) suggests, the impact on children is dependent on the following:

- *Type and severity of illness*: Most studies suggest the severity of a parent's mental illness and extent of their symptoms is a more important predictor of parenting success than diagnosis. Within each diagnostic category there is a wide range of parenting capacity (Kanapaux 2004 cited in Groves 2008). Thus, the main risk for children does not lie in temporary situation-specific stress reactions but in disturbances that are pervasive and persistent over time (Alakus 2000:86).
- *Available treatment and support*: It is important to recognise levels of recovery and the cyclical nature of some mental disorders. At times the ill parent may require more intensive treatment and various levels and types of social support (Ackerson 2003b).

- *Individual characteristics*, particularly the extent to which parents have insight and understanding of their illness, also impacts on risk.
- *Social environment and family context*: Poverty, the presence of substance misuse, domestic violence and/or lack of extended family support can increase risk.
- *Child characteristics*: Genetic vulnerability, age, behaviours, temperament, illness, disability and resilience are also factors to take into account when assessing risk.

### Direct effects on children

The greatest risk to most children is the threat to their own attachments, development and mental health (Ahern 2003). Young children are particularly vulnerable. Children of parents with a mental illness are at increased risk of being placed in foster care, developing behavioural and/or mental illness, relationship difficulties and life-long under-achievement (Mowbray, Oyserman, Bybee, & MacFarlane 2000, Oyserman, Bybee & Mowbray 2002, Darlington et al 2005).

### Children who care for a mentally ill parent

Growing numbers of children are caring for parents with mental illness. It is estimated that 17% of carers in Australia are aged under 26 years, and 10% of all young people aged 15 to 25 years in Australia undertake a caring role. There is an estimated 14,800 young carers under the age of 18 living in South Australia (Carers Association of South Australia 2010 http://www.carers-sa.asn.au/yc/). According to The Young Carers Research Project (Noble-Carr 2002) young carers predominantly care for a mother with a physical disability or mental illness.

Although many young carers may 'embrace' their role, young caring is a contentious issue. There is considerable debate regarding whether care giving amongst children is better conceptualised as the parentification of children's roles. As a general principle, children's development and childhood experiences can be adversely affected when caring becomes long term and disproportionate. That is, where the onset of practical and emotional responsibility is not congruent with a child's age and level of maturity and understanding (Aldridge 2006:83).

## 1.1.6 The impact of mental health disorders on child protection work

Darlington et al (2005:243) have suggested that parental mental disorders can introduce clusters of behaviours that present a range of challenges for child protection workers. Parents may lack insight into their illness which results in them rejecting or withdrawing from preventative services. The episodic and unpredictable nature of some mental disorders can make it difficult for parents and workers to work towards the major goals of intervention. Planning and putting supports in place can be difficult as symptoms can change rapidly. The episodic nature of a disorder can also impact upon parenting capacity assessments which may show strong variation depending on the parent's mental health status at the time the assessment is conducted.

In a study conducted by Sheehan (1997:317), the concerns expressed by child protection workers in Court applications related to the nature and consequences of parental mental illness. Common concerns included how poor concentration, lack of motivation, the side effects of medication and impulsivity affect a parent's ability to participate in intervention and therapeutic programmes for their child; and the parent's ability to carry through with agreements. It was reported that parents with significant psychiatric problems struggled to understand their child's developmental needs, were unable to acknowledge their mental health problems, unable to negotiate with others about important issues (e.g. child care arrangements) and generally lacked insight into their own or their children's difficulties, often holding unrealistic expectations regarding child behaviour, responsibility and independence.

### 1.1.7 The parent's perspective

Having a mental illness can be hard work and parents with a mental illness can have a difficult time caring for children and providing them with a stable and predictable environment. Ackerman (2003) explored how parents coped with the dual demands of parenthood and their mental disorder. Common themes emerging included: problems with diagnosis and treatment, stigma and discrimination, difficulties maintaining relationships with significant others, managing single parenthood, concerns over custody issues, vulnerability to losing their children, and the need for social support, particularly at times of crisis.

### 1.1.8 Service requirements of families with mental illness

Where concerns exist about the safety and welfare of a child, Children of Parents with a Mental Illness (COPMI http://www.copmi.net.au/cpj/index.html) suggest three clear roles for child protection workers. These are:

1. working to support and strengthen families in the provision of care for their children
2. leading the process by which parenting ability and family capacity is assessed
3. developing a safety and monitoring plan for the child.

In their view, parenting capacity assessments need to be comprehensive and based on:

- an acknowledgement of the family's strengths
- child-parent observations in natural settings over a period of time, recognising the often episodic nature of mental illness
- linkage of specific qualities and functional aspects of parental behaviour with protective or risk factors for the child
- a multi-method, multi-source approach that includes, where possible, information from mental health professionals who are familiar with the parent's mental health status.

Interventions that are effective are those that help increase family stability, strengthen parents' abilities to meet their children's needs, and minimise children's exposure to negative manifestations of their parent's illness. Early intervention programs are advocated to prevent or minimise the long-term consequences of disrupted or dysfunctional child-parent relationships. A recurring message in the literature is that services are often 'inflicted' on people during crisis whereas preventative, long-term, flexible, supportive, empowering and low-key service provision could actually be far more effective (Alakus 2000).

## 1.2 Divergence between adult and child focused services

The interface between the child protection system and the adult mental health system is 'a complex matrix of services, thresholds, differing knowledge bases, different ways of experiencing and understanding the world and diverse ethical and legal considerations' (Tye and Precey 1999:170). Within the existing literature, dominant themes include the problems of fragmented services, disparate training and the tensions inherent in balancing the interests of adults and children.

Primarily, child protection workers need support from adult mental health services to assist them in determining whether a child is 'at risk' due to the parent's mental health status. Darlington et al (2005:1086) suggest, however, that mental health services often fail to incorporate the clients' families into their perspective, with both inpatient and outpatient facilities having little awareness of a patients' parental roles and responsibilities. Alakus (2000:49) maintains that even where mental health workers are aware of the existence of children, they do not necessarily have the assessment or clinical expertise to meet child-specific needs. Although mental health staff can provide information about a person's psychiatric condition, offering an opinion on how a person's diagnosed mental illness impacts on parenting is much more difficult and problematic. The prevailing view is that parenting is a child welfare concern, not a mental health issue. Within mental health research and policy there is, however, a growing emphasis on developing family-focused adult mental health services.

# 2 The current study

## 2.1 Purpose and research questions

This study is concerned with exploring child protection processes and decision-making in cases involving parents with mental health difficulties. It aimed to increase knowledge and understanding of the prevalence and nature of parental mental health difficulties associated with protective concerns for children and young people and the service responses required by these families. Essentially, the study sought to:

- identify the proportion of substantiated child abuse and neglect cases where parental mental health is identified as a significant risk factor
- develop a clearer understanding and articulation of what is recognised and termed a 'mental health problem' in child protective casework practice
- identify the indicators and descriptors used by caseworkers to inform decision making regarding parental mental health and protective concerns for children
- describe the service responses to families where parents are experiencing mental health difficulties and where there are child protection concerns
- provide evidence to inform and facilitate new strategies and partnerships between child protection and mental health services.

Improved knowledge and understanding in this area is important for the development of effective assessments, focused interventions and improved outcomes for children and families. It may also facilitate improved collaboration between child protection and mental health services which in turn, may contribute to placement prevention and family preservation.

The key overarching questions addressed in this study were:

- What proportions of substantiated cases of child abuse and neglect are associated with parental mental health difficulties?
- How do child protection workers assess parental difficulties as mental health concerns?
- How do child protection workers assess parenting capacity where parental mental health is an issue?
- What types of mental health difficulties are associated with protective concerns for children?
- What would assist child protection workers in their practice with parents who have mental health difficulties?
- How can parents experiencing mental health difficulties be supported to meet the needs of their children?

