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EVALUATION OF THE MENTAL HEALTH LIAISON PROJECT

Final Report and Recommendations: Worker and Parent
Perspectives
July 2006

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This external evaluation of the Mental Health Liaison Project at Families SA (formerly CYFS), Aberfoyle Park District Centre was funded by the Children Youth and Family Services (CYFS) Innovations Funding.

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Acknowledgements

A number of people have contributed to this evaluation by providing important support and information to the research team.

Thank you to staff and managers at Aberfoyle Park Office, Families SA (formerly CYFS), who supported this evaluation, wrote the initial funding application and reviewed literature which has been used to inform this report.

Thank you to workers in Families SA and Mental Health Services who took the time to attend interviews and focus groups and shared their experiences and suggestions for the Mental Health Liaison Project as part of the evaluation and research process.

Thank you to parents who have been or are clients of Families SA who shared their experiences and suggestions for the evaluation of the MHLP project.

Many thanks to Lynette Clothier, Student Social Worker at Aberfoyle Park District Office, for seeking consent from the parents to participate in this evaluation research.

As well, to the Human Research Ethics Committee, University of South Australia and Research Development Committee, Department for Families and Communities, for their prompt approval of this project.

Executive Summary

In the context of deinstitutionalisation in the areas of intellectual disability and mental health, and high levels of interpersonal violence and increasing drug dependency in society, children of parents struggling with these difficulties make up a high proportion of child protection cases (Department of Human Services, 2002; 2003).

The Layton Report (2003), which reviewed child protection in South Australia, has recommended a collaborative whole-of-government approach to child protection service provision that focuses firstly on the child's needs and secondly on services which impact more indirectly on children, such as adult mental health services and drug and alcohol services. Through its "Keeping them Safe" child protection reform agenda the South Australian Government is driving work place and work culture reform across child protection, and enhancing collaborative practice through formal agreements between the Department for Families and Communities, the Department of Health, and the Department of Education and Children's Services. Nationally, initiatives such as the Children of Parents with a Mental Illness (COPMI) project by the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), are also working to enhance collaboration between traditionally child-focused and adult-focused services.

The Mental Health Liaison Project (MHLP) is an innovative project designed for parents experiencing mental health difficulties who are clients of the Aberfoyle Park District Office of Families SA (formerly Children, Youth and Family Services -CYFS). The MHLP takes a multidisciplinary approach that seeks to "fast-track" referral for parents experiencing mental health difficulties, with the aim of assisting them to continue to care safely for their children. The MHLP sites an experienced Mental Health Nurse (the Project Officer) within the intake and assessment team at Families SA, Aberfoyle Park District Centre. The Project Officer assists with the assessment of parents and mobilisation of services according to a family's level of need.

The MHLP contributes to the Strategic Directions of the Department for Families and Communities (DFC) and the Families SA Strategic Plan. The MHLP and this evaluation are also aligned to the objectives in the 'Keeping Them Safe' report, by evaluating a program designed to provide integrated and early action across agencies (Early Intervention and Prevention theme). The 'Keeping Them Safe' report (DFC, 2004) names five key reform priorities: support to children and families; effective and appropriate intervention; reforming work practice and culture; collaborative partnerships; and improved accountability. The MHLP contributes to all of these priorities.

This evaluation, conducted by the Australian Centre for Child Protection at the University of South Australia, examined the views of workers, supervisors, managers and clients about what worked well, and what could be done differently, when including a mental health worker with child protection services. Using action research methodology to review changes made to the project by staging interviews with workers and clients, this final report details the results from the first and second stages of a process evaluation of the MHLP. The first stage of the evaluation in late

December 2005 to January 2006 obtained the perspectives of 14 individuals through worker interviews and focus groups undertaken in Families SA and Mental Health Services (MHS). The second stage of the evaluation conducted in May 2006, obtained the perspectives of 11 workers through interviews and focus groups in Families SA and Mental Health Services. The first stage of the evaluation project obtained the perspectives of 5 clients (three who were involved with the MHLP and two who were clients of child protection prior to the project commencing) and the second stage interviewed 3 clients involved with the project. The results from interviews with workers and parents showed overwhelming support for the project, and recommended its continuation.

Worker perspectives

Features of the project that were identified as working well and facilitating intersectoral collaboration from worker perspectives included:

- The ability of the project to address collaboration at both a “ground-roots” and systemic level.
- The project served as a bridge or link that improved communication between workers in each service.
- Cross service and cross discipline education strategies initiated by the project worker improved the knowledge of workers in both services.
- Joint client assessments with the Project Officer were a key project activity that enabled improved client focused communication between mental health and child protection services.
- The expertise, personality, experience, skills, knowledge and availability of the Mental Health Nurse in the project are of paramount importance in ‘making the project work’.
- The links, knowledge and support provided from the Reference Committee was pertinent to the cross fertilisation of ideas.
- The matrix of supervision for the Project Officer was supportive.
- The flexible referral process enabled improved accessibility.
- The advocacy and access to services and resources that the Project Officer was able to provide for families were very helpful.

However, differing organisational orientations and bureaucratic processes presented barriers to effective communication and collaboration between services. The barriers between mental health and child protection services evident in this evaluation reflected themes in literature concerning inter-organisational conflicts between child-focused services and adult-focused mental health services. Research shows that adult-focused services such as MHS are concerned about confidentiality and threatening their relationships with the parent if they are seen to be too closely aligned with child-focused child protection services. However, child protection services need evidence from adult mental health services to assist them in determining whether the child is ‘at risk’ due to the parent’s mental illness. Employing a Mental Health Nurse in a child protection office increased the capacity of both services to positively respond to parents with a mental health problem and was instrumental in facilitating and increasing communication across service systems.

Client Perspectives

Parent perspectives about what was working well particularly focused on

- the empathic, respectful approach as well as sensitivity and commitment of the Project Officer;
- the importance of such a project being permanently available to access when needed;
- the nature of the assistance provided by the MHLP such as referrals to new support services; and
- having a Mental Health Nurse in child protection services was useful because it prevented parents from having to “tell my story again, again and again”, and it was effectively “like two appointments in one”.

Some barriers identified by parents included:

- A lack of follow up support, limited funding, few resources and staff turnover, which affected worker-client communication;
- Waiting lists to access psychiatric support and other services as well as not fitting the criteria of services.
- The stigma of being involved in child protection services whose interventions were at times perceived as surveillance (although this did not refer to the MHLP); and
- The ability and capacity of parents to follow up and persist with suggestions made by workers and referrals to services.

There is a high level of support for this project and for service collaboration by workers, by clients and at the higher policy level. This project fits with the collaborative aims of the interministerial agreements between the Minister for Health and Minister for Family and Communities. It is hoped that this policy initiative will impact on systemic and organisational change and assist the facilitation of information exchange at the local level. Projects like the MHLP start to bridge the gap between services and improve client access to services but staff numbers, training, systemic and legislative support are required to further sustain the project.

This Final report adds to the findings of the Interim report (January 2006) and discusses the project background, the evaluation methodology, the research findings from both workers and parent perspectives, and makes recommendations based on the interview data. There was a high degree of consistency in the proposed recommendations of clients and workers across different levels and in different service sectors. The recommendations in this evaluation report have been clustered into short term, medium term and long term.

Short-term recommendations (as a priority)

1. To continue the Mental Health Liaison Project and consider permanently funding the project on a fulltime basis.
2. To continue to address recommendations from the Interim Report as outlined in Appendix One.
3. To disseminate information about the success of the MHLP and to use this project as a model for the future.

4. For the Project Officer to formalise practices - document key details and plans for individual clients about the processes involved in obtaining information, accessing services, key people involved - what to do, who to contact and how.
5. To develop a Joint Risk Assessment Form for child protection and adult mental health workers.

Medium term recommendations

1. For the Project Officer to participate in the development of agency policies and procedures, to assist collaboration at a policy level between mental health and child protection services.
2. To increase the capacity of the MHLP to further build links and networks, such as with Child and Youth Health nurses involved in the family home visiting program, child-parent attachment programs, and other intersectoral programs and initiatives. For example, the findings of this evaluation and the 'learnings document' can contribute to the SA COPMI Partnership Plan.
3. For the Project Officer to document 'learnings' from the project - what she has been doing, what is valuable, key things that are good to repeat (noting transferabilities) and record any information to pass onto workers about what worked well and what didn't. The sharing of this information could be done in a number of ways, including writing a journal article, preparation of training, and conference presentations.

Long-term recommendations (for consideration by funding bodies)

1. To expand the Mental Health Liaison Project and employ more Mental Health Nurses in Families SA. Particular attention should be paid to the manner, skills and expertise of any Mental Health Nurses employed on the project. The project requires Project Officers with a child and family focus and adult mental health experience, and to be at least a Level 3 Nursing classification. These characteristics were highlighted as important facilitators of intersectoral collaboration and parent engagement.
2. To include rigorous outcomes and process evaluation methods with any expansion of the program, including changes in worker knowledge as a result of the program, and details of how aspects of the project officer-client relationship can influence client engagement and outcomes.
3. For child protection and mental health services to develop stronger early intervention roles (and thus, assist the Mental Health Liaison Project to achieve its preventative aims).
4. To explore links with non-government organisations, to initiate new services and develop current ones, that offer in-home support for parents with a mental illness.

5. To support the multidisciplinary training of agency staff at multiple levels, including through University undergraduate and postgraduate courses.
6. To liaise with agencies (such as SA COPMI) that can assist in the training of staff across different organisations to improve staff ability to talk with children about their experiences of having a parent with a mental illness.
7. To consider a longitudinal research study that assesses the longitudinal outcomes of the MHLP, which includes monitoring interventions (such as child removal) over time, as well as how the project impacts on staff attitudinal changes and improves the knowledge and understanding of workers in both agencies.

Purpose of the Report

The key objective of this project is to conduct an action-research evaluation of the Mental Health Liaison Project (MHLP) at Families SA (formerly Children, Youth and Family Services, CYFS), Aberfoyle Park District Centre. The evaluation examined the views of workers, supervisors, managers and parents about what worked well, and what could be done differently, when including a mental health worker with child protection services. Using action research methods the information and recommendations from the first stage of the evaluation (Appendix One) were used to inform and enhance the practice of the MHLP. This is the final report on the evaluation.

Background

Parental mental illness and its impact on children are well documented (Oyserman et al, 2000; Cleaver et al, 1999; Cowling, 1999). Statistics from the United States identify that parents with a mental illness are vulnerable to losing custody of their children. Studies indicate that as many as 80% of mothers hospitalised for severe mental illness do not retain custody of their children (Joseph, Joshi, Lewin, & Abrams, 1999). The Australian Bureau of Statistics (2003) estimate that almost 10% of the population have long term mental or behavioural problems. Other surveys in Australia have shown that between 29% and 35% of mental health services clients are female parents of dependent children under the age of 18 (Children of Parents with a Mental Illness (COPMI) Website, accessed 24/01/06).

In the last fifteen years, South Australia has experienced a deinstitutionalisation movement. This means that it was no longer desirable for people with mental health issues to be cared for in institutions. Apart from a small percentage of people voluntarily admitted or assessed as detainable by a medical practitioner (Mental Health Act of South Australia, 1993), the majority of people continue to live in the general community, thus relying heavily on community mental health services for support. With these changes, a greater number of people have gained the freedom to experience parenthood. The reality of this impact is identifiable for a significant number of children and families assessed by Families SA in child protection investigations, interventions and reunifications. The mental health status of a parent is often a key factor impeding the parent's ability to care safely for their child(ren) (Hollingsworth, 2004). For example, Victorian data show that in the early 2000s, 19% of substantiated cases of child abuse or neglect and 31% of child placements, involved a parent with a psychiatric disability (Department of Human Services, 2002; 2003); and data from Western Australia has shown that 28% of cases in which children were on care and protection orders involved parental psychiatric illness (Farate, 2001). These proportions also seem to be increasing over time (Department of Human Services, 2002; 2003). The Victorian Child Death Review Committee (2004) also identified "indicators of parental mental health issues" as a risk factor in 11 of the 20 child death inquiry reports that were reviewed in 2003-2004.

There are a number of new and different challenges facing workers in child protection. In the past, poverty was a major factor contributing to children coming into State care

but this has now been complicated by social vulnerabilities affecting parents such as mental health and development issues, domestic and family violence and problematic substance use (Thorpe and Thomson, 2003). The comorbidity of mental health problems with other issues has been highlighted by the fact that in almost 50% of investigated child protection cases that involved a parent with a psychiatric disability, there were also issues of family violence. Alcohol and substance use issues were also identified in significant proportions of families with a psychiatric disability (Department of Human Services, 2002).