### 2.1.1 Methodology and sampling

The study was undertaken in three stages. In Stage One, data relating to all substantiated cases of child abuse and neglect for the financial year 2007-2008 was drawn from a statutory child protection agency (Families SA, Department for Families and Communities) administrative data system. These cases were then analysed to determine those where caseworkers had assessed that the primary caregiver was experiencing problems in the areas of either their emotional or mental health. In cases of substantiated abuse and or neglect, Families SA caseworkers are required to undertake a 'Family Needs and Strengths Assessment'. These assessments are used to identify critical family problems and help plan effective service interventions. Two items in the Family Needs and Strengths Assessment tool ask about the primary caregiver's emotional and mental health status. Caregivers can be scored according to the following:

(a) appropriate responses

(b) some problems

(c) chronic or severe problems

(d) above average emotional stability.

Those cases where the primary caregiver had been identified as having either (b) some problems or (c) chronic and severe problems in emotional and/or mental health were selected for inclusion and then analysed in more detail.

In Stage Two, a random sample of 30 cases was drawn from the total number of cases where child abuse and neglect had been substantiated in the financial year 2007-2008, and where parental emotional and mental health was assessed as being problematic according to the Family Needs and Strengths Assessment. In-depth, semi-structured interviews were undertaken with caseworkers (see Appendix A for interview questions) to explore:

- how caseworkers had assessed parental difficulties as including a mental/emotional health problem
- how the parent's mental/emotional health difficulty had impacted upon the care of the child, and
- how the parent's mental/emotional health difficulty had impacted upon working with the family.

Interviews also explored the service response received by parents and caseworker's thoughts about what would assist them in their practice.

In Stage Three, three focus groups with Families SA Psychological Services and two with Anti-Poverty Services were conducted. Thematic responses provided from the in-depth interviews with individual caseworkers (Stage Two) were used to guide

discussions.

In reporting the qualitative findings of the study, pseudonyms have been used to protect confidentiality. Identifying details in some of the comments have been removed; however the meaning of these comments has not been altered.

### 2.1.2 Ethics approval

This study was undertaken with the approval of the Families and Communities Research Ethics Committee.

### 2.1.3 Research limitations

There are several limitations to the study and the methodology used that need to be acknowledged. Firstly, figures regarding the prevalence of parental mental health difficulties are based on administrative records drawn from caseworker assessments. These assessments may not be based on a clinical diagnosis of mental disorder. Further, while child protection workers have expertise in child, adolescent and family welfare, their knowledge of mental disorders may be limited. The reliability of the Family Needs and Strengths tool as an accurate assessment of parental mental health difficulties is therefore limited

Second, at the time of the sampling, the Structured Decision Making tools had not been fully rolled out and implemented across Families SA. Prevalence rates are therefore indicative only, and it is probable that the number of families identified with substantiated abuse or neglect and parental mental health difficulties is an undercount.

# 3 Findings

## 3.1 Administrative Data Analysis

Data relating to all substantiated cases of child abuse and neglect for the financial year 2007-2008 was drawn from Families SA's administrative data system. These cases were then analysed to determine those where caseworkers had assessed that the primary caregiver was experiencing problems in the areas of either their emotional or mental health using the 'Family Needs and Strengths Assessment' tool. This section reports on the results of this analysis.

### 3.1.1 Prevalence

Families SA reported 2331 substantiated notifications of child abuse and neglect for the year 2007-2008 (AIHW Table 2.4). 1830 children were the subject of a substantiated notification (some children are the subject of more than one substantiated notification in a year). At the time of analysis, 720 (39.3%) children were recorded as having had a 'Family Needs and Strengths Assessment' completed, with 370 (51.3%) of these assessments indicating problems with the primary caregiver's emotional and/or mental health.

The availability of completed 'Family Needs and Strengths Assessments' limits the ability to report on prevalence. The results suggest that parental mental health difficulties are likely to be present in approximately half of all substantiated cases of abuse; however, this figure is derived from caseworker assessments which may not be based on a formal clinical diagnosis by a mental health professional.

### 3.1.2 Sample demographics

There were 370 children (in 201 families) with a substantiated notification whose primary caregiver had been assessed by caseworkers as having emotional or mental health difficulties. The demographic profile of these children is provided in Table 1 below. As shown:

- males and females were fairly evenly represented
- 27.6% of the children were Aboriginal and/or Torres Strait Islanders
- almost half (47%) were under 4 years of age
- the mean (SD) age of the children was 6.4 (4.8) years.

Approximately two thirds (71.6%) of the children were aged less than 10 years, highlighting the vulnerability of the children in this age group.

Table 1: Child characteristics

| Child characteristics | N | % |
|---|---|---|
| **Age** | | |
| 0 to 4 years | 174 | 47.0% |
| 5 to 9 years | 91 | 24.6% |
| 10 to 14 years | 90 | 24.3% |
| 15 to 18 years | 15 | 4.1% |
| **Gender** | | |
| Male | 182 | 49.2% |
| Female | 188 | 50.8% |
| **Cultural background** | | |
| Aboriginal and/or Torres Straight Islander | 102 | 27.6% |
| Non-Aboriginal and/or Torres Straight Islander | 257 | 69.5% |
| Unknown | 11 | 3.0% |

On average, children had been the subject of 2.7 substantiations (range = 1 to 16). 58.6% of children had experienced one type of maltreatment; 40.3% had experienced multiple types of abuse.

The types of maltreatment recorded are summarised in Table 2. As shown, the most common maltreatment included:

- other emotional abuse - 42.2%
- other neglect - 27.8%
- failure to meet basic needs - 19.5%
- caregiver alcohol and/or drug abuse - 14.6%, and
- child left without supervision or unattended – 14.1%.

When grouped according to abuse and neglect type, neglect (63.6%) and emotional abuse (56.8) were the most common forms of abuse experienced.[1] Physical (10.8%) and sexual abuse (4.3%) were less common. The patterns of types of abuse or neglect for the sample group were therefore similar to national and state patterns[2] with emotional abuse and neglect being the two most common types of substantiated abuse.

1 Figures do not add up to 100 as children may be the subject of more than one type of abuse or neglect.

2 National child protection data for the year 2007-2008 show that emotional abuse and neglect are the two most common types of substantiated abuse (AIHW 2009:26). Total South Australian figures regarding the number of children who were the subject of a substantiation of a notification by type of abuse and neglect for the same time period were: emotional abuse (46%), neglect (37%), physical abuse (13%) and sexual abuse (5%) (AIHW, 2009 Table A1.1 p.69).

Table 2: Type of maltreatment reported for children

| Maltreatment type | N | % |
|---|---|---|
| Other emotional abuse | 156 | 42.2% |
| Other neglect | 103 | 27.8% |
| Fail to meet basic needs | 72 | 19.5% |
| Caregiver alcohol/drug abuse | 54 | 14.6% |
| Left without supervision/ unattended | 52 | 14.1% |
| Other physical abuse | 28 | 7.6% |
| Caregiver suffers psychiatric disorder | 16 | 4.3% |
| Severe verbal abuse | 16 | 4.3% |
| Abandonment | 11 | 3.0% |
| Other sexual abuse | 10 | 2.7% |
| Continual rejection | 10 | 2.7% |
| Child threatened with abuse | 10 | 2.7% |
| Failure to provide medical care | 8 | 2.2% |
| Social/physical isolation | 7 | 1.9% |
| Other bruising | 6 | 1.6% |
| No code recorded | 4 | 1.1% |
| Severe bruising | 3 | 0.8% |
| Exposed to sexual behaviour by others | 3 | 0.8% |
| Cuts/abrasions | 2 | 0.5% |
| Inappropriate fondling | 2 | 0.5% |
| Fracture other than skull | 1 | 0.3% |
| Penetration by penis | 1 | 0.3% |

At the time of sampling, the majority of the children (75.4%) were not on a Care and Protection Order and were still living at home with their birth parent(s) (77%)[3].

### 3.1.3 The parents

201 primary caregivers were assessed by caseworkers as having emotional and or mental health difficulties. The majority (83.6%) were women and 72.1% were non-Aboriginal Australians.

3 Some children were living at home whilst also on a Care and Protection Order.

Caseworker assessments are shown in Table 3. The 'Family Needs and Strengths Assessment' tool can score caregivers as having: (a) appropriate responses, (b) some problems, or (c) chronic and severe problems with either their emotional or mental health functioning. As Table 3 indicates, 60 (29.9%) parents were scored as having appropriate responses in the category of mental health but some problems in emotional health. The majority of parents (78.6%) were not assessed as having chronic or severe problems in either their emotional or mental health.

Table 3: Caseworker assessment of parent's emotional or mental health

| Mental health | Emotional health | Number of parents | % |
|---|---|---|---|
| Appropriate response | Appropriate response | 0 | 0% |
| Appropriate response | Some problems | 60 | 29.9% |
| Appropriate response | Chronic or severe problems | 2 | 1.0% |
| Some problems | Appropriate response | 14 | 7.0% |
| Some problems | Some problems | 84 | 41.8% |
| Some problems | Chronic or severe problems | 15 | 7.5% |
| Chronic or severe problems | Appropriate response | 1 | 0.5% |
| Chronic or severe problems | Some problems | 5 | 2.5% |
| Chronic or severe problems | Chronic or severe problems | 20 | 10.0% |
| Total | | 201 | 100.0 |

According to the 'Family Needs and Strengths Assessment' the parents in the sample also experienced other problems:

- 72.6% were assessed as having difficulties in parenting
- 56.2% had limited social supports
- 52.7% were experiencing domestic violence
- 39.3% had difficulties sustaining interpersonal relationships
- 39.3% had substance misuse issues
- 34.3% had experienced abuse as a child
- 21.4% were experiencing housing difficulties
- 40.3% of children were reported to have behavioural difficulties.

When compared to parents who had been assessed as having appropriate responses or some problems, parents who had been assessed as having chronic or severe problems were significantly more likely to have been assessed at a higher level of severity for:

- substance abuse issues (23% to 5%)
- impaired parenting ability (37% to 14%)
- impaired intellectual capacity (9% to 1%)
- limited social supports (23% to 8%)
- ineffective community interactions (23% to 4%) and
- difficulties in income and financial management (12% to 8%).

This profile is consistent with findings from other research, which suggests that parents with mental health problems are vulnerable in many ways. They tend to have high rates of relationship discord, often experience poverty, housing problems and unemployment and are more likely to experience parenting and child welfare concerns (Byrne et al 2000:21, Lewis and Creighton 1999).

## 3.2 Caseworker interviews

30 cases were randomly selected from the total of 370 cases. The Families SA caseworker was interviewed regarding the nature of the parent's mental health difficulty, caseworker's assessments of such, and the impact on parenting, decision-making and service provision. In total, 28 caseworkers were interviewed. Of these, 52% were front-line case workers and the median length of time worked in Families SA was 57 months (range = 4 months – 29 years). The following section summarises results from these interviews.

### 3.2.1 Type of mental health difficulty

The types of mental health difficulties experienced by the caregivers in the random sample (as reported by caseworkers) are indicated in Table 4. The most common mental health disorders were borderline personality disorder (29%) and depression (25%). According to caseworkers, a clinical diagnosis had been made in 16 (57%) cases, usually by a psychiatrist – 12 (75%) cases.

Table 4: Type of mental health disorder

| | Clinical diagnosis | No clinical diagnosis | Total sample |
|---|---|---|---|
| Type of disorder | N (%) | N (%) | N (%) |
| Borderline Personality Disorder | 5 (18%) | 3 (11%) | 8 (29%) |
| Depression | 2 (7%) | 5 (18%) | 7 (25%) |
| Substance disorder | - | 3 (11%) | 3 (11%) |
| Adjustment Disorder with depressed mood, Personality Disorder, Anxiety, Anti-social behaviour, Post Traumatic Stress Disorder | 1 (4%) | - | 1 (4%) |
| Anxiety | 1 (4%) | - | 1 (4%) |
| Bi-polar and Severe Depression | 1 (4%) | - | 1 (4%) |
| Borderline Personality Disorder, Anxiety and Depression | 1 (4%) | - | 1 (4%) |
| Chronic Schizophrenia | 1 (4%) | - | 1 (4%) |
| Depression and Avoidant Personality Traits | 1 (4%) | - | 1 (4%) |
| States of uneasiness and distress | 1 (4%) | - | 1 (4%) |
| Psycho-social Situational Crisis and Borderline Personality Disorder Traits | 1 (4%) | - | 1 (4%) |
| Schizoid Affective Disorder | 1 (4%) | - | 1 (4%) |
| Learning disability | - | 1 (4%) | 1 (4%) |
| Total | 16 (57%) | 12 (43%) | 28 (100%) |

### 3.2.2 Assessment of parental mental health difficulties

Caseworkers were asked to describe the factors that informed their assessment of the parent's emotional or mental health difficulties. The most common responses included:

- psychiatric and/or psychological assessments
- client history (including clinical diagnosis)
- client observations and
- behavioural indicators.

It was usual for caseworkers to report a combination of these. Where there was no clinical diagnosis, caseworker responses predominantly involved accounts of behavioural indicators and were generally couched in terms of parents' emotional regulation (or lack of):

> *"I guess it's just stuff like they've got no will to get up everyday, they want to sleep all day, they're not coping with their children and they might give examples of basic things that a child might do that gets them agitated to the point where they can't control their behaviour…or they can't stop crying. All that emotional stuff where you go okay they are having difficulties regulating their mood, maybe we need to flesh this out a little bit".*

> *"She was abusive, she couldn't regulate her emotions and we questioned personality disorder".*

> *"She would be very defensive, very blaming, very quick to anger, and just almost screaming within a very short period of time".*

> *"I guess the long and the short of it was that we couldn't engage with mum, mum wouldn't engage with us, she was highly abusive – you can all go away, keeping everyone at bay. She'd gone off at the school, at the teacher and she threatened her partner. There seemed to be a pattern where she would go okay for a while but then she would escalate and it was really hard to calm her down, then she'd go okay for a while, and that's what we were seeing."*

Caseworkers also talked about their observations of children's behaviours. They described infants who were gaze avoidant, toddlers who were watchful and vigilant, parentified older siblings and children who were 'out of control'.

> *"In the weeks leading up to the incident and the day I removed [the child], that little baby was dirty, she wasn't clean hygienically and that hadn't been the case previously. There was definitely deterioration in [the child's] presentation. She was gaze avoidant with mum. She was very… just too quiet".*

*"When you watch these kids its actually quite interesting. They'll come straight in through the door and they'll take one look at mum and they will know straight away. You can see it written on their face, in their expression. If mum's not having a good day they'll tend to give her a wide berth, they'll interact, but distantly. If they can see that things are really great they will run to her and put their arms around her and all that. If she's in a bad mood they don't want a bar of her".*

*"The older children certainly had a lot of responsibility placed on them. They had unrealistic expectations. And we can still see it now. The older ones play a big part in caring for the younger ones, and they still look to the older ones to have their needs met. It's taken a long time to get them out of it, to be kids again".*

Observations regarding the condition of the home environment also influenced caseworker assessment.

### 3.2.3 Impact upon parenting

Caseworkers described parents' mental health difficulties as impairing their ability to perform basic parenting tasks such as feeding and clothing, nurturing, and maintaining adequate discipline and supervision.

*"[The mother] would just get so frustrated with [the child's] crying …she was continually taking her back or ringing the carers to come and get her saying "I can't do this". There was one stage where she actually rang Families SA up and said "come and get her, I don't want her". So obviously she couldn't manage her".*

*"She just could not move beyond the stagnancy of her life. She was struggling just to meet her own needs ...the children were running totally amok".*

More often, caseworkers referred to parent's inability to meet or focus on their child's emotional and developmental needs, and a lack of empathy and insight. Parents were variously described as being 'emotionally detached' or 'disinterested' and as holding unrealistic expectations of their child's behaviour, responsibility and independence.

*"That lack of empathy. She can do the food but psychologically being able to hold her child in mind" [shakes head].*

*"That inability to focus on [the child]; the way that everything is about her. You know, we'd sit down and try to speak with her about the concerns and she just wouldn't be able to stay on track with that. She wouldn't acknowledge anything. She'd disappear for weeks at a time then come back and want to see him with no acknowledgement whatsoever".*

*"It's all [the child's] fault, she's a bad child, she is very stubborn and she needs to be punished. [The mother] can't understand that the way she responds to [the child's] behaviour is actually affecting her, compounding it. And when [the child] is naughty, she says "look at what you are doing to me; you are making me look bad".*

*"Just no insight into what he needed and what a normal life would be like for a little boy that age. Didn't care and wasn't interested. It was just overwhelmingly sad. I mean we walk into messy houses all the time but…this wasn't even a home. I mean I can cope with mess if there's a few photos, a few knick-knacks, but this was just bleak".*

### 3.2.4 Impact upon engagement

The impact of mental health difficulties on the caseworker's ability to engage and work with the parents was reportedly influenced by:

- the type and severity of mental health difficulty
- parental compliance, and
- the presence of substance misuse.