The Layton Report (2003), which reviewed child protection in South Australia, has recommended a collaborative whole-of-government approach to child protection service provision that focuses firstly on the child's needs and secondly on services which impact more indirectly on children, such as adult mental health services and drug and alcohol services. Through its "Keeping them Safe" child protection reform agenda the South Australian Government is driving work place and work culture reform across child protection, and enhancing collaborative practice through formal agreements between the Department for Families and Communities, the Department of Health, and the Department of Education and Children's Services. Nationally, initiatives such as the Children of Parents with a Mental Illness (COPMI) project by the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), are also working to enhance collaboration between traditionally child-focused and adult-focused services.

There is increasing recognition that multidisciplinary, intersectoral approaches to working with clients presenting with complex case histories can produce benefits not only economically, but also in terms of improved service flexibility and effectiveness, and enhanced communication and trust between practitioners from different agencies (Considine, 2005; Darlington et al, 2005a). While both policy-makers and practitioners have positive attitudes towards intersectoral collaboration, in general, there are a number of systemic and professional barriers that have been identified in preventing collaboration between child protection and mental health services (Darlington 2005a; 2005b). These barriers include issues to do with:

- communication between practitioners in different sectors;
- knowledge and confidence around mental health problems;
- role conflict and problems with role clarity for common clients;
- resource issues;
- a lack of supportive structures and policies to facilitate intersectoral collaboration;
- confidentiality; and
- statutory requirements (Darlington, 2005b; Scott, 2005).

A recent South Australian study (Thompson, 2005) which looked at adult mental health nurses' beliefs and practices in working with people with a mental illness who were also parents found that a quarter of the nurses reported barriers to discussing parenting issues with their clients. More than a third of the nurses had not made a mandatory child protection notification to child protection services even though the nurse believed there were significant child protection concerns. The main reason given was a lack of confidence in child protection services by the adult Mental Health Nurse. There has been a call for increased mental health education and resources for practitioners working in the child protection sector to address some of these barriers,

as well as for greater knowledge of children's needs by adult mental health practitioners.

In addition, the lack of intersectoral collaboration has an impact on families beyond the initial child protection assessment and investigation. A recent study by Sheehan (2004) found that low involvement by mental health workers in child protection cases precluded the Children's Court in Victoria from taking into account aspects of the children's or parents' emotional wellbeing and their mental health needs.

The Mental Health Liaison Project (MHLP) based at the Aberfoyle Park Families SA Office in South Australia, was proposed by workers in response to barriers they identified regarding clients accessing mental health services. These barriers included: waiting lists; strict criteria; clients' reluctance to follow up mental health assessment voluntarily or the inability to access services due to geographical location; client denial of mental health issues; and that the child protection focus is on the child rather than the parents.

The MHLP is a multidisciplinary approach that seeks to "fast-track" referral for parents experiencing mental health difficulties, with the aim of assisting them to continue to care safely for their children. The MHLP sites an experienced Mental Health Nurse (the Project Officer) within the intake and assessment team at the Aberfoyle Park District Centre. The Project Officer assists with the assessment of parents and mobilisation of services appropriate to a family's level of need. A copy of the proposal for the MHLP is attached as Appendix Two. The MHLP was funded by child protection services to build a bridge between the two agencies and improve joint intervention outcomes. However, Families SA were unable to employ a Mental Health Nurse directly, so the nurse was employed by Mental Health Services and seconded to them, who commenced on the project in April 2005.

The aims of the MHLP are to:

1. Improve outcomes for adults and children
2. Improve communication across mental health and child protection services
3. Develop collaborative processes and understanding across the service systems working with this client group.

The MHLP contributes to the Strategic Directions of the Department for Families and Communities (DFC) and the Families SA (formerly CYFS) Strategic Plan. The MHLP and this evaluation are also aligned to the objectives in the 'Keeping Them Safe' report, by evaluating a program designed to provide integrated and early action across agencies (Early Intervention and Prevention theme). The 'Keeping Them Safe' report (DFC, 2004) names five key reform priorities: support to children and families; effective and appropriate intervention; reforming work practice and culture; collaborative partnerships; and improved accountability. The MHLP contributes to all of these priorities.

By using an action research methodology to guide process improvement, this evaluation project also contributes to the Learning theme of the Keeping Them Safe objectives. The National Mental Health Plan 2003-2008 (Commonwealth of Australia, 2003) also advocates for early intervention, prevention and treatment, and innovative service partnership responses to mental health and mental illness. This is exemplified

by the innovative MHLP in the Families SA Aberfoyle Park District Office and by national initiatives such as the COPMI project.

This evaluation examined the views of workers, supervisors, managers and parents about what worked well, and what could be done differently, when including a mental health worker with child protection services.

It is important to examine the views of parents about what worked well, and what could be done differently, when including a mental health worker with child protection services. Thorpe and Thomson (2003) advocate that parents need to be key stakeholders in the client/worker partnership. The views of parents can contribute to developing improved child protection services and practices and offer important feedback for quality control purposes (Dale, 2004). Previous research about parents' perspectives of the child protection system has reported that interventions are often experienced negatively. Peter Dale's (2004) research with 18 families who have had contact with child protection services in Britain found that 50% of parents reported some positive benefit from child protection interventions and 20% said such interventions had caused them harm. This final evaluation report incorporates the voices of eight parents about the MHLP.

Methodology

Research Questions

The following research questions were addressed in this evaluation:

- What were staff and clients' perceptions of the Mental Health Liaison Project?
- In this project, what were the facilitators and barriers to intersectoral collaboration between mental health and child protection services?
- What changes could be made to the program to improve intersectoral collaboration and to improve the process for families?

Design

A qualitative action research methodology was used in which the researchers worked in mutual collaboration with key stakeholders to consciously seek to change or improve a situation, through: development, implementation, evaluation, analysis, refinement, implementation of refinements, and re-evaluation (see Figure 1). Key stakeholders were the Project Officer employed on the project, managers and staff in child protection and mental health services, and parents who were clients of child protection services. Interviews with the key stakeholders were conducted as outlined in Figure 1. The research includes data from face to face semi-structured interviews with staff (seven in Families SA and four in MHS) and focus groups (four in Families SA and one in MHS) and eight telephone interviews with Families SA clients. The information gathered from these interviews and focus groups was used to make informed changes to the MHLP.

Participants

Participants included a total of nineteen child protection workers and six mental health workers in the evaluation and re-evaluation phases. In addition, client perspectives

were taken from telephone interviews with six parents who were clients of the project and, for comparative purposes, two parents who were clients of child protection services prior to the commencement of the MHLP.

Procedures

Staff

Staff participants were invited to attend an individual interview or focus group through email contact, depending on their level of involvement with the project, and the site at which they are based. After obtaining informed consent, the interviewer audiotaped worker interviews and focus groups and transcribed them. A content analysis and inter-rater reliability analysis were conducted on all transcripts to highlight themes that emerged in interview data. Vignettes from the transcripts are used to highlight key points but identifiable details were removed, to protect confidentiality.

Parents

A randomised list of client numbers was generated by the evaluators, and the parents were then contacted in that order by a Families SA intake worker. The intake worker explained the evaluation project and its aims to parents and then invited their participation. Parents who agreed to participate were sent information sheets and consent forms seeking their consent for telephone interviews and review of their casenotes held at Families SA.

In Stage One, 17 families involved with the MHLP were randomly ordered and contacted by the Intake Worker; ten families couldn't be contacted, four did not want to participate and three completed interviews (a 43% participation rate). In addition, 18 Families SA clients prior to the commencement of the project were randomly sampled and the intake worker attempted to contact them to invite them to participate; 13 families couldn't be contacted, three did not want to participate and two completed interviews (a 40% participation rate). The process was repeated in Stage Two, in which 9 families were randomly sampled. Two of these families included teenage mothers under the age of consent (and so were excluded), three were not able to be contacted by phone, and of the four contactable and eligible families, three participated in the research (a 75% participation rate).

Apr 2005	Apr 2005-Dec 2005	Dec 2005 - Feb 2006	Jan 2006-Feb 2006	Mar 2006	Mar 2006-Jun 2006	Jun-Jul 2006	Jul-Aug 2006	August 2006-Ongoing
MHLP began	Development and implementation	Evaluation	Analysis and Reporting	Refinement	Implementation	Re-evaluation	Analysis	Refinement
	Partnership between mental health and child protection services Reference Committee Advancing Agency Sharing Forum Identifying Mental Health Resources and Education Joint Assessments and Mental Health Consultation Case Conferences and linkages with Drug and Alcohol Services, and Community Women's Health High Risk Infant Program Subcommittee External Evaluation Marion Families SA and DASSA Partnership Project	Eight interviews and three focus groups with a total of nine child protection and five mental health staff. Also interviews with three parents who were clients of the MHLP and two parents who were clients of child protection services before the MHLP began.	Content analysis, 100% of interviews assessed for inter-rater reliability. Interim report with recommendations.	Recommendations from interim report	Changes based on recommendations: Additional information and resources at team meetings; Development of a mental health resource board for the child protection office. Development of mental health checklists or referral tools. Joint training initiatives undertaken such as Families in Mind Training Mental Health First Aid training, Additional referrals to the MHLP Changes not based on recommendations: Project Officer working part time to extend the life of the project	Three interviews and two focus groups with a total of 10 child protection and one mental health staff. Also interviews with three parents who were clients of the MHLP after changes recommended in the interim report had been made.	Content analysis, 100% of interviews assessed for inter-rater reliability. Final report with recommendations.	Recommendations from final report to be implemented

Figure 1. Action research process for the Mental Health Liaison Project.

Interviews with parents were conducted by telephone, and the interviewer took notes of the interview. Parents were paid \$50 as acknowledgement of the time and effort taken to participate in the evaluation. Parent interviews lasted 45 minutes to 1.5 hours. All participants consented to the researcher viewing their case notes, to ascertain pathways of families as a result of their involvement with Families SA and the MHLP.

Measures

Semi structured interviews were conducted with staff and parents. The interviewer asked broad, open-ended questions, and then depending on the type and level of participants' involvement with the Mental Health Liaison Project (MHLP) - a range of graded prompts were used. These were different for staff and parents as the questions are designed to examine the MHLP from different viewpoints – that of practitioner, and that of client.

The following broad questions were used for all staff and parents:

*What has been the extent of your involvement with the project?
How helpful has it been?
What worked well?
What could have been done differently? How?
What else would you like the project to undertake or assist with?*

Examples of graded questions for workers were:

What effect did it have on the way the team worked? Or on your awareness of mental health/child protection? Or on agency collaboration?

An example of a graded question for parents was:

What effect did the program have on your ability to access services?

Research Limitations

It should be noted that this research project was unable to undertake an outcomes evaluation; therefore any results presented that refer to whether the aims of the project were achieved are the perceptions of the respondents.

High staff turnover resulted in many new workers in the Aberfoyle Park Office who had little previous involvement with the MHLP. This limited the numbers of workers available for the focus groups. In Stage One, workers initially involved with the MHLP had moved to other offices, so they were also contacted and some agreed to be interviewed individually about their perspectives of the project. Understandably, workers also had to prioritise client crises over attending focus groups or individual interviews. The available pool of mental health staff involved with the project was small, so this limited the number of worker interviews from MHS. Also, because involvement in the evaluation was voluntary, there may be other views about the MHLP that are not represented in this report.

In regards to accessing parent perspectives, many clients had moved, the telephone numbers were wrong or disconnected, a few declined and some clients had been transferred to other areas. These factors all contributed to reduced numbers of parents being involved in this research.

Types of data and information that were collected for this final report:

Because of length restrictions, this final report does not contain all of the information that was collected for the interim report. Although there is some overlap (e.g., the recommendations from the interim report are included as Appendix One) it is recommended that to obtain a better picture of the MHLP and this research project, that both the interim and final reports be consulted.

The types of data that were collected for this final report include:

1. Project Referral Data, activities and method of work with clients (the list of activities for the project is attached as Appendix Three).
2. Changes made to the MHLP between the first assessment and evaluation (in December- January 2006) and the second (in May-June 2006).
3. Focus groups and individual face to face interviews with workers: were held at Families SA, Aberfoyle Park District Office-the Intake and Assessment Team and Reunification Team (changed name to Children and Family Assessment Team-CFAT), and in Noarlunga Mental Health Services. This final evaluation report documents the findings of five worker focus groups in total - four in Families SA and one in MHS. Individual interviews were undertaken with workers who had left the Aberfoyle Park Office, managers, shift workers and those who were working in diverse MHS teams and Families SA offices.
4. Individual telephone interviews with parents involved with Families SA before and during the MHLP. The total number of parents interviewed in the first stage of the evaluation was five, three had been involved with MHLP and two were clients of the service prior to the project. In the second stage of the evaluation three parents involved with the MHLP were interviewed, totalling eight parent interviews.
5. Case Scenarios were developed by the Project Officer (Mental Health Nurse) illustrating gaps in services for parents involved with the MHLP. As part of the data gathering process and after consent was obtained from all parents, case-note reviews and client pathways were documented by the evaluators, to compare pathways between clients who had or had not accessed the MHLP.
6. Dissemination activities by the Project Officer and evaluators included: an Australian Centre for Child Protection research seminar, an invited guest lecture, Association of Children Welfare Agencies (ACWA) conference presentation and the drafting of articles for publication.