Cases where parents were assessed as experiencing temporary situation-specific stress tended to be seen as less complicated and open to traditional problem solving / crisis intervention. As problems were addressed, coping capacity (or mental health) improved and with that came improved parenting. Typically and importantly, these parents were also able to demonstrate insight or awareness of the potential or actual effects of their mental health or other adversity (e.g. family violence) on their child and were able to seek help and accept responsibility for their behaviour.

*"It was quite an up and down thing. Initially she'd pay us lip service, but then what she did was, when we got the kids out, she was quite angry, but then she spent a lot of time thinking about it, and talked with her parents and she said to me, you know, you were right".*

*"She showed a lot of insight into her situation and her perception of her children's needs and how important that was and how she had felt that this whole thing was a wake-up call for her in a sense. She really looked at things and recognised that she needed to make changes and take some responsibility for her part in the violence".*

In these cases, workers reported good working relationships and expressed greater job satisfaction as child and family situations improved and positive outcomes were achieved.

When mental health difficulties were clinically diagnosed, severe, and accompanied by pervasive functional impairment with a long history and connections with mental health service providers, cases were also perceived as more straightforward and manageable. It was generally accepted that these parents were unable to function adequately, parenting incapacity was clear and case management focused on the needs of the child in placement and 'best connections' between parent and child. Although worker-client relationships could be strained at times, there was an acceptance that the parent's behaviour was influenced by illness which could result in emotional outbursts, eccentric demands, hostility and attempts to influence the child against the carers/workers. Basic to this understanding was empathy for a parent who was unable to provide sustained parenting even though they loved their child.

*"You can't fault the love that they have for her. And in all of this, underlying everything, there is just sadness that neither of them can provide that kind of care".*

*"She has that insight that she can't care for [the child]. She loves [the child], it is because of her capacity, or her lack of capacity to care for [the child]. That is something preventing her from having that capacity to care for [the child] and she understands that. She is aware of her own shortcomings".*

Parents experiencing temporary, situation-specific mental health difficulties and parents with a chronic and severe mental disorder (e.g. schizophrenia, bi polar mood disorder or major depression) were, however, the exception rather than the norm.

It was more common for parents to present with conditions that would not normally be regarded as serious mental illnesses, such as anxiety, depression of lesser intensity and some personality disorders, particularly the borderline type. These parents were extremely challenging. Parental impulsivity and poor anger control were barriers to engagement, as were the parent's inability to acknowledge the child protection concerns and focus on the needs of their child.

*"Well it's very hard, very hard when she doesn't acknowledge the things that she's done, like it's hard to explain or for her to understand our actions when she doesn't think that she's done anything wrong".*

*"She just had no ability to take on board the concerns. One minute she'd say one thing about the case, next minute it would be completely different. We couldn't sustain any length of contact with her. She couldn't focus on [the child's] parenting needs, it was all about her. She just really can't focus on anything other than herself really".*

Acknowledging abuse has traditionally been seen as the hallmark of progress in child protection - with acknowledgement comes the potential for change. As Donald and Jueridini (2004:14) propose, once the statutory agency has confirmed abuse, the first step of a parenting assessment is to establish the carer's initial level of acceptance of that fact and the degree of responsibility taken. In their view, discussion with parents about their harmful behaviour will provide important information about capacity. The intent is not to 'look for expressions of remorse, but rather for statements that indicate the parent's capacity to see the experience from the child's point of view and to realistically appraise what might need to change for the child to thrive in their care'.

Sporadic and superficial engagement also impacted on caseworkers' ability to work with parents.

> *"She'll engage with services that provide an audience for her but anything that means some real change and work on her part, it won't happen".*

> *"She could focus on [the child] for short periods of time, and engage with services for a short period of time but it was all really very superficial and as soon as it's not on her she can't then engage".*

Parental lack of motivation and follow-through were major sources of frustration, particularly when parents were depressed.

> *"I found it really disconcerting, because there was no attempt made to fight for the children. I'm working with another mum who has mental health issues and we've just removed the baby and she is fighting me tooth and nail and that's what I'd expect, and I admire her for her energy and her struggle. It's sad but…with this one there's just nothing".*

> *"Her presentation was curious. There was no doubt that she was an intelligent woman. But it became obvious fairly quickly that there was that superficial compliance, that avoidant behaviour. She would basically agree with you and say what you wanted to hear but she didn't have the energy or the capacity to make the changes".*

While there was a generalised sense of frustration from workers as parents minimised, denied, or didn't appear to have the capacity to understand the child protection concerns, there were some notable differences in terms of worker response. Inexperienced workers were more likely to report feeling very intimidated and threatened.

> *"I found it extremely hard to work with [the mother] at the beginning. I've never experienced anything like it. She was quite, very confronting. She was in your face, right there in your face and she could be extremely abusive".*

*"When she gets angry it's hard to reason with her, it just escalates the situation and you can't bring her down and she can't either. She needs someone else to do that for her and I'm not the person to do that. Like if she does get very angry with me it's going to be a struggle for me to calm her down and bring her back to reality".*

Frustration spilled over into perceived levels of confidence. When asked how confident (on a scale of 1 -10) they felt in working with the family, caseworkers generally responded in one of two ways. They either considered their response in relation to their own personal ability and confidence levels, or they responded in terms of the likelihood of achieving a positive case outcome such as reunification.

*"How confident do I feel at all?"*

*"You could go 1 and 10 - confident as in talking to her and asking her to do things – a ten; confident that she is going to follow through and do things – a zero".*

*"In having a positive outcome? None at all".*

64% of workers reported confidence ratings of 6 and over. Higher confidence levels were reported in cases where:

- parents were connected with treatment and services
- parents engaged well and worked with Families SA
- case direction was clear
- there was good collaboration and support from other services and/or carers.

*"I am confident because I have a lot of support from other services, they have been fantastic. And she is compliant and she rings me to let me know what is going on".*

*"…Because of Mum being so straight down the line…because she is just brilliant. So open and so honest, because she doesn't have to tell me that she had a bad week, but she does".*

*"I guess in comparison to other families where there can be a lot of aggression and hostility, we haven't had that, either from the mother or the father, and the carers have been really supportive".*

Confidence was lowest where behaviour was abusive or threatening, where there was poor compliance with treatment, problematic relationships with and amongst professionals and diagnostic uncertainty.

*"Gosh, whenever I have to ring her I pray. She is one of the hardest clients. I really really struggle… I feel… I feel like a first year out. I'm floundering".*

*"When they are not engaged with services it's really hard. Like this one, we don't have a proper diagnosis so you're kind of guessing around what it could be and trying to pick a good or bad time to talk".*

### 3.2.5 Impact on decision making

The factors that impacted on caseworkers' abilities to engage with parents mirrored the factors that impacted on decision-making: capacity to understand or acknowledge the child protection concerns; ability to understand and respond to children's developmental needs and ability to seek help. When making decisions, caseworkers placed strong emphasis on the child's emotional well-being.

*"It's not just about their physical safety, it's the emotional and psychological safety that certainly forms part of my assessment always. How safe is this environment for this child? Because we do know now, the research is clear that children don't thrive if they are not psychologically safe. And it doesn't have to be perfect but it has to be at a consistent level".*

*"The fact that we had tried so many times and ways to engage her, make her see that her behaviour was impacting on the child…I'm still not quite sure if her inability to change is actually connected to her mental health…If it is mental health yes it's having a huge impact and it's led us to the decision that there is no hope of change now, she cannot change. I'm not quite sure if she's choosing not to or she cannot, because I don't have any definitive diagnosis. I don't have a psychological assessment but it's enough to say this child can't suffer any longer while we wait".*

*"She's got very poor emotional regulation, she's very difficult to talk to, yet she shows us times, when things are calm and going well that she can be an engaging girl, you know. And there are strengths there, but the baby, you know, basically we just have to do what we have to do".*

*"The big thing is the kids can't wait for mum to be ready to do it. The kids need somebody that's there for them emotionally now and can give them a safe, hygienic environment".*

*"When they become unwell, they become really unwell and, mum, we clearly have seen the impact she can have on the little one. And, in the long run, little one's needs and her future has to come first".*

Where parents consented, mental health professionals undertook assessments and these guided and informed key decision making, particularly around reunification. Overall, there was a strong sense that child protection workers rely heavily upon the expertise of mental health professionals to provide information and opinion. "We're not the experts" was a common phrase.