Interpretations of Data - Worker and Parent Perspectives

1. Project Referral Data

The project commenced in April 2005 and between then and July 2006 the project received 29 client referrals that required face-to-face assessments (including one off and ongoing assessments by the Project Officer), two referrals/assessments via the telephone and 15 consultancy referrals. The majority of the referrals were from the Intake and Assessment Team at Aberfoyle Park Families SA District Office but some referrals were from Noarlunga and Marion Families SA as well. Child protection concerns were very serious and only one family had a Tier Three rating.

With regards to the client group, 27 clients from 16 families were the focus of the MHLP. Of these 27 clients: two were adolescent girls experiencing mental health problems as a result of child protection issues; 19 clients were sole mothers (3 of these mothers were teenage mothers); two were fathers in two parent families whose partners were not involved with MHLP; and two mothers and two fathers were involved as couples as part of the MHLP. Families referred to the project had 1 to 4 children (total of 53 children), with ages ranging between 2 months old and 15 years.

Clients were diagnosed with a range of mental health problems: in nine families one client had a current diagnosis or previous history of major depression, in four families a parent had diagnosis of schizophrenia, in three families a parent had a current diagnosis of hypomania and the referrals included four clients demonstrating self-harming behaviour or suicidal ideation.

Other mental health problems included personality disorders, post-traumatic stress disorder, anxiety, phobias and situational crises. All clients had multiple social issues that affected their parenting, including substance abuse (10 clients), domestic violence (7 clients), a history of childhood abuse, low intellectual and learning abilities (4 clients) and literacy problems.

2. Changes made to project

All short-term recommendations in the Interim report (Appendix One) were addressed, with the exception of the development of partnership proformas, which requires change at a higher level. In the first stage of the evaluation, workers advocated for further education and training in both mental health and child protection sites; practical suggestions to improve access to mental health resources in the Aberfoyle Park Office were made and one worker suggested that a checklist could be developed as an education strategy to help identify indicators of mental illness.

Participants involved in the second stage of evaluation interviews noted a number of changes. Workers reported positively on the information and resources provided by the Project Officer at team meetings and the

development of a mental health resource board for the child protection teams in the office. As well, work has commenced on developing mental health checklists or referral tools. Joint training initiatives undertaken with COPMI such as Families in Mind Training were well attended by child protection workers. The Project Officer has also arranged for Mental Health First Aid training, which was noted by respondents. Due to improved staffing levels, more referrals to the MHLP occurred during the second stage of the evaluation project, and thus Families SA workers were able to utilise the Project Officer more.

However, the project worker changed to working part time for a short period, which was able to extend the life of the project but participants felt that the MHLP had to be a full time position, in order to be able to maintain its accessibility. Furthermore, some workers were feeling disappointed with the possibility of the project not being re-funded.

3. Findings of interviews and focus groups with workers

A large amount of information was collected from the interview and focus group respondents, and many common themes were identified. The results from workers have been presented in four main sections that reflect the questions asked during the interview. The first section examines respondents' general perceptions about the program (and a discussion of whether it met its objectives). The second section looks at specific activities conducted as a part of the Project that were highlighted by respondents as "working well". The facilitators and barriers to intersectoral collaboration are discussed in section three, with specific reference to the MHLP. Finally, participants' responses to the questions "What could be done differently and how?" are discussed under the heading, Project Improvement Themes.

General Perceptions

There was unanimous support from respondents for the continuation of the MHLP. Comments from workers about their experiences with the project were overwhelmingly positive, as exemplified by the following comment from a child protection worker:

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

A Mental Health Services (MHS) worker also comments:

The project profile within CYFS [Families SA] has made it easier for liaison with MHS to happen and certainly made workers in CYFS more aware about mental health issues, I have noticed improvement in responses in the last 5-6 months from workers in Aberfoyle Park Office and 4-5 months from Marion CYFS Office due to informal education

undertaken by the Project Officer...workers appear to more readily go out and are happy to have joint visits.

Families SA workers also noted a better response from MHS because of the Project Officer's personal network, credibility, her ability to use and understand mental health terminology and her knowledge of services. Her previous experience working in, and professional links with, MHS within the region were invaluable in fast-tracking client referrals and opening lines of communication between the two sectors.

Overall, participants commented that the project needed to “*continue to do more of the same*” and that the Project Officer needed to be “*cloned*”. As one mental health worker stated:

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

Project Objectives

Broadly, the goals of the Mental Health Liaison Project were to:

1. Improve outcomes for adults and children, which included the aim to prevent or reduce child removals
2. Improve communication across mental health and child protection services
3. Develop collaborative processes and understanding across the service systems working with this client group.

This process evaluation is unable to assess longitudinal outcomes of the project such as reducing the need for alternative care services. However, as one participant stated:

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

Statistically the project did not prevent child removal because high staff turnover, limited staff resources and an adversarial culture in child protection services meant workers mainly focusing on court issues and child removals. All workers reported that the MHLP was instrumental in “improving outcomes for clients” but workers understanding of ‘outcomes’ was complex and varied. A consideration of the best interests of the child was paramount in every case and at times child protection workers’ considered child removal the best option for the child in that context:

Mum and Dad both have a mental health issue and a newborn... the assessment we got from 3 weeks [admission in a residential mental health service for parents and babies facilitated by project worker] really made us understand that these parents are really sick, they can't care for their child, so as a result the child was a lot safer, because we

weren't going to put the child back into the parents' care as we once planned, in a way it is a good outcome because the child is safe.

At other times, family preservation was perceived by child protection staff as the best outcome:

The Project Officer was very good at coordinating everyone, put her foot down and really escalated through Mental Health Services, we would have got to the point where would have had to remove ...I think for me we probably would have removed long ago because I would have got to the point where I would not have known where to go. She has been a great asset.

Child protection workers positively commented about the approach, skills and expertise of the Project Officer and how the project 'improved client outcomes', as illustrated below:

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

The 'outcome' here was defined as improving client access to mental health services, to a mental health assessment and to new counseling, psychological and psychiatric resources. The project assisted in improving the assessment and support needs of clients, as well as supporting the development of worker knowledge.

The more thorough, detailed parenting assessment that was enabled by the MHLPP could assist child protection work to move away from 'evidence collecting' (for removal) to 'working with families' and making good assessments and interventions. The skill lies in the worker being able to talk to the families to get assessments done, to 'help' rather than to 'remove'. As one child protection worker said:

"What we really need to be looking at is a different way to be doing our work".

The MHLPP was seen to offer support to improve a range of work practices, which includes a range of different 'outcomes' and importantly, facilitates a more thorough and detailed assessment of client need and alternative interventions, which enables a more positive family focused way of working.

Specific MHLPP activities that worked well

The MHLPP was viewed as instrumental in improving communication, collaboration and understanding across services through a range of positive collaborative processes such as cross-agency training and education strategies. Improvements evident to workers interviewed were both systemic and individual in nature, although most participants commented that more time

and resources would be needed for the full benefit of this project to be experienced at a systemic level.

The Project Officer initiated systems advocacy strategies across services and participated in joint client and family assessments. The flexibility of the referral process was seen to allow for greater accessibility to the project. Working at the individual level, joint assessments (where opportunities were available) and the Project Officer's involvement in family case conferences were reported to be effective at improving information sharing between mental health and child protection services.

Particularly in Stage One, many respondents made requests for more capacity-building activities involving all staff, but acknowledged that resourcing issues and client crises had limited their ability to attend some activities. The project was able to improve the knowledge of staff in both services through:

- initiating capacity building activities such as sharing information, organising the Advancing Agency Sharing Forum and case conferences involving a range of services,
- the dissemination of reference or resource materials at team meetings and on the resource board, as well as
- by facilitating training and education initiatives such as Families in Mind and Mental Health First Aid training.

Linkages with other interagency collaborative projects such as the Children of Parents with Mental Illness Initiative (COPMI), Adaire Clinic's Parenting Support Project (funding not continued), the Marion DASSA-Families SA Partnership Project, and attendance at partnership meetings, were key to developing strategies for systemic change.

Facilitators and Barriers to Service Collaboration

Key themes about how the project was viewed as contributing to improved collaboration included:

- The project served as a bridge or link that improved communication between workers in each service.
- Cross-service and cross-discipline education strategies initiated by the project worker improved the knowledge of workers in both services.
- Joint client assessments with the Project Officer were a key project activity that enabled improved client focused communication between mental health and child protection services.
- The expertise, personality, experience, skills, knowledge and availability of the Project Officer in the project are of paramount importance in 'making the project work'.

The results from interviews with workers in both child protection and mental health services showed overwhelming support for the project and for the innovative idea of a Mental Health Nurse working in child protection services.

As worker participants highlighted, by improving collaboration between child protection and mental health services, the MHLP was seen to:

- enable clients to have a better understanding of what the roles of different agencies are;
- improve networking across services;
- provide ongoing advocacy and support for parents with a mental illness within the child protection system;
- make for more efficient services;
- reinforce case plans for clients;
- offer a multidisciplinary mix of ideologies;
- enable mental health and child protection workers to have fewer conversations that focused on child removal and to have conversations that were more client-focused; and
- enable joint intervention which resulted in different pathways for families.

Participants reported that the MHLP improved communication, information sharing and knowledge across both services and facilitated a shared emphasis on parents and children, while maintaining distinct role definitions. The formal and informal mental health networks developed by the project worker enabled her to engage in advocacy across services for better client outcomes and for improved service collaboration.

The advocacy strategies developed by the project worker in mental health services aimed to increase the awareness of workers when conducting their risk assessments about the importance of considering the parenting responsibilities of parents with a mental illness. In child protection services, the advocacy strategies were aimed at improving parenting assessments that included the development of mental health knowledge and understanding, which enabled an improved response to parental mental health issues by child protection workers. Some participants advocated a family-centred focus as a component of the child centred approach. Improving access to a range of mental health and family preservation resources (such as parenting support agencies that provide practical help and behavioural programs for parents) was seen to be important.

The availability and accessibility of the Project Officer were also important to the success of the project. Personal and professional expertise such as displaying a calm manner, having a high profile, a good reputation, good mental health knowledge, the skills, knowledge and the ability to be supportive, being able to take a pragmatic approach, to be receptive to ideas, an intersectoral mind-set, and the commitment to taking a collaborative approach were deemed important.

The Project Officer was able to gather and interpret mental health information about clients and understand the language of mental health that assisted in facilitating accurate parenting assessments and intervention by child protection workers. The sharing of confidential information was made possible because key individuals in the mental health services had trust, respect and confidence in the clinical skills of the Project Officer. Respondents identified that part of the reason for the project being so successful was because of the clinical skills

and extensive experience of the Project Officer. This was typified by the comments of one child protection worker:

Her personal skills shine in the office-no matter how difficult the client or difficult the situation, it is her years of experience, she knows how to do that and she sees from our perspective now how difficult it is because each agency has fences up, gate-keeping to stop work flow. We are working on ours they are working on theirs, and trying to see how we can break down some of these fences and find some boards across and if we can co-work, rather than "it is your responsibility", how about "we do this together, this is my role, this is the information I can share with you" and trying to improve that general flow (of information).

To be effective at collaboration, this type of project requires experienced staff with credibility in child protection and mental health services, an ability to network, have knowledge of both services and be able to develop links between organisations. Therefore, the project requires Project Officers with adult mental health experience; a child and family focus and who have at least a Level 3 Nursing classification.

According to one participant, overseas research affirms that the MHLP is on the right path because in order to succeed in interagency collaboration it is important to develop protocols from the local level. The process of having to work on protocols together at the local level is just as important for developing an improved understanding and practice model as what is achieved. Thus, both the process of collaboration and the outcome (e.g. a policy) are key to effective partnership projects.

The Mental Health Liaison Project had a high profile because a range of services and individuals supported the innovative nature of the project. Strong links and networks were developed with other workers involved in intersectoral collaboration. Broad support for the project at the higher policy levels and local support from workers ensured that many individuals were committed to the issue of supporting parents with a mental illness and to agency partnerships. However, whilst there is policy support 'across government' for collaborative partnerships, it was also apparent to workers in both services that many barriers to collaboration still existed.

Barriers preventing collaboration between mental health and child protection services

Workers identified a number of barriers to service collaboration, including:

- Bureaucratic processes that delayed the start of the project
- Uncertainty about an ongoing commitment of dollars and resources
- A lack of bipartisan support (advocating for joint child protection and mental health funding and partnership)
- Lack of time to build relationships between mental health and child protection services
- Staff turnover and volume of work (including issues about a perceived flood of referrals if services collaborate)
- Bunker or silo ways of working and thinking
- Fear of the unknown and change

- Inadequate staff training
- The myths and mystique around what child protection and mental health services do
- Different legal responsibilities and interpretations of legislation (for example of the youth court compared to the guardianship board)
- Confidentiality
- Staff 'on the ground' in both services being asked to broaden their horizons - some enjoy this and some resist.
- Different service orientations - for child protection services, the client is the child and for mental health services, the client is the adult.
- Different service timelines
- The 'us and them' culture, which has a long history
- Professional attitudes and lack of understanding
- The complexity of cases
- Community perceptions

Although the project was seen to significantly improve collaborative processes between the two services, it was noted that a strong 'us and them' culture still exists between child protection and mental health services, and one person is not enough to change this systemically. As one child protection worker comments on the limitations of one person:

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

The attitude and knowledge of professional workers employed in both services and community understandings of the role and function of child protection and mental health services are key hurdles that need addressing.

As one child protection worker states below, the education initiatives implemented by the project were slowly working on these attitudes:

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

The complexity of cases that the services and project dealt with were also reported as barriers to interagency collaboration because both services were holding the other service accountable to help 'fix the problem' or find a solution. This is well expressed by a child protection worker who said:

Interagency or inter professional conflict is worse in bad cases, what happens is you see the other person as having the solution, you can't fix

it, so you imagine they can fix it, so you blame them for not fixing it and then get angry... I could see that all over the place.

Project Improvement Themes

Respondents made a number of suggestions about how the project could be improved. The project is seen as innovative because it was the first example of a mental health nurse being employed in child protection services, but it took many months to negotiate how child protection services could employ a Mental Health Nurse. Therefore, in order to expand this inter-organisational project, procedural issues relevant to the secondment of workers could be improved.

The most common vision for the project was to fund a MHS worker in every Families SA office throughout the state, with the support of a consulting visiting psychiatrist and a coordinator (similar to what is already in place with psychologists). According to one MHS worker, support for mental health nurses in child protection would be needed because they are working in a non-traditional nursing area. The following suggestion was made:

I would recommend that CYFS offices across the metropolitan area employ a Mental Health Consultant, one person to coordinate all Consultants to provide support and direction for workers and ensure standardisation of the consultancy across CYFS offices.

Families SA staff discussed the value of having a Mental Health Nurse work across teams within the same office, across District Centres and across other services. One Mental Health Nurse that works across different teams is able to share the workload and provide good consistency for families, as long as the worker is not overwhelmed with referrals. The MHLN linking with both the Child and Family Assessment Team, and the Intake and Assessment Team is important because as one respondent said:

It takes time, if a child or baby has been removed, it can take time to work through the mental health issues of parents and really giving them a chance... that is really important.

Mental health is a dominant and important issue to consider in child protection assessments. Participants from both services suggested that child protection services develop “pockets of expertise” such as mental health teams, so that people with expertise can be available for training, consultation and co-working. As the Project Officer was not attached to a caseload, she was highly accessible and responded quickly to requests for consultation and assessment. However in Stage Two of the Evaluation, when the Project Officer position had decreased to part time, it was recommended by all participants that the project be continued in a full time capacity.

Another popular suggestion was to nominate a primary person in child protection and one in mental health services to work together on systemic change. However, one nominated key person in mental health services, who was also working on a partnership project had lost its funding, which decreased the focus on working with supporting parents in that particular office of mental health services, and made collaboration across services more difficult.

In Stage Two, there was a great deal of concern that this short term funded partnership project was facing the same fate. All participants were keen for the project to be continued and permanently funded. As one child protection worker stated:

She has very much been accepted in the office, everyone likes her and wants her to stay... I have had feedback from workers who are saying what am I going to do if she goes?

In conclusion, in response to Stage One of the Evaluation of the MHLP, most short-term recommendations in the Interim report were fulfilled. Many new resources and training and education initiatives organised by the Project Officer had been accessed and were well received by child protection workers. However, as one participant stated, the ongoing funding of the MHLP is dependent on political will, it needs 'dollars' and both child protection and mental health services need more resources to jointly fund the project. The MHLP needs bi-partisan funding support by both mental health and child protection.

4. Findings of Interviews with Parents

Many similar themes emerged when analysing the perspective of parents. Parents stated that an improvement in both mental health and child protection services was needed and overwhelmingly agreed that the project was useful, funding should continue and that it should be made permanently available. From the perspective of parents, the limitations regarding child protection and mental health services, generally (although these were not applied to the MHLP) were related to:

- a lack of communication with service users;
- staff turnover;
- access to appropriate services;
- a perceived lack of follow up support by crisis services;
- the ability and capacity of families to follow up referrals;
- parents' relationships with workers;
- how appointments were managed;
- the limited effectiveness of interventions; and
- few available support, respite and mediation services to assist in improving parenting skills.

Seven out of the eight parents interviewed were women and six were single parents. Some participants argued that services for women escaping violence and for single parents needed to be a funding priority.

The evaluation of the MHLP by parents elucidated positive themes regarding the approach, accessibility and assistance of the Project Officer that was similar to worker perceptions. Negative comments about services by parents were more generalised and related to both mental health and child protection services not being able to offer them what they needed or wanted, the effect of statutory surveillance and in one instance, the issue of confidentiality and

cross-agency information sharing was raised. Key findings are discussed below, using the interview questions asked as a framework for discussion.

What has been working well with the MHLP?

The approach of the Project Officer: The Project Officer was reported as empathic, respectful, easy to talk to, very helpful, sounded good, listened to concerns and what people did and didn't want, sensitive, polite, and well-mannered. Parents felt confident in her ability to assist and she referred clients to a diverse range of services including mental health services. She also acknowledged parent expertise about previous experience with services and 'is very committed to her job'. This ability to develop positive relationships and the experience and skills of the Project Officer led to hopefulness and high expectations of services being able to assist. All participants were happy to be involved with the project and in some cases had recently asked for the Project Officer to contact them.

Parents said that the Project Officer employed in MHLP helps by talking, listening, *"really cares about people she is working with", "makes me feel very much at ease"*, is non judgmental and acknowledges parent decisions. She is clear about intervention plans and guidelines, respects confidentiality but also her mandatory responsibilities to report. The Project Officer was seen to offer optimistic, positive affirmations, such as

[She] tells me I'm a good Mum, doing the best I can, doing great with what I have got; you don't need people judging you. This increases my confidence and ability to parent, makes me feel good about myself.

Accessibility of the project: The Project Officer was seen as always accessible and available. Participants felt confident that they could contact her to make an appointment and that this would happen. Although one participant stated she had tried to ring the office, asked her Families SA worker and other services to contact the MHLP but they *"did not seem to know who [the Project Officer] was"*.

Talking, listening and practical assistance for both parents and children: Parents reported positive effects of being able to talk about problems and being listened to respectfully by the Project Officer, which is valuable and makes parents feel that their issues are important. The project was able to arrange practical assistance to both the parents and the children and this was seen as particularly helpful.

How has it improved service to adults and children?

The Project Officer was able to facilitate referral to services that assisted both adults and children, which was broader than access to mental health services. For example, one referral enabled parents to have respite from parenting responsibilities and support for themselves. In another situation, the MHLP and Families SA worker assisted a family to access domestic violence emergency accommodation:

[The workers] helped me get out of situation I couldn't get out of myself

The Project Officer was instrumental in this because *“she made me realize I was not worthless... kept respect for me”*.

The majority of participants indicated they were involved in a number of supportive services that Families SA and the MHLP referred families to, but not all of the services could offer what clients wanted regularly. At times participants felt there were not enough support services available for them and they had developed their own ways of coping. As one participant said:

Workers suggest strategies or guidelines about how to do things but it doesn't work... in the end you are on your own and find your own strategies.

Participants stated that contact with the project assisted them to parent more effectively and help them with their thought processes:

It is good to have a Mental Health Nurse in CYFS for people like me, to help me 'keep my mind straight', so I don't lose control at the children.

Another participant said:

Not just for me but for all parents with a mental health problem and a child with a disability, children are hyperactive, on drugs...parents need someone to help and guide them as to what to do with any child, even normal children can get out of hand...[services] can help with the right way to deal with it.

Parents also saw the project as being able to advocate for the needs of parents with a mental illness within child protection services, as indicated in the following quote:

[Families SA] workers are not equipped to understand mental health, sometimes we are just not well at the time...we won't always stay that way. The MHS worker is an advocate in FAYS [Families SA] that there is not the need to remove children, that children are what is keeping the parents together and the MHS worker understands this.

This parent predicted that if the support of the MHLP continued there would be less child removals from parents with a mental illness.

What could be done differently?

When referring to what the MHLP could do differently, participants suggested a number of things they could be assisted with, such as accessing a psychiatrist and medication that suits them and they are happy with, practical assistance or services that would help them to care for their children, help with attending medical appointments, transport to shopping and assistance with the family court. One participant felt frustrated at the lack of change in the family situation and said:

We were referred to 4 organizations and then didn't hear from [project officer] or CYFS... still nothing has changed practically and the situation is still the same.

A number of participants felt that their own ability to follow up referrals could have been different:

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

Another parent said:

I have hunted high and low for that card she gave me but I can't find it...now I am more ready.

One participant gave the project a rating of 8 out of 10 and the 2 out of 10 loss was *"that I should have kept in contact and followed up"*.

The general consensus was that the Project Officer *"does all that she can with what she is given"*, that she *"does everything within her capacity"*. Barriers to working with both services were when workers were unhelpful, disrespectful or condescending and their intervention further increased the parents' stress, anxiety or depression levels. General comments made were that 'the government' should give more funding to services in the areas of mental health, child protection, drug and alcohol and domestic violence services. There are few appropriate vacancies in domestic violence services, long waiting lists and more time needs to be allocated for workers to be able to deal with multiple client issues.

However, most negative comments were not in relation to the MHLP but were related to parents' experiences of accessing and being clients of Mental Health Services and Families SA more generally, as can be seen, below.

Mental Health Services

There were obvious barriers in accessing the services that participants were seeking, and experiences of mainstream mental health services weren't always helpful. One participant said:

MHS seem to think I don't need them...that I need more parenting support not mental health support.

As well, one participant wanted a female psychiatrist and another wanted a male psychiatrist but neither were able to access the psychiatrist of their choice. Similar to the perspective of some workers, one participant who had difficulties accessing a psychiatrist said:

Why don't CYFS have their own psychiatrists (female and male), so parents can access them?

One participant who reported some improvement in parents' experiences with MHS said:

Sometimes services are not 100% but they are better than nothing... If there was no mental health project, it would be a lot worse.

Families SA (formerly CYFS)

Parent perspectives about their involvement with Families SA were mixed. It was commented that Families SA (formerly CYFS and FAYS) continually

changing names did not make it any more family friendly, that it makes no difference, 'no matter what' workers still have the power to remove children.

One participant offered a glowing report of the support Families SA were able to offer and stated she therefore did not require the services of the MHLP. She said: *"everything was covered from A to Z"*.

In relation to referrals to the MHLP by child protection workers, one participant suggested that:

The [Families SA] worker could have seen me a few more times because it felt like 'pass the parcel' to the Mental Health Nurse.

Worker-parent communication about the plan for their case was a key area discussed that needed improvement. The staff turnover in the Families SA office was evident to clients:

They gave me too many Social Workers, they closed the case and I didn't know, they didn't ring me.

Another participant said:

The SW went to another job and never heard from anyone since. Nearly one year has passed and I have not met the new SW, case-manager. Don't know who it is and who the right person to talk to is.

Another said:

I didn't find out that my worker at [Families SA] had changed until I rang for a financial counseling appointment.

On the other hand, one participant had experienced good consistency of workers *"who know and understand the family background"*. She had 4 different workers in 3 years, which the parent thought was *"not too bad"*.

Participants who had not been involved with the MHLP advocated for child protection workers to ring to make convenient time to discuss notifications instead of arriving at homes unannounced. Living with this uncertainty was reported as very stressful, particularly for parents with mental health issues and it was feared that it could lead to a mental *"breakdown"*. Whilst child protection workers had a respectful manner, some parents mentioned they felt under surveillance:

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

The fear of child protection services and statutory intervention caused them stress and some participants suggested that their involvement with Families SA contributed to reducing their mental wellbeing and making it even more difficult to parent.

However, one participant said that surveillance was 'good' for her:

Although... surveillance is 'doing good for me', it keeps me having to do things, to keep myself together. I'm different to some other clients; I asked for help and embraced the help.