*"You want them to make that assessment because they are mental health workers. I mean, I could see that her behaviour was a little bit odd but I can't make an assessment on what state she is in, whether she needs to be detained".*

*"After that incident the worker wrote a report saying that she didn't think reunification would work, so we went to the Women and Children's Hospital to the Mental Health Unit there to see if a parenting capacity assessment would be appropriate. But they read the reports and they spoke to the previous caseworker and they said that it wasn't worthwhile, that the relationships were too damaged for reunification…none of the reports were positive enough to suggest working further on reunification".*

Even if parenting capacity had not been assessed by a mental health professional, caseworkers used key components of such assessments to inform their decision making e.g. the parent's motivation to change, acceptance of responsibility and the availability of family and other supports.

*"It's the lack of motivation and inability to engage and probably the big concern is that she's not taking her medication which would also be impacting on stabilising her condition too".*

*"The indications were that her mental health was really quite strong. She showed a lot of insight into her situation and her perception of her children's needs and how important that was and how she had felt that this whole thing was a wake up call for her in a sense. She really looked at things and recognised that she needed to make changes and take some responsibility".*

When caseworkers were asked about case plan intent they reported that 15 (54%) children were to be placed under Guardianship to 18 years. Another 2 (7%) were already being cared for by relatives or kin and this was likely to be for the long-term. There were only 4 (14%) cases where decision-making and case direction was unclear, due to uncertainty around the parent's mental health. In two of these cases, the parent was pregnant and workers were keen to monitor how well they managed during the ante- and post-natal period before making any long-term decisions. In one case there was diagnostic uncertainty and more thorough assessment was required. In the remaining case, the mother had recently begun to engage with Families SA and was beginning to make therapeutic connections with services.

### 3.2.6 Service connections and supports

Although 16 (57%) parents had a clinical diagnosis, only 9 (32%) parents were reported to have connections with mental health service providers[4] prior to the substantiation of child abuse and neglect. Three parents were under the care of a psychiatrist, one parent had prior connections with a specialist mental health service focusing on mother/infant attachment issues, and the remainder were connected with community-based mental health professionals.

Where parents were already connected with adult mental health services, 66% were known to be taking medication prior to the child protection involvement and 55% were receiving therapeutic support. However, worker knowledge of the type of medication being taken and the type of therapeutic support being received was limited, suggesting poor collaboration and communication with adult mental health services and limited knowledge of treatment and therapeutic care for adults.

Following child protection involvement, the proportion of parents connected with adult mental health services increased. Caseworkers reported that 50% of parents (vs 32% previously) were currently connected with mental health service providers and that in 39% of cases child protection involvement had been the catalyst.

However, reports of service connections lacked detail and there was little evidence of joint work between child protection workers and adult mental health services. Most workers relied on parental self-report of service connections. Usually, child protection workers were only active in linking parents in with mental health services for assessment and recommendations regarding children's long term care and/or services required by the parent. Generally, workers were more focused on assessing risks to children than working with mental health services to strengthen parent-child relationships.

> *"She keeps asking me why I haven't got her a psychiatrist. And I keep explaining to her its not my role to get her a psychiatrist, that if the boys needed one I could get them one but that we are not here to get you those sorts of things, that you need to take steps for yourself".*

In cases where there was joint work between Families SA and adult mental health services there were sometimes tensions between a child and adult focused approach. Families SA workers sometimes perceived adult mental health services as 'over-identifying' with parents and not recognising the potential harm to the child, problems with diagnosis and treatment, and a lack of clarity around lead agency and primary worker resulting in confusion for families and agencies being 'played off' against one another. Eligibility criteria also impacted on the capacity to collaborate or work together.

4 Mental health professionals included social workers, psychologists, adult psychiatrists, clinical nurses and general practitioners.

*"It's hard when they [parents] don't acknowledge that they have an issue, and it makes it hard, like with [the mother], she's been told by this other person that 'no, no, no, you don't have this mental health issue' and then you have told her that she has. Well that's just so confusing for her and I don't know how to continue working with her when she doesn't think that she has a problem but we have to keep working with her as if she does have a problem. It can get quite difficult and I can understand why she thinks as she does".*

*"…all the way through we had problems with what's in the child's best interests versus what's in mum's best interests".*

*"[The mother] is like one of those people that engage really well. She presents really well, she's really engaging. People like her; they always feel like she's been very hard done by. It doesn't matter what service she gets involved with, you have a lot of problems with them saying you're not doing the right thing here. And she comes across well. Well, she's a genuinely loving person and that's never been a problem but people don't pick up how unwell she is quite often. So…there was this really torn thing with the staff and there was conflict of opinions. Some thought that there was no risk; some thought that there was real risk to [the child]".*

### 3.2.7 Impact upon supportive relationships and networks

Strong social supports and interpersonal relationships can buffer people from risks and adversities. The majority of parents (78%) were described as socially isolated with strained and damaged relationships and limited capacity to maintain quality, supportive links with family, community, professional and statutory supports.

*"She didn't have the capacity to sustain supportive relationships and her relationship with her parents and siblings were quite damaged".*

*"It just makes her vulnerable to people that abuse her because that's all she knows... she doesn't appear to have a lot of supportive friends because she doesn't get close to anyone. She just goes to people to meet that immediate need and then moves on".*

### 3.2.8 Strategies that worked

Caseworkers were asked to identify successful strategies for engaging parents. Responses frequently demonstrated good social work practice in challenging situations. Workers employed a non-confrontational, non-adversarial practice style to avoid arguments and address anxieties and defensiveness. There was a conscious effort to normalise the difficulties the family may be experiencing and stress the ways in which Families SA might help.

*"When I talk with her about visiting and working with her I talk about the positives for her. The best way I found to work with [the parent] is to explain how it would actually help her, and how we are actually trying to help her and support her. And then she is more likely to engage".*

*"Normally you can engage and get people to shift their thinking. Most people don't deliberately abuse their kids; it's always situations. Once you start bringing in a different perspective, normally you can bring them around pretty well. It's very hard for a person to remain angry with you when you are agreeing with them and offering support".*

*"I think not letting her know that you are getting frustrated or angry or anything like that; using that low soothing tone. The more she gets to know that she's not going to break you, and you are not going to walk out and say I'm not doing this anymore, that worked".*

Using the principles of partnership practice, for instance being open and honest with families without being defensive, were also key strategies.

*"Being accountable really but then being honest. And in my experience you can take a child and still preserve your relationship with the parents. It's showing that empathy but at the same time being clear: 'I'm sorry that you had that experience but I'm not going to compromise this child".*

*"Being clear about your role, because for me, the first time I met them I had to be clear that I was their children's caseworker but in terms of supporting your children then that means that I have to help you address the problems so that things can be better with your children".*

Practitioners also used principles of motivational interviewing, such as giving advice only when individuals are receptive, and 'rolling with' resistance.

*"My thing with her is you have to talk to her about things that are not annoying her. If you start to talk to her about her parenting and that's starting to annoy her then you change the topic to how are the children going at school. Then she calms down and you can then go back to the parenting issues".*

*"I decided to run with the characteristics she was exhibiting, that overblown sense of self, her ego, her narcissistic personality. So its "yes, how are you, how's your health, tell me all about you and your needs", and then I think that got me in".*

Workers felt that it was important to allow families time to take in and understand concerns and processes before risking engagement. This included being accessible when parents were ready and utilising such opportunities to craft change.

*"If she wanted to talk to me then she had to come to me because I wasn't going to play chasey with her. That strategy worked very well. Because if you chase people they are not going to give you what you want anyway, but when they are ready they will come and talk to you".*

*"Trying to be able to respond when he presented; when he turned up, because that was the right time for him".*

Clear lines of communication between workers, agencies and families were essential.