Comments on stigma and confidentiality

Most parents said that workers were: “*very careful about confidentiality*”, they had signed consent forms and the Project Officer informed parents that they could withdraw consent as well as what her mandatory requirements were. They felt that sharing information across services was good “*so I don't have to tell my story again, again and again*”. As one parent stated:

It gets depressing telling the same thing over and over again, you start to think to yourself, 'God is it that bad?' and feel depressed, get more depressed, get judged by more people, feel more put down.

It was perceived that having the Mental Health Nurse work together with child protection services was “*like two appointments in one*”. However, on occasion the parents discussed the stigma associated with being a client of child protection and mental health services and that seeing two government workers made them feel like they had to defend themselves. One parent also suggested that the Project Officer could introduce herself as “*working in the field of mental health*”, as the title “Mental Health Nurse” could imply that she is assessing clients for admittance to residential mental health care. This participant suggested there was a need for an independent Mental Health Nurse and a voluntary family mediation service that can visit parents intensely when situations change, without the unnecessary involvement of a threatening statutory government service.

One participant suspected that a Families SA worker had information about her from MHS without her consent and was not happy with how the child protection worker confronted her about an incident documented in the case-notes of mental health services. She suspected that the worker:

...had been reading on the computer, talked to MHS about my private stuff, and got it 'all mixed up'

This illustrates the need for a Mental Health Nurse in child protection services to be able to sensitively address and discuss mental health issues with parents and to be in a position where they are seen as legitimate in sharing information with MHS.

Interrelationship between different social issues

Participants discussed the interrelationship between parental mental illness and childrearing:

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

Other issues discussed that interrelated with mental illness and child protection included experiencing domestic violence, children witnessing domestic violence, poverty, the stress of being a single parent, drug and alcohol issues such as smoking marijuana and how this interrelates with mental well being and parenting ability. As one parent said, issues interlink (and so should services):

Mental Health is a big thing, especially for people with kids, especially for people with drug problems; it's more common than you think, now that it is out in the open.

Parents' visions for the MHLP

All participants advocated for the project to continue. They all stated that the project and funding should continue and that it should be made permanently available. As one parent said: *"I totally believe that she should be permanently funded"*. A suggested vision for the project was that:

They have more than one Mental Health Nurse in [Families SA], that one Mental Health Nurse to 10-15 clients would be ideal...that each office should have at least one Mental Health Nurse and major offices should have two...They are always advocating to 'keep families together'... this is how they can help.

They believed that the Mental Health Nurse would:

...help [Families SA] workers deal with parents with a mental illness because they don't understand mental illnesses much.

One participant commented on the importance of being able to access a Mental Health Nurse:

...sometimes people need it and sometimes they don't but it is up to them if they needed one and if they needed one, a Mental Health Nurse would be available.

Overwhelmingly, parents stated that: *"there is not enough being done around mental health"* and that there are certain times when people with mental health problems are less receptive to help, so ongoing follow up support by the MHLP after a crisis is needed.

Potential of the MHLP to assist parents who have not had any involvement with the project

Furthermore, parents who had not been involved with the MHLP thought it would be good to have an accessible Mental Health Nurse in Families SA because it would improve services and help support children and parents. One participant thought it would be useful for the Mental Health Nurse to *"speak to kids about the trauma they have experienced"* and to parents about depression and suicidal thoughts.

The majority of parents wanted support and assistance and found it helpful to have people to talk to and *"guide me through"* decisions, which the Mental Health Nurse could do. They wanted to be, and believed in being, *"good*

parents” and saw that the MHLP may be able to assist with that. As one participant said: “*I do what I can to the best of my ability*” and extra support at times is useful. These parents thought the MHLP would assist them to work towards being the best parents they can be and they would consider becoming involved with the project if it was available.

5. Case Note Reviews and Client Pathways

As a component of the evaluation, case notes were reviewed (with client consent) and client pathways were documented, with the aim to illustrate differences as a result of the MHLP before and after the Project Officer commenced in child protection. The limitation of the pathways case studies are that they are a ‘snapshot’ of a moment in time and changes in intervention and family circumstances after the case reviews are unable to be documented.

Consent was given by all eight participants to view case notes. However, the small sample group, the complexity of issues and other factors influencing client pathways including the severity of the allegation, the level of disability as a result of mental illness, whether or not the parent wanted mental health intervention and the number of different service referrals, made it difficult for the pathway analysis to draw any conclusive findings that were different to the interview findings regarding the perceived impact of MHLP involvement. Case notes reviews tended to mainly reinforce or enrich and give more detail and depth to data collected through research interviews. However, one noted finding was that for both families where the MHLP was not involved, unaddressed mental health issues had an impact on parent wellbeing and these issues were not assessed by child protection services, including suicidal thoughts (with a likely impact on parenting issues).

6. Dissemination Activities

Participants stated that it is important to disseminate information about the effectiveness of this project to a wider audience, it is important to say ‘we have got a better way of working’. As one mental health worker said:

This is a big breakthrough, to employ a MHS person in a CYFS office, it is very appropriate for independent people to talk about how that looks... Is it a good idea? Is it a waste of resources?...the dissemination of that.

The Mental Health Liaison Project offers a fundamentally different approach, which is supportive to parents and their children as well as to staff in Families SA and MHS.

After the interim evaluation of the MHLP, the Project Officer and the Australian Centre for Child Protection have collaboratively presented the project and the findings of the evaluation at a research seminar, and also gave an invited guest lecture. The evaluation findings were presented at the Association for Children’s Welfare Agencies Conference in Sydney in August 2006, and will be presented as part of a plenary symposium at “Borders and Bridges”, the Australian College for Child & Family Protection Practitioners Conference in

May 2007. As well, the Project Officer and evaluators are in the process of collaboratively writing journal articles to disseminate the results of the project. To date the dissemination activities have led to inquiries from the United States, New Zealand, Victoria, New South Wales, Queensland and the ACT about the model, as similar initiatives are being developed, trialled or disseminated in these areas.

Conclusion

Many similar themes emerged when analysing the perspective of parents and workers. Key themes emerged in the evaluation of this innovative mental health project and these were:

- that this project was an exciting innovative idea, which needed ongoing funding to continue and to expand;
- an acknowledgement that the person employed in partnership projects made a difference to the success of the project;
- that child protection and mental health services working together to assist individual clients is of key importance; and
- that change at a systemic level is required for partnership projects to be sustainable.

This evaluation of the Mental Health Liaison Project had a number of broader implications for child protection services and illustrated a number of factors that facilitated and were barriers to developing collaborative relationships with mental health services. Clearly, a more preventative approach to child protection and mental health was indicated; and extensive, ongoing work is needed in addressing fundamental differences in the 'us and them' culture that exists between child protection and mental health services.

Recommendations

There was a high degree of consistency in the proposed recommendations of clients and workers across different levels and in different service sectors. The recommendations in this final evaluation report have been clustered into short term, medium term and long term.

Short-term recommendations (as a priority)

1. To continue the Mental Health Liaison Project and consider permanently funding the project on a fulltime basis.
2. To continue to address recommendations from the Interim Report as outlined in Appendix One.
3. To disseminate information about the success of the MHLP and to use this project as a model for the future.
4. For the Project Officer to formalise practices - document keys details and plans for individual clients about the processes involved in obtaining information, accessing services, key people involved - what to do, who to contact and how.
5. To develop a Joint Risk Assessment Form for child protection and adult mental health workers.

Medium term recommendations

1. For the Project Officer to participate in the development of agency policies and procedures, to assist collaboration at a policy level between mental health and child protection services.
2. To increase the capacity of the MHLP to further build links and networks, such as with Child and Youth Health nurses involved in the family home visiting program, child-parent attachment programs, and other intersectoral programs and initiatives. For example, the findings of this evaluation and the 'learnings document' can contribute to the SA COPMI Partnership Plan.
3. For the Project Officer to document 'learnings' from the project - what she has been doing, what is valuable, key things that are good to repeat (noting transferabilities) and record any information to pass onto workers about what worked well and what didn't. The sharing of this information could be done in a number of ways, including writing a journal article, preparation of training, and conference presentations.

Long-term recommendations (for consideration by funding bodies)

1. To expand the Mental Health Liaison Project and employ more Mental Health Nurses in Families SA. Particular attention should be paid to the manner, skills and expertise of any Mental Health Nurses employed on the project. The project requires Project Officers with a child and family focus and adult mental health experience, and to be at least a Level 3 Nursing classification. These characteristics were highlighted as important facilitators of intersectoral collaboration and parent engagement.
2. To include rigorous outcomes and process evaluation methods with any expansion of the program, including changes in worker knowledge as a result of the program, and details of how aspects of the project officer-client relationship can influence client engagement and outcomes.
3. For child protection and mental health services to develop stronger early intervention roles (and thus, assist the Mental Health Liaison Project to achieve its preventative aims).
4. To explore links with non-government organisations, to initiate new services and develop current ones, that offer in-home support for parents with a mental illness.
5. To support the multidisciplinary training of agency staff at multiple levels, including through University undergraduate and postgraduate courses.
6. To liaise with agencies (such as SA COPMI) that can assist in the training of staff across different organisations to improve staff ability to talk with children about their experiences of having a parent with a mental illness.
7. To consider a longitudinal research study that assesses the longitudinal outcomes of the MHLP, which includes monitoring interventions (such as child removal) over time, as well as how the project impacts on staff attitudinal changes and improves the knowledge and understanding of workers in both agencies.

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APPENDICES

Appendix One: Recommendations from Interim Report

The recommendations for the interim report were based on the interview data from respondents in that stage of the study and have been clustered as short term, medium term and long term recommendations. Additional recommendations will be developed on the basis of feedback from clients and the results of action research in the second stage of the evaluation. The recommendations in the interim report should therefore be regarded as provisional. However, it should be noted that there was a high degree of consistency in the proposed recommendations of workers across different levels and in different service sectors.

Short Term Recommendations (for action research that can be achieved for Stage 2 of the evaluation)

1. For the project to continue and to include monthly supervision;
2. To continue to enable the supporting of Families SA (and MHS) staff on individual cases, including joint assessments on new investigations (as needed such as where parents have barriers and/or complex issues) and working across teams;
3. Develop Mental Health Resources for Aberfoyle Park District Office Families SA (for workers from all teams), including initiating and updating a Mental Health Resource Board, a mental health information folder for the computer and more pamphlets about diagnoses, treatment and mental health related services;
4. Nominate key liaison persons in MHS and Families SA to work together, with the aim to further improve communication and understanding across services;
5. Continue training and education sessions in team meetings of all MHS and Families SA teams;
6. Given the complex needs of this client group, continue to develop links with drug and alcohol and domestic violence services; and
7. To further examine the role of the MHLP with families in which a notification has been classified as "Tier 3".

Medium Term Recommendations

1. Develop a Cross Agency Education Program, to teach Families SA about mental health and to teach MHS about the role of the project and Families SA, and assist to develop a family focused approach in both services;

2. Offer regular 45 -minute education and training sessions on different aspects of mental health and invite all Families SA teams, if attendance at team meetings is not possible;
3. Continue to develop cross agency case conferences and Agency Sharing Forums, and invite all staff;
4. Enhance the preventative focus of the project by formal inclusion with the High Risk Infant project;
5. Develop strategies to help workers engage children around parental mental health issues; and
6. Develop proformas for secondment, referrals and assessments to improve efficiency in employing staff across service systems.

Long Term Recommendations (for consideration by funding bodies)

1. Make the project permanent and embed it in policy and practice. Examine bilateral funding options;
2. Scope resourcing and expansion of the project to other District Offices and across teams within each office, with support from the Families SA Head Office and the Department of Health. This would include: adequate infrastructure (e.g., policies and procedures around employment, referral, governance and information-sharing); the appointment of senior Clinical Nurse Consultants (CNCs) with experience in the region/district in which they would be seconded; and ensuring the CNCs can continue to be highly accessible and available for Families SA and MHS workers (i.e. no individual caseloads);
3. Develop pockets of expertise in Families SA, (e.g., a small mental health team working in Families SA with a Families SA focus, which would include a visiting psychiatrist); and
4. Use this innovative project as an example for future partnership projects in a variety of different settings within Families SA and other services (e.g., drug treatment, domestic violence and disability services).

Appendix Two: Proposal for the Mental Health Liaison Project

Expression of Interest Application Form

1. Lead Unit and Contact Details

Gayle Bartlett, Supervisor

Intake and Assessment Team, Aberfoyle Park DC CYFS

Shop 15 Aberfoyle Hub Shopping Centre Hub Drive Aberfoyle Park

Ph: 8374 6111 Fax: 8374 6100

2. Project Title

This innovation submission seeks funding to trial a multi-disciplined approach that will provide assessment a 'fast track' referral for parents experiencing mental health difficulties, with the aim of assisting them to continue to care safely for their children. This project would employ an experienced Mental Health Nurse within the intake and assessment team to work with parents with Mental Health issues.

3. Summary of Project

Proposal Statement

Children in families in which the parent(s) have mental health issues are known to be at heightened developmental risk. Although services exist in South Australia to assist adults with mental health concerns these services do not assess or focus upon the needs of a substantial subgroup, that of the children in their families who are identified by CYFS as "at risk".

A Mental Health Nurse in the Aberfoyle Park District Centre Team, can assist with the assessment of parents and mobilisation of services appropriate to a family's need, thus it is possible for families 'affected' by mental health problems and disorders to remain intact and functional. This requires proper assessment of the 'affected' parents presentation and parenting with the goal of facilitating relationships with mental health services in order to gain appropriate services for these parents.

Objectives

It is hoped that over the cycle of the project this mental health assessment / liaison position will:

- Improve the quality of life for families where mental illness is an issue for the parent and reduce risk factors (children as carers, psychosocial impact on the child) for children who are assessed as at risk by CYFS.

- Trial a multi-disciplined approach to providing assessment and referral for parents experiencing mental health difficulties to continue to care for their children.
- Assist parents involved with CYFS to access a range of services (psychiatric, psychological and counselling).
- Increase the parent's ability to retain the care of their children and thus reduce the Departments applications to the Youth Court in cases where the mental ill health of the parent(s) is a key factor.
- Facilitate networking that will enhance the ability of adult mental health workers and others (community response) to provide family-focused (parenting/child welfare focused) care to clients with dependent children.
- Identify further possibilities and develop creative methods of increasing the ability of CYFS to preserve these families and thus lessen the impact on the children and State alternative care services.
- Assist with a thorough evaluation of the position including statistical data, strengths of the position and challenges.

For further background information see attachment 1

4. Outcomes

Relevance to 2004-2005 CYF'S Strategic Plan.

This proposal seeks to trial a way of working that embraces the 2004-2005 Strategic Plan (Draft Only). The following Goals are highlighted.

- 1.1 Across government and community sector integrated policies and programs for prevention and early intervention
- 1.2 Families are supported and strengthened to protect and care for their children and provide safety for all family members
 - Care and Protection – Refocus resources towards family support.
 - Better Business Management – Evaluation frameworks for new service initiatives.
 - Strengthening Families – Build partnerships to ensure services are delivered to highest needs cases.
- 5.2 CYFS has a skilled, diverse, confident, multi-disciplinary workforce
 - Workforce Capacity and capability – develop multi-disciplinary teams.
 - District Centre Employees can be directly involved with planning.

Relevance to 2004-2005 South Australian Strategic Plan.

This proposal is consistent with the State Strategic Plan. It fits within Objective 2: Improving Wellbeing. In particularly *The Plan* subsection, *Work to close the gaps, Place more emphasis on prevention and Protect our children* (State Strategic Plan, 2004, p: 33). The *Priority Actions* for the subsection *Healthy South Australians* are particularly relevant for this project. They are:

- *Give greater priority to prevention, early intervention and health promotion*
- *Strengthen primary health care services, including opportunities for general practitioners, allied health workers and issues to work together to provide easier access to their services.*

- *Improve health services for the most vulnerable people in the community, in particular Aboriginal people, children and young people, people with a mental illness and the frail aged (State Strategic Plan, 2004, p: 35).*

5. Key Partners

The following is a list of supporters of our project, they are not contributing financially but may assist with clinical supervision of the employee.

- Mental Health Services
- Noarlunga Mental Health Services
- Adair Clinic
- Helen Mayo House
- Flinders Medical Centre (Psych Liaison)
- Division of Southern GP's
- Flinders CPS
- ARAFMI Assoc of relatives and Friends of the Mentally 111
- COMIC Children of Mentally 111 Consumers
- COPMI Children of Parents with Mental Illness

To see support letters and emails see attachment 2 to 5

6. Support / Resources

It is expected that this position will work alongside the social workers and thus access to Child Protection skills and experience would be compatible with current employees.

- Colleagues: PSO 1's working in the area of child protection
- Infrastructure of office
- Key partners

7. Budget

Budget Considerations (based on already existing Department Project Planning Estimations)

The budget is based on an RN2 (Increment 4) award but may be less (for period of 12 months).

ITEM	BUDGET	NOTES
Salary & Related Payments	52,966.00	RN 2 (Increment 4)
Operational Expenditure		
TOTAL OPERATING EXPENSE	18,109.00	Includes car
Accruals and On Costs		
TOTAL ACCRUALS & ON COSTS	14,337.00	
Advertising Costs	1,000.00	Newspaper advert
Evaluation Cost	20,000.00	Based on estimates from UniSA
TOTAL EXPENSES	\$106,412.00	

For further detail of budget see attachment 6

8. Evaluation Process

The team has begun a process of discussion with UniSA to assess their possible involvement in the Evaluation. It is expected that the evaluation be outcome focused and identifies clearly how this multi-disciplined approach has impacted on 1) clients directly, 2) the team 3) the organisation 4) relationships with other services.

It is hoped that the evaluation will incorporate:

1. Statistical collection – data (a data sheet has been devised already, see attachment 7)
 - Personal details
 - Intakes
 - Court Cases
 - Re-unifications data
 - Children removed for MH issues (reduced/increased)
 - Parents accessing MHS (increased)
2. Qualitative information collected from key stakeholders. Including:
 - The Nurse
 - Workers
 - Manager
 - Supervisor
 - Clients
 - MHS workers
 - The Steering Committee (made up of key partners)
3. We intend to collect data throughout the project (See attachment 7).
4. We hope to have a short evaluation half way through and then a larger evaluation at completion
5. We hope to disseminate the information via a report and presentation.

Dissemination

1. A written report highlighting the outcome will be undertaken by the DC.
2. This report will be provided to the:
 - Manager of the District Centre
 - Regional Manager's
 - Directors
 - The Chief Executive Officer
3. A presentation will be held for those above and interested parties prior to completion of the project.

In conclusion the impact of parental mental illness on family life and children's wellbeing can not be overstated. The challenges in working with families experiencing these difficulties will not reduce over time. Innovative positions of this kind are needed to begin to develop a response to this growing area of concern.

Attachment 1. Further Background Information

Background (The interaction between Mental illness and Child Protection).

Parental mental illness and its impact on children are well documented in a variety of journals. Statistics from the United States identify that parents with mental illness are vulnerable to losing custody of their children. Studies report rates as high as 70%-80% of parents experiencing mental health lose the custody of their children (NMHIC accessed 12/7/04). Australian statistics describe that a significant proportion of the community experience serious mental health concerns. In the last fifteen years South Australia has experienced a deinstitutionalisation movement. This means that it became desirable for people with mental health issues to no longer be cared for in institutions. Apart from a small percentage of people voluntarily admitted or assessed as detainable by a medical practitioner (Mental Health Act, SA 1993), the majority of people continue to live in the general community and rely heavily on community mental health services for support. With these changes a greater number of people have gained the freedom to experience parenthood.

The reality of this impact is identifiable for a significant number of children assessed by CY&FS throughout child protection investigations, interventions and reunifications. The mental health status of a parent is often a key factor impeding the parent's ability to care safely for their child(ren). In fact American research identifies that "women and men with mental illness are at least as likely, if not more likely ... to become parents" (NMHIC).

Service Needs and Barriers.

On consultation with members of the Aberfoyle Park District Centre, it was found that the recurring barriers to services are:

- The waiting lists at mental health specific services
- The strict criteria of the services means that many clients "fall through the gaps"
- Clients reluctant to follow up with mental health services as they are voluntary services
- The client's denial of any mental health issues
- Willing client's not being able to access services due to location
- The agencies focus on their client ie the adult

The Aberfoyle Park District Centre of Children, Youth & Family Services provide the following statistical data to identify the prevalence of children (in our jurisdiction) experiencing a less than satisfactory childhood where the parents' mental health condition is a key factor:

All current families (often more than one child) open.	69
All families where the parents "mental health issues" are a key factor.	28
All families where the parent is not receiving assistance from a mental health service.	19
All families taken to Youth Court in the previous two years where the parents "mental health issues" were a key factor.	16
All families currently under 12 month orders where the parents 'mental health issues' are a key factor impeding reunification.	11

Attachment 2. Support Letter from Mr Don Tustin from Noarlunga Health
Services

Noarlunga Health Services
Division of Mental Health
Adaire Clinic

Alexander Kelly Drive
Noarlunga Centre
South Australia 5168

Telephone: (08) 8384 9599
Facsimile: (08) 8374 1629

17 August 2004

Gayle Bartlett
Team Leader, Intake and Assessment Team
Children, Youth & Family Services
Aberfoyle Park District Centre
Shop 15,
Hub Shopping Centre 5159

Dear Gayle

I am writing in support of your proposal to seek new initiative funding to introduce a multi-disciplinary position in the Intake team that will assist in assessing the mental health state of parents who are referred to your service. I understand that you are planning to advertise for an RN2 position.

I agree with the argument that was presented at the recent meeting where this proposal was discussed that it is beneficial to obtain a mental health assessment from a professional who is familiar with mental health services, and that this assessment is best conducted as part of a holistic assessment while your staff are present. I agree that it is difficult to arrange for staff of the mental health services such as ACIS to be present on a joint visit. It will be very beneficial to obtain an assessment from a person who has worked in community emergency services, and whose assessment will be well regarded by services such as ACIS.

I wish you well with this exciting proposal. I am confident that if your application is successful then the initiative will be a great step forward in enabling our services to operate together in a more coordinated way than has been possible in the past, to the benefit of both clients and services.

Thank you for the opportunity to participate in this innovative proposal.

Sincerely,

Signed

Don Tustin
Team Leader

Attachment 3. Support Letter from Dr Ann Sved Williams, Ms Sue Ellershaw,
Mr Peter Ballard and Ms Wendy Thicle from Perinatal & Infant Mental Health
Services

**Women's & Children's Hospital
Adelaide**

Family Unit
Helen Mayo House
Division of Mental Health
226 Fullarton Road
PO BOX 17 Eastwood SA 5063
Telephone: (08) 8303 1425
Facsimile: (08) 8357 9717

19th August 2004
Ms Gayle Bartlett
Supervisor, Intake and Assessment Team
Child, Youth and Family Services
Shop 15, Hub Shopping Centre
Hub Drive
ABERFOYLE PARK SA 5159

Dear Ms Bartlett

**Re: Project Submission – “Innovation Plan” for a mental Health Worker based
within the Intake and Assessment Team**

Thank you for inviting Perinatal and Infant Mental Health Services to be a part of the
planning and thinking around this project submission.

We are extremely interested and supportive of this very innovative useful and positive
project concept.

The project proposal of piloting the employment of a mental health specialist within
the Child, Youth and Family Services Intake and Assessment team, we believe will
add significant value to the service provided by the team and will result in better
outcomes for families and children, in particular, where a parent is experiencing a
mental illness.

In addition to tis position providing expertise, advice and assessment of mental state of
parents to the Intake team there are added benefits to the team and agency. These
benefits include:

- Increased knowledge and understanding of mental illness and its impact on an
individual.

- Increased knowledge and awareness of the impact of mental illness on an individual's ability to parent.
- Increased knowledge of the impact of parental mental illness on infants and children and appropriate interventions and supports for these families.

The earlier timely & appropriate services are provided to parents and parents to be with a mental illness the better the outcomes for the infant. It is in these very early stages of a child's life that significant trauma can occur that may potentially compromise their future physical, social, emotional and academic development.

With the implementation of the recommendations of the Generational Health Review and subsequent moves to greater collaboration and joint service provision to ensure better health outcomes for South Australians', this project proposal will provide direction for the development of leading edge services for families where a parent has a mental illness.

It is our view that whoever is employed in this position will require not only high level clinical skills (ie in RN3 range for nurses or PSO3 for allied health) but will also require high level negotiation and networking skills, and initiative to negotiate the complex nature of both the client population and service delivery systems.

We applaud the notion this project presents of a multidisciplinary, multi agency approach to service delivery for this client population.

We wish you every success for your submission and should you be successful are happy to actively support and participate in the initiative.

Yours Sincerely

Dr Anne Sved Williams
Medical Unit Head
Director
Perinatal and Infant Mental Health Services

Co Signatories

Ms Sue Ellershaw
Nursing Unit Head

Mr Peter Ballard
Senior Social Worker

Ms Wendy Thiele
Perinatal and Infant
Mental Health in the
Community
Project Manager

Attachment 4. Support Email from Paola Mason and Nerrelle Goad from COMIC

Galeano, Maria (DFC-CYFS)

From: Comic.admin (comic.admin@bigpond.com)
Sent: Saturday, 14 August 2004 12:39PM
To: Galeano, Maria (DFC-CYFS)
Subject: Re: Mental Health Nurse

To whom it may concern

We at COMIC will always support the growth within the mental health system to improve circumstances for people with mental illness and in particular children/families. As you will appreciate, we are continuously lobbying and advocating for more services, more service providers etc. COMIC believes that with further supports, we here in South Australia are moving towards aligning ourselves with other states in achieving outcomes within the National Mental Health Strategy. We wish you the best of luck with your proposal and look forward to hearing of a positive outcome in the near future.