*"We make sure that everyone knows exactly what has been said. If I make one statement I'm making four phone calls so she has got absolutely no room to bend the boundaries, and that's working. And she deals with things fairly well. She still rings up and, and fibs, and I say, well that's not what she said, I've got this email here that says… So it's just about making sure that all the relevant parties are informed".*

### 3.2.9 What would assist workers?

Most caseworkers said that more training would help them and specifically information and practical strategies.

*"Training around how to engage parents with mental health difficulties and how to understand the diagnosis more, how the medication impacts on them".*

*"More training would probably help. A bit more specific training aimed at strategies around what works".*

*"I'd like to know more about how to identify the specific mental health conditions, ways of working with those people. We did a bit at uni, but it doesn't really prepare you for it".*

*"…training from the mental health sector where we get people to come out and do stuff on how it impacts on their ability to parent to give us a better understanding. We don't learn all that at uni in any great detail at all. But, I don't know how to say this, but good training, training that's not coming from someone reading out of a text book but someone who's like dealing with it every day, who works with and knows mental health".*

### 3.2.10 What would assist parents?

Most workers considered that more supportive connections between parents, child protection workers and adult mental health services would assist parents safely care for their children. Recurring themes included the need for:

- child protection workers to be more knowledgeable about mental health
- better collaboration between child protection and adult mental health services
- adult mental health services to consider their clients as parents and address parental roles
- ongoing support from adult mental health services beyond periods of crisis.

*"Us having a better interface with the mental health services would then help the parents. Looking at what our goals are with families when there is mental health and ensuring that the goals are realistic. I sometimes think that we make these goals for families and say "look, these are the things we want you to achieve in order to have your child back", but if their mental health is such that that's not going to be appropriate then we're setting them up to fail before they've even started. So I think we really need to have more of a grounding in the mental health stuff so that we're clear about what we are doing with families".*

*"I think that if we could work with all these other professionals and have good communication and be involved in planning, understanding and building that relationship with the treating professionals so that we can discuss it from our perspective, and doing that regularly. Not just talking to them on the phone and saying "I want a report". In a way it's our issue too because we want stuff from them to support our court applications, for example, we're not going to them saying we want to work with you around this person's mental health, or not often".*

## 3.3 Focus group findings

This section provides results obtained from five focus groups held with Families SA Psychological and Anti-Poverty Services. Participants were provided with a brief overview of the study and the findings from the caseworker interviews and asked to consider:

- whether the findings were consistent with their own experiences
- challenges they have experienced
- what would assist them in their practice with the families, and
- what would assist the families to safely care for their children.

### 3.3.1 Psychological Services

Families SA Psychological Services respond to referrals from Families SA case workers. A psychological assessment informs Families SA case workers (and often the Youth Court) about issues such as the impact of abuse and neglect on the child, the ability of the parents to provide adequate care and protection, and the nature of the relationship between the child and their family. Opinions regarding appropriate future care and contact arrangements are also usually requested.

Across all focus groups, psychologists estimated that parental mental health difficulties would be a presenting factor in 80-90% of referrals. They reported that they mainly encounter parents with personality issues; parents whose diagnosis was uncertain or did not meet diagnostic criteria; or parents with a dual diagnosis. Complex trauma was believed to be a common (underlying) issue in the majority of cases.

Some reported that the mental health problems experienced by parents are generally not acute enough for them to be eligible for a government mental health service, yet have a profound impact on social and family functioning and can adversely affect the development, and in some cases, safety of children. Drawing from their experience, they reported that depression and borderline personality disorder were the most compromising of parenting capacity; borderline personality disorder because it was often more difficult to treat.

As in the caseworker interviews, tensions between child and adult focused approaches were raised. Whilst it was understood that adult mental health workers should provide assertive advocacy for their client, it was felt that an adult-centric view can dominate (e.g. "she is less likely to attempt suicide if the children are home", "her mental health will improve if the children are returned home") and that the experiences of children may be minimised or lost.

Concern was expressed regarding 'superficial' engagement with services by parents and 'mythical' thinking regarding what could realistically be achieved in short time frames. Risks included children being returned home too early simply because a parent was engaged in therapy.

Some participants also discussed how issues of unresolved trauma manifested in assessment sessions, creating ethical dilemmas. Parents often opened up about their histories of trauma and then felt betrayed when the psychological report commented negatively on parenting capacity and recommended therapy. It was believed that the assessment process could, therefore, further compound the parent's mistrust of professionals.

Service availability in rural and remote areas of South Australia were also noted as a key issue. The lack of specialist services and the costs associated with accessing a private practitioner; difficulties in recruiting and retaining professionals and waiting lists and eligibility criteria were cited as challenges.

Participants argued that these complex adult mental health issues needed to be addressed through specific clinical services.

The benefits and limitations of specific therapeutic approaches were discussed, for example, dialectical behavioural therapy (DBT), which focuses on building skills such as mindfulness (ability to stay present focused and manage intrusive thoughts), conflict negotiation, emotion regulation and distress tolerance, with the primary aim being to reduce self-harm and the need for hospitalisation. It does not, however, target broader issues such as the impact of childhood trauma and poor attachment on relationships including with children.

### 3.4 Families SA Anti-Poverty Services

At the time of data collection, Families SA Anti-Poverty Services assisted people who are on low incomes and/or experiencing financial hardship by providing financial support services to ameliorate the impact of financial crisis and poverty. Anti-poverty workers also work collaboratively with Families SA case workers and families where there are child protection concerns.

Anti Poverty workers suggested that parental mental health difficulties are a feature in 50-90% of their caseloads with depression and anxiety the most common. Workers generally identified these by the client's presentation and also from reports of taking anti-depressants when income-expenditure is discussed. Depression and anxiety were believed to be associated with financial crisis, addictions and relationship breakdowns.

There were distinct differences between the two focus groups regarding the challenges in working with parents, probably attributable to the demographics of the two offices in which focus groups were held (one office is situated in a small, rural, close-knit community and is part of a Connected Service Centre, with the other in a disadvantaged metropolitan suburb).

The rural office talked about the advantages of smaller caseloads and strong, collaborative service connections. They advised that they receive many referrals from adult mental health services and that the two agencies often worked together. Clients were therefore likely to be managing their mental health, although problems such as poor memory and concentration were challenging. Workers cited a lack of confidence in talking about mental health during financial counselling interviews and thought they could probably be more active in referring clients out for other services and making those connections with clients.

The larger metropolitan office described clients as presenting with more complex, overlapping, entrenched issues and untreated problems. Their client group was seen as more unpredictable (aggressive) and people with a dual diagnosis were highlighted as a concern. Superficial service engagement and limited motivation (due to their mental health issues) were a source of frustration.

Both focus groups suggested that further training in identifying mental health problems would be beneficial, including suicide awareness training.

# 4 Summary: key results

This study was unable to report with confidence on the prevalence of substantiated child abuse and neglect associated with parental mental health difficulties due to the limitations of the available data. Families SA reported 2331 substantiated notifications of child abuse and neglect for the year 2007-2008 (AIHW Table 2.4) and 1830 children were the subject of these substantiated notifications. However, only 720 (39.3%) of these notifications had a completed 'Family Needs and Strengths Assessment'. Apart from manually and individually examining all cases of substantiated abuse or neglect, there was no other means of identifying from the administrative data which cases featured parental mental illness.

However, we were aware from the outset that prevalence results would be indicative. This was, however, an essential element of the study – it was designed to explore broader understandings of emotional or mental health difficulties in child protection practice i.e. how child protection workers identify parental mental health disorders, what they classify as such, and how this impacts upon decision-making.

Notwithstanding the above, on the basis of the available administrative data, we found that of the 720 substantiated notifications of child abuse or neglect with a completed 'Family Needs and Strengths Assessment', 370 (51.3%) indicated problems with the primary caregiver's emotional and/or mental health – more or less half of all cases.

Significantly, our analysis of the administrative data found that in the majority of cases (78.6%), child protection workers did not assess parents as having chronic or severe problems in either their emotional or mental health. These results suggest that parents who come to the attention of child protection agencies are likely to have conditions that would not normally be regarded as serious mental illnesses (such as schizophrenia, bi polar mood disorder or severe depression). The caseworker interviews confirmed this finding, with borderline personality disorder and/or depressions of lesser intensity the most common disorders. A clinical diagnosis had been made in 57% of cases, and only 32% of parents were connected with mental health services prior to the substantiation of child abuse or neglect.