Yours sincerely

Paola Mason & Nerrelle Goad
Co-convenors
COMIC (Children of Mentally 111 Consumers)
www.howstat.com/comic

16/8/2004

Attachment 5. Support Email from Natasha Miliotis from Mental Illness
Fellowship of South Australia

Galeano, Maria (DFC-CYFS)

From: MIFSA (mifsa@mifsa.org.au)
Sent: Monday, 16 August 2004 5:56PM
To: Galeano, Maria (DFC-CYFS)
Subject: Re: Mental Health Nurse

Dear Maria,

Thank you for your email. Your proposal to include a Mental Health Nurse position on your team will certainly prove to be a valuable resource. The Mental Fellowship support any government initiative to increase support and appropriate services to people with mental illness, their families and significant others. Specific mental health knowledge within your field of work will offer opportunity to provide a more tailored and specialised service to your clients and their families. We wish you all the best with your endeavours.

Yours sincerely,

Natasha Miliotis
Acting Executive Director
Mental Illness Fellowship of South Australia.

Attachment 6. Detail of Budget

Budget Considerations (based on already existing Department Project Planning Estimations)

The salary is based on a RN2 (Increment 4) award but may be less.

ITEM	BUDGET	NOTES
Salary and Related Payments	52,966.00	RN2 (Increment 4)
Operational Expenditure		
Car hire with petrol	10,000.00	Estimate based on previous costs
Staff Development	1,059.00	Training @ 2% of Salary
Computing	2,500.00	Purchase PC (Estimated price)
Communications	1,000.00	Estimate based on previous costs
Administrative Expenses	1,000.00	Estimate based on previous costs
Plant & Equipment Maintenance	250.00	Estimate based on previous costs
Plant & Equipment purchase	1,000.00	Purchase Desk/Chair Etc
Rent & Leases	1,000.00	Estimate based on previous costs
Insurance	50.00	Estimate based on previous costs
Other Expenses	250.00	Estimate based on previous costs
TOTAL OPERATING EXPENSE	18,109.00	
Accruals and On Costs		
Long Service leave	1,748.00	Provision @ 3.3% of salary
Payroll Tax	3,046.00	Provision @ 5.75% of salary
Superannuation	5,403.00	Provision @10.2% of Salary
Other Related Payments	3,640.00	Workers Comp/FBT Provision etc
Depreciation and Amortisation	500.00	Depreciation on Computing etc
TOTAL ACCRUALS & ON COSTS	14,337.00	
Advertising Costs	1,000.00	Newspaper advert
Evaluation Cost		Based on estimate from UniSA
External evaluation	20,000.00	
TOTAL EXPENSES	106,412.00	

Attachment 7. Data Collection Tool

Mental Health Nurse: Data Collection Sheet

CHILDREN

Name	D.O.B		

PARENTS

Name	D.O.B	Relationship to children	

Tier Rating (identified in Intakes)

- 1
- 2
- 3

Neglect/Abuse Identified (in intakes)

- Neglect
- Emotional
- Physical
- Sexual
- Mental Health (parent) Concerns

Services already involved

Observations of parent during initial Social Work Visit (specific to MH Concerns).

Observation of parent interaction with child(ren) in initial social work visits.

Actions Taken

- Home Visit
- Office Visit
- Assessments conducted _____
- Client would not engage
- Located service appropriate (If could not locate provided details) _____

- Referral to other agency made
 - Noarlunga Emergency Mental Health Services
 - Flinders Medical Centre
 - Helen Mayo House
 - Glenside Services
 - Carramar Clinic
 - Adair Clinic
 - ACIS

- Marion Community Care Team

- GP _____
- Private Psychologist _____
- Private Psychiatrist _____
- Other _____

Outcomes

- Parent was not referred to service (please state reason) _____

- Release of information gained from parent
- Parent continued with service referral (as identified prior to closure of file).
- Progress report (verbal or written) gained from service provider.
 - Client continues to make good progress
 - Client making limited progress
 - Client not making progress
 - Other Comments _____
 - Date of closure _____

- Parent did not continue with service after referral was made (as identified on closure of file).

H:\intake team\Alison Visser\Innovation\Data Collection Sheet – issy.doc

Attachment 8. References List

References List

Children of Parents with Mental Illness,
www.mhcs.health.nsw.gov.au

Department for Families and communities (2004) Children, Youth and Family Services: *Draft Strategic Plan 2004/2005*. Government of South Australia, Adelaide.

Mental Health Association, Nurturing Families When Parents are Coping With Mental Illness.
www.mhafc.org/pwmi

Mom's Mental Illness Doesn't Result in Loss of Child
www.thecarsonlawfirm.com

Nurturing Families When Parents are Coping with Mental Illness,
www.mhanys.org

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Attachment 9. Declaration

Declaration

I declare that the information supplied in this application is true to the best of my knowledge.

Name:	Gayle Bartlett	Position	Supervisor
Organisation:	CYFS	Signature	signed
Date:	Friday, 20/8/04		
Endorsed by:	Cathy Heinrich	Position:	Acting Manager
Organisation:	CYFS	Signature:	signed
Date:	Monday, 23/8/04		

Title

Mental Health Liaison Project

Appendix Three: List of Activities undertaken by Project

Mental Health Liaison Project – Project Activities

Partnership with Flinders Medical Centre/Southern Mental Health

Because Families SA could not employ a nurse directly, a Memorandum of Understanding (MOU) was developed and signed by Flinders Medical Centre and Families SA. This allows for Flinders Medical Centre to employ the Mental Health Clinical Nurse Consultant (Project Officer) and second the position to Aberfoyle Park Families SA, with Families SA reimbursing Flinders Medical Centre for the costs from the project funds.

This structural partnership has benefited the project in many ways. It has allowed for a closer working relationship between adult mental health services and Families SA through the Project Officer, which allows for a freer exchange of information between the two agencies, and the use of community mental health assessment forms by the Project Officer.

Reference Committee

Terms of Reference were developed by the members of the Reference Committee, and were agreed upon by Ron Lepley (Manager, Aberfoyle Park Families SA) and Ruth Lange (Project Officer, CNC). The committee members are:

- Mr Ron Lepley, Manager of Aberfoyle Park Families SA and Chair of the committee
- Ms Lucy Abadie, Supervisor of the Intake Team
- Ms Carolyn Makris, Nursing Director of Southern Mental Health
- Ms Elizabeth Fudge, National Project Manager, COPMI
- Mr Don Tustin, Team Leader, Brief Intervention Program, Adaire Clinic, Noarlunga Health Service and
- Ms Ruth Lange, Clinical Nurse Consultant, Mental Health, Aberfoyle Park Families SA, recorder for the committee.

Monthly committee meetings have been held since the first meeting on the 9th May 2005.

Supervision

Due to the innovative nature of employing an adult mental health worker in a child protection agency, the need for close supervision was recognised. It was felt that this would allow for closer monitoring of any problems and early problem solving.

With this in mind the following supervision arrangement was agreed upon:

- Aberfoyle Park's Intake Supervisor for day-to-day management
- Aberfoyle Park's Manager, Ron Lepley, for overall management
- Nursing Director, Southern Mental Health for professional supervision

It was initially agreed that clinical discussion could be sought from Noarlunga Emergency Mental Health Services or Southern Assessment and Crisis Intervention Service (ACIS) if a referral was likely to take place. However, as the complexity of the issues for clients became apparent, formal clinical supervision

was arranged with Dr Anne Sved Williams, Medical Director of Helen Mayo House, Women's and Children's Hospital. The Project Officer now has clinical supervision monthly with Dr Anne Sved Williams.

Advancing Agency Sharing Forum, August 16th 2005

From the beginning of the Mental Health Liaison Project it was recognised by the Project's Reference Committee that information sharing would be a significant issue in attempting to improve inter-agency collaboration in the area of child protection and adult mental health. In an effort to explore this issue further with both senior staff and those working in the clinical or field setting the Advancing Agency Sharing Forum was held (details of the forum are included in Appendices Four to Six). Sixty participants attended from a broad range of areas, such as community and inpatient mental health service staff, child protection social workers from District Centres, senior project staff and management staff from Families SA, Child Protection Service, The Guardianship Board of South Australia, solicitor from the Crown Solicitor's Office, project staff from the Department of Education and Children's Services, Drug and Alcohol Services SA, Nunkuwarrin Yunti, COPMI, CAMHS, and the Australian Centre for Child Protection. The purpose of the forum was to discuss the issue of information sharing and collaborative interagency work in depth to reach a consensus. The forum was well attended and enthusiasm was high on the day. The findings of the forum were summarised and sent to all participants to disseminate in their work-place, including the MOU for Information Sharing Working Party who were writing policy to support the MOU.

The Advancing Agency Sharing Forum also allowed for the introduction of the Mental Health Liaison Project to other local agencies and state-wide services. This allowed linkages with other agencies to be developed early in the project, and has been helpful in allowing for joint problem solving to develop closer inter-agency collaboration.

Consumer/Carer Telephone Conference

The majority of the carer and consumer groups who were invited to the forum were unable to attend on the day due to other obligations. In order to include their voice, a telephone conference discussing the consumer and carer views was held on the 4th November and included representatives from: COMIC (Children of Mental Ill Consumers); Mental Health Consumer, Helen Mayo House, and the Southern Consumer Advisory Group. A summary of their comments were then disseminated to all of the participants of the Advancing Agency Sharing Forum participants.

Identifying Mental Health Resources and Education

- Staff representatives from all of the teams from Aberfoyle Park FAMILIES SA were invited to attend the Advancing Agency Sharing Forum.
- The staff of Aberfoyle Park Families SA have been receptive to the offer of education on mental health and how it can affect parenting and what resources are available in the area. Educational sessions have been offered and taken up by all of the teams. The benefits of a more comprehensive educational program on mental health have been agreed upon by the

supervisors of the Intake and Assessment Team and the Children and Family Assessment Team. Mental Health First Aid Training through Relationships Australia (course developed by Australian National University) was held for Aberfoyle Park and other southern Families SA District Centres. This received very positive feedback from participants. The Mental Health First Aid is supported by the SA Mental Health Unit as an important initiative in upskilling the community on mental health issues.

- The benefit of mental health assessment tools for the Intake Team staff has started to be explored. The Edinburgh Postnatal Depression Scale has been distributed to the staff of the Intake Team. This has been found to be a useful tool at times.
- The Project Officer has liaised with UK Lead Nurses (mental health nurses working in the large health trusts, whose focus is child protection) and received resources, disseminating them to the Intake Team at Aberfoyle Park Families SA and senior project staff of Families SA and member of the Project's Reference Committee. Other relevant electronic resources are obtained from various electronic mailing lists and networks.
- Books on the area of child protection and mental health have been identified and obtained for the project and the staff of Aberfoyle Park FAMILIES SA. A text on adult mental health has been purchased as a reference for Aberfoyle Park Families SA. The office has purchased the series of fact sheets from Mental Illness Fellowship and these have been distributed to the staff.
- For the first 6-months the Project Officer has been working two days per week for the Children of Parents with a Mental Illness (COPMI) Initiative, in assisting to develop a pilot training module on COPMI issues (on preventing illness and early intervention, enhancing and strengthening family well-being, promoting the care and protection of children and their families, and promoting multi-agency and multi-disciplinary practice). The pilot training module "Families In Mind" was successfully held in the southern region and a number of staff from Aberfoyle Park Families SA were able to attend (as well as a small number of mental health staff from the region).

Aberfoyle Park District Centre

Internal Mental Health Referral Form

Date of referral:

Families SA Case Worker:

Does the referred person know about this referral?

Has an ROI been obtained?

Any safety concerns for visiting at home as a single practitioner?

Name of client you are referring (parent):

DOB:

Address:

Phone numbers (incl mobile):

Client(s) registered with Families SA & DOB(s):

Intake Number:

Reasons a **mental health referral** are indicated (*incl. any expected outcomes from referral*):

The main child protection concerns and suggested underlying causes:

Orders being applied for (or granted):

Will they be seen by CPS?

Case Conferences and linkages with Drug and Alcohol Services, and Community Women's Health

Families come to the attention of Families SA because of a range of underlying factors. The SA Government's document "Keeping Them Safe" lists them as:

- Domestic and family violence;
- Low income, parental unemployment, and/or limited access to the labour market;
- Poor parenting;
- Overcrowding, homelessness and high mobility, transience;
- Poor schooling;
- Mental illness;
- Low birth weight;
- Substance abuse; and
- Living in a disadvantaged neighbourhood.