Families where a parent has a mental health difficulty were found similar to other families who present to the child protection system, with high rates of complex and co-occurring problems. Over half had limited social supports and were experiencing domestic violence; approximately 40% had difficulties sustaining interpersonal relationships and their mental health was complicated by substance misuse; over a third had experienced abuse as a child; and approximately one in five had housing difficulties. Parents were vulnerable in many ways: poor quality support and social isolation in association with multiple adversities (domestic violence, unstable partner relationships, poverty and histories of self-harm and childhood traumas).

Neglect and emotional abuse were the most common forms of abuse experienced. Across the general population, emotional abuse is the most common, however for this sample it was neglect. This finding is largely consistent with previous studies which suggest that the symptoms of mental illness can impair a parent's ability to perform basic tasks such as feeding and clothing, nurturing, and maintaining adequate discipline and supervision.

Ultimately, child welfare decisions were based, not on the presence or absence of a diagnosis of mental illness, but on an assessment of parenting capacity. Key factors included the parent's ability to seek help and treatment compliance; their ability to manage stress; motivation and acceptance of responsibility; the quality of support available to the family; the child's developmental status; the parent's ability to meet the child's needs and the relationship between parent and child. Caseworker assessment was clearly underpinned by understandings of child development and attachment theory.

Caseworkers appeared to have little difficulty in assessing parenting capacity at a point in time, but were less confident in using their judgements to predict how mental health difficulties would impact on future ability to parent effectively. This assessment was seen as the domain of mental health professionals, some of who were reported to be reluctant to provide such a prognosis.

Child protection workers' knowledge of specific mental health disorders and the impact of the illness on the adult was often limited. Most wanted more training and information regarding including a focus on practical strategies for more effective engagement.

Results indicated the need for more supportive connections between parents, child protection workers and adult mental health services. In particular, many parents require ongoing support beyond periods of crisis and specialist interventions to resolve or process adverse childhood experiences and prevent the intergenerational transmission of dysfunction.

# 5 Implications and future directions

This study has explored child protection assessment processes and decision-making in cases featuring parents with mental health difficulties. The key areas of opportunity for policy, practice and service development are identified below.

## Increasing knowledge and building confidence in practice

The child protection workers in this study worked well to secure child safety, and address the impact of parental mental health problems on children. Strengthening families through promoting recovery and the well-being of parents was, however, more challenging. Working in partnership with parents who lack emotional stability or motivation and experience other overlapping adverse social issues is difficult for even the most experienced and skilled practitioner. When presenting behaviours are related to a mental health disorder, working with parents to address child safety issues and preserve families becomes even more complicated. Parents who have experienced attachment difficulties, for example, are very likely to reproduce problematic relational patterns when under duress and in their relationships with agencies. Such factors can negatively influence parents' engagement with services and recovery. Without the necessary knowledge and skill foundation, child protection workers can find the complexities of mental health a barrier.

Child protection workers need a comprehensive understanding of mental health and mental health care provision so that they can build trusting and constructive relationships with parents, and make timely and informed decisions. They also need intervention strategies and skills to engage with parents. Good systems for training, support and supervision are essential for workers to successfully manage the challenges of a demanding environment.

## Collaborative working across service interfaces

Research has shown that adult and children's services need to work together for the benefit of children. Accordingly, adult services are being challenged to become more child-sensitive and incorporate a family-centred approach. Adult-focused services are ideally positioned to protect and improve the well-being of vulnerable children. A key finding from this study was the need for greater and earlier involvement from mental health professionals in child protection cases where parents have, or are thought to have, mental health problems. Child protection workers valued the information that mental health professionals provide to support their assessments, interventions and decision making.

Working collaboratively across the tensions and boundaries that can emerge at the intersection of child protection and mental health is not easy. Different agency mandates and operational priorities influence the ways in which agencies work together and staff can be wary of stepping outside of agency defined roles and responsibilities. Good collaboration and embracing new ways of working takes time and commitment and requires organisational structures that foster and encourage practitioners to innovate and cooperate.

As Scott (2009) has noted, there have been some important and encouraging developments in fostering cross sectoral collaboration. For example, the Commonwealth Australian Government Initiative; The Children of Parents with a Mental Illness (COPMI), is working to build the capacity of adult mental health services to respond to the needs of children and address the parental roles of adults. The South Australian Government has embraced a 'whole of government' policy approach through its 'Keeping them Safe' child protection reform agenda and provided the platform through which improved collaboration and information exchange between staff at the operational levels of the Department for Families and Communities, SA Health, and the Department of Education and Children's Services can be strengthened. At a local level, Families SA, Aberfoyle Park Office initiated 'The Mental Health Liaison Project' whereby an experienced mental health nurse was co-located within a child protection office and incorporated into the Intake and Assessment team. An independent evaluation of this small-scale pilot project reported many benefits including improved communication, information sharing and knowledge across both services and the development of a shared emphasis on parents and children (Arney, Zufferey and Lange 2010:3).

This study indicates the critical need for a continuing and strong focus on cross-sector collaboration. Investment in training and staff development is one element in this, and in particular joint training, which can break down barriers and increase people's understanding of other service areas and responsibilities (Pearce 2003).

## Borderline personality disorder

Borderline personality disorder has occupied an uneasy place within the mental health field. It has been the subject of diagnostic controversy and individuals carrying this diagnosis have typically been viewed as 'difficult' and even untreatable. Individuals with borderline personality disorder are often not considered to have problems which to meet the criteria for hard-pressed mental health resources.

Recent research has emphasised the relationship between borderline personality disorder and early childhood trauma and adversity and suggests that the core features associated with this disorder will have an immediate impact on parenting, compromising the promotion of attachment security and healthy child development. Parents with borderline personality are 'high risk' parents, who, as this study has demonstrated, are likely to be over-represented in child protection services. Children of mothers with borderline personality disorder present with various clinical syndromes and types of emotional disturbance (Newman and Stevenson 2005:386). There are significant community and public health implications if the needs of these parents remain unaddressed – borderline personality disorder can impact on parenting and on the child over time and across generations.

Although there is excellent work happening to promote awareness and the need for services and support in this area, there are still few specialist services. Research suggests that parents with borderline personality disorder benefit from long-term support and services with specific clinical expertise and interventions that draw on attachment and trauma theories as their basis and focus on building resiliency and strengthening social support.

## Generating further evidence

This study has emphasised the need for further research and evidence about methods that openly support 'joined up' working across child protection and adult mental health services. We also need to know more about 'what works' for families confronted by mental health problems, and specifically, how to better understand, engage and support parents. This includes consideration of the skills, knowledge and qualities needed to make such work possible.

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# 7 Appendices

## 7.1 Appendix A: Caseworker interview questions

1. Tell me briefly about the case (E.g. who is involved, child protection concerns, abuse/neglect that occurred, other family factors – co morbidity.)
2. What was it about this case that led you to believe the parent(s) had a mental health problem? (E.g. behavioural indicators, observations, credible notifier, historical information, medical psychological or psychiatric assessment.)
3. Has a clinical diagnosis of the parent(s) mental health difficulties been made? If yes, when was the diagnosis made, who made the diagnosis and what is the clinical diagnosis?
4. Was the parent(s) already connected with a mental health service provider prior to Families SA's involvement with the family? If yes, who and what treatment was being provided?
5. Is the parent currently receiving treatment for their mental health difficulty? If yes, who is providing the treatment and what kind of treatment is being provided?
6. Is the parent receiving treatment because of Families SA's involvement? (E.g. casework referral/recommendation, court ordered treatment)
7. How does the parent(s) mental health impact upon their ability to safely care for / meet their child's needs? (E.g. parenting capacity, likelihood of relapse) N:B If there is more than one child, does the parent's mental health impact differentially? (E.g. younger/older children.)
8. How does the parent(s) mental health impact upon their ability to maintain supportive adult relationships? (E.g. intimate, familial, community.)
9. How does the parent(s) mental health impact upon your ability to engage with the parent and work with the family? (prompt how did they manage this, what strategies worked well?)
10. Are there any culturally specific issues/considerations regarding constructs of mental health that apply in this case? (If yes, explore).
11. What is the current case plan intent? (E.g. reunification, long term orders?)
12. How did the parent(s) mental health impact on your decision making regarding (reunification, seeking long term orders)?
13. When did you know that you were going to reunify, seek long-term orders?
14. How confident (on a scale of 1-10) are you in working with this family?

1…….. 2…….. 3…….. 4…….. 5…….. 6…….. 7…….. 8…..…. 9…..…. 10

Not very confident Very confident

Explore reasons around confidence level

15. What would assist you in your practice with parents who have mental health difficulties? (E.g. training, more information, more support)
16. What would assist and support parents experiencing mental health difficulties to meet the needs of their children?
17. Is there an allocated Anti-Poverty worker co-working this case?
18. Any other thoughts, impressions, feelings, comments about this or other similar cases?

Caseworker demographics:

i. Age in years_____

Or

<20 years

21-30 years

31-40 years

41-50 years

51-60 years

>60 years

ii. Gender

Male Female

iii. Country of birth: _____

iv. Do you speak a language other than English at home?

Yes No

v. Are you of Aboriginal and or Torres Strait Islander origin?

Yes No

vi. How long have you worked in Families SA?

_____years

_____months

vii. What is your current position level in Families SA?

OPS3 OPS4 PSO1 PSO2 PS03

## 7.2 Appendix B: Tables

Table 1: Number of substantiations of abuse and/or neglect per child

| | N | % |
|---|---|---|
| 1 | 136 | 36.8% |
| 2 | 93 | 25.1% |
| 3 | 44 | 11.9% |
| 4 | 39 | 10.5% |
| 5 | 27 | 7.3% |
| 6 or more | 31 | 8.4% |
| **Total** | **370** | **100.0%** |

Table 2: Number of recorded maltreatment types for children

| | N | % |
|---|---|---|
| 0 | 4 | 1.1% |
| 1 | 217 | 58.6% |
| 2 | 99 | 26.8% |
| 3 | 44 | 11.9% |
| 4 | 6 | 1.6% |
| **Total** | **370** | **100.0%** |

Table 3: Caregiver characteristics

| | N | % |
|---|---|---|
| Age | | |
| ≤ 17 | 10 | 5.0% |
| 18 to 24 | 34 | 16.9% |
| 25 to 39 | 37 | 18.4% |
| 30 to 34 | 38 | 18.9% |
| 35 to 39 | 34 | 16.9% |
| 10 to 45 | 22 | 10.9% |
| 45+ | 9 | 4.5% |
| Unknown | 17 | 8.5% |

| | N | % |
|---|---|---|
| **Gender** | | |
| Male | 33 | 16.4% |
| Female | 168 | 83.6% |
| **Cultural Background** | | |
| **Aboriginal** | **34** | **16.9%** |
| **Non-Aboriginal** | **145** | **72.1%** |
| **Unknown** | **22** | **10.9%** |

Table 4: Family strengths and needs assessment

| | No. of families | % of families | % of families with chronic MH or EH problems* ‡ | % of families with MH or EH problems but not chronic †‡ |
|---|---|---|---|---|
| **Substance abuse** | | | | |
| No evidence of substance abuse | 122 | 60.7% | 48.8% | 63.9% |
| Caregiver with substance abuse problem | 61 | 30.3% | 27.9% | 31.0% |
| Caregiver with serious substance abuse problem | 18 | 9.0% | 23.3% | 5.1% |
| **Domestic violence** | | | | |
| No evidence of problem | 95 | 47.3% | 34.9% | 50.6% |
| Domestic discord | 62 | 30.8% | 39.5% | 28.5% |
| Serious domestic discord/domestic violence | 44 | 21.9% | 25.6% | 20.9% |
| **Parenting ability** | | | | |
| Adequate skills | 49 | 24.4% | 14.0% | 27.4% |
| Improvement needed | 108 | 53.7% | 48.8% | 55.4% |
| Destructive/abusive parenting | 38 | 18.9% | 37.2% | 14.0% |
| Parent skills have strengthening effect on family | 5 | 2.5% | 0% | 3.2% |
| Not reported | 1 | 0.5% | | |
| Experience of abuse as child | | | | |
| No evidence of problem | 129 | 64.2% | 72.1% | 62.4% |
| Some problems | 41 | 20.4% | 11.6% | 22.9% |
| Evidence of abuse | 28 | 13.9% | 16.3% | 13.4% |
| Caregiver has addressed their own issues | 2 | 1.0% | 0.0% | 1.3% |

| | No. of families | % of families | % of families with chronic MH or EH problems* ‡ | % of families with MH or EH problems but not chronic †‡ |
|---|---|---|---|---|
| Not reported | 1 | 0.5% | | |
| **Intellectual capacity** | | | | |
| Average/above average functional intelligence | 144 | 71.6% | 41.9% | 80.3% |
| Some impairment/difficulty in decision making | 50 | 24.9% | 48.8% | 44.6% |
| Severe limitation | 6 | 3.0% | 9.3% | 1.3% |
| Not reported | 1 | 0.5% | | |
| **Social support** | | | | |
| a. Appropriate abilities | 72 | 35.8% | 25.6% | 38.9% |
| b. Limited support system | 91 | 45.3% | 48.8% | 44.6% |
| c. No support or isolated | 22 | 10.9% | 23.3% | 7.6% |
| s. Strong support skills | 15 | 7.5% | 2.3% | 8.9% |
| u. Not reported | 1 | 0.5% | | |
| **Community interactions** | | | | |
| Appropriate abilities | 107 | 53.2% | 30.2% | 59.9% |
| Ineffective/limited ability to sustain relationships | 63 | 31.3% | 41.9% | 28.7% |
| Hostile/destructive interpersonal relationships | 16 | 8.0% | 23.3% | 3.8% |
| Positive community, social, familial relationships | 14 | 7.0% | 4.7% | 7.6% |
| Not reported | 1 | 0.5% | | |
| **Physical health issues** | | | | |
| No health problems | 142 | 70.6% | 65.1% | 72.6% |
| Health problem or disability affects family | 33 | 16.4% | 20.9% | 15.3% |
| Serious health problems/physical disability | 6 | 3.0% | 7.0% | 1.9% |
| Caregiver in excellent health | 19 | 9.5% | 7.0% | 10.2% |
| Not reported | 1 | 0.5% | | |

| | No. of families | % of families | % of families with chronic MH or EH problems* ‡ | % of families with MH or EH problems but not chronic †‡ |
|---|---|---|---|---|
| **Income and financial management** | | | | |
| Minor problems | 83 | 41.3% | 53.5% | 38.2% |
| Some financial difficulties | 57 | 28.4% | 27.9% | 28.7% |
| Financial crisis | 18 | 9.0% | 11.6% | 8.3% |
| Adequate and well managed | 42 | 20.9% | 7.0% | 24.8% |
| Not reported | 1 | 0.5% | | |
| **Housing** | | | | |
| Adequate housing | 133 | 66.2% | 67.4% | 66.2% |
| Unsanitary, unsafe housing | 26 | 12.9% | 16.3% | 12.1% |
| Homeless or uninhabitable housing | 17 | 8.5% | 9.3% | 8.3% |
| Promotes children's wellbeing | 24 | 11.9% | 7.0% | 13.4% |
| Not reported | 1 | 0.5% | | |
| **Child factors** | | | | |
| Age appropriate, no problems | 119 | 59.2% | 58.1% | 59.9% |
| Child(ren) have moderate problems | 59 | 29.4% | 32.6% | 28.7% |
| Child(ren) have severe/chronic problems | 22 | 10.9% | 9.3% | 11.5% |
| Not reported | 1 | 0.5% | | |

* Families with reported chronic or severe problem for MH or EH (n=43)

† Families with parental mental health difficulty but did not report chronic or severe problem for MH and EH (n=157)

‡ Families with not reported were excluded

Table 5: Case plan intent

| Case plan intent | N | % |
|---|---|---|
| Guardianship to 18 years | 15 | 54% |
| Uncertain | 4 | 14% |
| Case closure | 3 | 11% |
| Ongoing family support | 2 | 7% |
| Informal relative/kinship care arrangement | 2 | 7% |
| Reunification | 1 | 4% |
| Case already closed | 1 | 4% |
| **Grand total** | **28** | **100%** |