The Project Officer found that generally, these issues did not occur in isolation, and parents involved with the project experienced several of the above issues. In particular, drug and alcohol issues and domestic violence were often present in such a way as to make it difficult to tease out which issue to deal with first or to reach agreement amongst services on how to prioritise services. Close clinical partnership was developed between the Project Officer and some of the regional drug and alcohol counsellors. In order to extend this partnership to the Intake and Assessment Team case conference meetings were set up. The invited agencies are Drug and Alcohol Services SA and Southern Women's Community Health Centre. So far, due to Intake Staff changes, only one case conference has been held.

Case Conference Proforma

Please follow the following format when presenting a case at the case conference meetings with the mental health worker, DASSA and Southern Women's Community Health Centre.

1. **Family Composition**: a brief description of the family (including family members name, age, relationships and cultural or ethnic background, living and work arrangements, general health information)
2. **Presenting Issues**: (including a rationale for agency involvement)
3. **Any relevant historical information**:
4. **Identify relevant agencies for this family**:

5. **What are the issues as identified by the family?:**
6. **What are the issues as identified by your agency?:**
7. **Provide any other relevant information:**

High Risk Infant Program Subcommittee

The Project Officer has been asked to work on the subcommittee for Families SA Southern High Risk Infant Program Subcommittee to assist in developing the Southern Family Focussed Clinical Forums.

External Evaluation

The Project Officer negotiated with the Project's Reference Committee to obtain the services of the Australian Centre for Child Protection at the University of South Australia as the external evaluators for the project.

Marion Families SA and DASSA Partnership Project

Harald Bodein, Drug and Alcohol Counsellor for St Mary's Drug and Alcohol Services, South Australia has developed a formal clinical partnership with Marion Families SA. This shared-care partnership facilitates access and take-up of interventions by parents with combined drug and alcohol misuse and child protection concerns. Secondly, there has been an endeavour to improve confidence of Families SA staff in working with parents with drug and alcohol misuse and for DASSA staff in working with families within the child protection framework.

The MHLP Project Officer has liaised with Harald Bodein in order to learn from the processes they have already set up and to provide an-ongoing exchange and partnership. This partnership is continuing.

Appendix Four: List of Attendees at the Advancing Agency
Sharing Forum

ABERFOYLE PARK DC

CYFS

ADVANCING AGENCY SHARING

FORUM

16/8/05

ATTENDANCE LIST

ORGANISATION	NAME AND TITLE
Australian Centre for Child Protection, Uni SA	Professor Dorothy Scott, Director
	Dr Fiona Arney Senior Research Fellow
Mental Health Unit, Department of Health SA	Dr John Brayley, Director
	Mr Alan Botrill, Chief Program Officer
CYFS	Mr Steve Ramsay, Executive Director
CYFS – Aberfoyle Park District Centre	Mr Ron Lepley, Manager
	Ms Ruth Lange, CNC, Mental Health Nurse
	Ms Keryn Feeney, A. Supervisor, Intake & Assessment Team
	Mr Michael Doldo, A. Supervisor, Reunification Team
	Ms Wendy Wallis, Senior Practitioner, Reunification Team
	Ms Isabel Burns, Social Worker, Intake & Assessment Team
CYFS	Mr Steve Ramsey, Deputy Executive Director
	Ms Bronwyn Warren, Principal Social Worker, Southern Metro Region
	Ms Annette Groat, A. Regional Principal Cultural Consultant, Southern Regional Office
	Ms Liz Tongerie, Aboriginal Cultural & Identity Co-ordinator, Marion
	Ms Joanne Bathern, Aboriginal Project Officer, Southern Regional Office
	Ms Mary Ann Carver, Project Manager, Child Protection Planning
	Mr Michael McKenzie, Privacy Liaison Officer, Social Inclusion, Strategy and Research Unit
	Ms Jan Blackwell, Manager, Noarlunga CYFS
?	Ms Marianne Richards, Senior Social Worker, High Risk Infant Team, Noarlunga
	Ms Ros Wilson, Manager, Business Planning
	Ms Jo Battersby, Child Protection Acting Director
Child Protection Service	Ms Sue MacDonald, Clinical Services Co-ordinator , CPS, Women's & Children's at Flinders, Flinders Medical Centre
Southern Area Mental Health Service	Ms Carolyn Makris, Nursing Director*
S-ACIS (Southern Assessment & Crisis Intervention Service)	Ms Denise Wright, CNC
Youthlink	Ms Ann Crago, Co-ordinator
Marion CCT	Ms Robyn Leane, Mental Health Worker, MCCT

Marion- MAC Team	Mr Dennis Stevens, A/Team Leader
Noarlunga Health Service	Dr Don Tustin, Team Leader, Noarlunga Early Intervention Service, Adaire Clinic
	Ms Helen Ritter, Mental Health Worker – Parent Support, Brief Intervention Service
Ward 4G FMC	Ms Michelle Kirby, A CNC
Guardianship Board of S.A.	Ms Barbara Robertson, Registrar
Helen Mayo House, Women’s and Children’s Hospital	Ms Sue Ellershaw, Nursing Unit Head
	Ms Wendy Thiele, PIMHIC Project Manager
CAMHS	Ms Cate Braham, A. Regional Manager, Onkaparinga Regional Services
	Ms Melinda Higgs, Clinical Psychologist ‘Keeping Them Safe’, Onkaparinga Regional Services
	Ms Sarah Wood, Clinical Social Worker ‘Keeping Them Safe’, Onkaparinga Regional Services
	Mr Stewart Bruinsma, Senior Clinical Social Worker
Crown Solicitor’s Office	Mr Mike Ahern, Solicitor, Administrative & Industrial Section
Southern Divisions of General Practice	Ms Fiona Huppatz, Manager of Better Outcomes in Mental Health
COPMI (Children of Parents with a Mental Illness)	Ms Elizabeth Fudge, Project Manager*
Consumer Advisory Group (CAG)	Ms Coralie Haynes
Southern Junction Community Services Inc	Mr Graham Brown, CEO
Community Living Options	Ms Mel Kubisa, Services Manager
Nunkawarrin Yunti	Mr Murray Harper, CNC, Mental Health
North West Area Health Service	Dr Daryl Watson, Director of Clinical Services
DASSA (Drug and Alcohol Service South Australia)	Ms Bev Drage, CNC
Intellectual Disability Services Council Inc	Ms Gail Starick, Southern Metro Office
Schools – Education Department	Ms Annette Bulling, Child Protection Initiatives Department of Education and Children’s Services
	Ms Judith Clelland, Policy Adviser, Child Protection Initiatives Department of Education and Children’s Services
	Ms Helen Scales, Project Officer, Beyond Blue
Child & Youth Health	Ms Rosie Ranford, Southern Manager
Southern Women’s Community Health Centre	Ms Celia Karpfen
Office of Health Reform, Department of Health	Margaret Nippert, Project Manager

Appendix Five. Summary of the Case Note Discussion at the
Advancing Agency Sharing Forum

Notes from the Advancing Agency Sharing Forum

Held by Aberfoyle Park DC CYFS on the 16th August, 2005

Summary of the case scenario discussions

In general

1. There was a sense of optimism that things are changing for the better with regard to sharing of information.
2. The scenarios were easily recognizable and typical

Increase understanding between agencies through education about other agencies, developing a common language and improving trust

3. There is a recognised need to increase the knowledge of agencies (incl. police) about each other's work – how they come to decisions, etc. This was a key theme of the group discussions.
4. There are two views of the concept of 'risk'. Education is needed in this area and also regarding people's/organisation's roles and how they work (e.g. MHS needs to understand the statutory issues). They need to meet with each other and 'demystify' their areas of work.
5. Consideration about the use of language (i.e. technical terms) is needed in an interagency setting as different words/terms have different meanings or are not understood. Examples given were that 'Tier 1 or 2' are child protection terms not well understood from other agencies. The term borderline personality disorder is not well understood or has different meanings to different staff/agencies.
6. Language is also relevant to the culture of particular groups (e.g. the 'Child Abuse Report Line' could be called the 'Child Protection' hotline')
7. MOUs are nothing without trust relationships- need to develop both formal and informal relationships/pathways between sectors and individuals
8. Develop joint assessments of mental health worker and CYFS worker. In joint work need to be clear about who is responsible for doing the assessment.
9. Need to break down the distrust other agencies have of working with CYFS
10. All agencies need to have a better understanding about how information shared will be then be used (i.e. court reports)

Issues in developing models of interagency collaboration

11. Need to develop models of inter-agency collaboration, which include case conferences
12. Principle Duty of care:
 Care of the child comes first:
 Confidentiality is second

 Concern as to how that works in real life
13. Informal exchange happens quite well and is appropriate/desirable as a starting point but there are often issues about continuity with workers leaving positions, transferring etc. and therefore formal systems of exchange are important. Documentation is also important for a range of other reasons.
14. Purpose driven information exchange is important. E.G. not just what information is required but why the information is being sought. The 'what' could be ascertained formally and the 'why' could be part of an initial informal request for information (e.g. a phone call).
15. Communication with various agencies is important – and the timeliness of that communication is important. It is a danger to isolate groups. At what point do you call a case conference? If you need to act due to danger for the child then don't wait for a case conference.
16. Child protection and mental health are usually working to different time-frames. Decisions sometimes need to be made quickly (i.e. discharge from hospital). These issues needs to be addressed when collaborative work practices are developed
17. If parent has a mental illness, then information is needed about treatment possibilities for mother in order to improve outcomes for child. Focus on mother/child dyad. Assessment needs to include a plan to determine what steps will be in place for the child as well as the mother. The plan must be reviewed – who will be the contact for the family?
18. Co-morbidities such as Personality Disorder and Drug and Alcohol Abuse – can make assessment of risk and planning of care difficult.
19. Significance of information given is more important than the quantity

General system issues

20. Why is there a CRISIS Care Line and a separate ACIS telephone line? – complicated for the general public and could result in better efficiencies if they amalgamated or worked more closely together.
21. Creative ideas are needed: about how to share responsibilities; in mental health how to give advice; don't assume that the person needs to be seen in Emergency Departments. They can be seen elsewhere (Youth Centres, ACIS Team offices during working hours, etc.) ? co-location after hours.

Consent

22. A core discussion point of the forum was that some people believed that parents should have a choice and parental consent obtained before proceeding with a plan. Others however, said that parents should be invited to participate in the plan but if agreement was not possible then the plan should continue.
23. Need to ensure that good practice regarding 'choice' and 'consent' of parent is undertaken in the first instance – even if later this has to be over-ridden by departments with duty of care responsibilities to the parent and the child.

Cultural safety

24. For Aboriginal families, assumptions should not be made about their culture. For example, the entire extended family should not necessarily be given information about the client. Clarification needs to be sought from individuals we are working with as to who the individual/family wish to be included in information sharing.
25. Take into account gender concerns

Carers and mental illness

26. Foster carers, when looking after a child whose parent has a mental illness, should be offered education about mental illness with the aim of developing an open and non-judgemental view of mental illness. This does not mean giving carte blanche information about the particular parent's mental illness.
27. Carers for children with parents who have a mental illness and intellectual impairment need special training

Who is included in exchange of information?

28. Difficult to separate drug and alcohol issues, mental health issues, domestic violence issues and child protection issues - need good communication early
29. The need to include GPs in case conferencing and advice to agencies.
30. Police need increased knowledge in the area of mental health and parenting and to be included in cooperative working between agencies.
31. Wanted school system informed so that they can support the child. DECS (Department of Education and Children's Services) wanted to be informed about the early warning signs of the parent's mental illness – and who to contact.
32. VicHealth study on burden of disease has shown that domestic violence is the main reason for women under 44 -years of age seeking health services. It is important to incorporate that in our planning and practice.
33. IDSC has strong confidentiality requirements. MOU should assist in overcoming this.

MOU – developing principles

34. On-going duty of care for the child (discussed in MOU) - This statement needs translation to reduce the number of people who have difficulty in knowing how to implement that

35. It would be good to include the Women's Health Policy and Women's Safety Strategy into the framework of the MOU and its policies (ie promotion, prevention, early intervention)
36. Field/clinical workers asked that the MOU authors be clear about what they wanted and how they wanted the field/clinical workers to work.
37. MOU – is in its infancy and is a massive task. The MOU encompasses broad concepts across a diverse and a large number of agencies.
38. MOU authors said they will write principles and procedures that will communicate what will change
39. The need to develop triggers within the system/ways of working that will remind the worker that this person is a parent. Need to work on how to use triggers more effectively. There are predictable points of contact which can be used to improve assessment of family
40. Need to include consumer groups in developing principles and practice

Service Development

41. Respite for parents with a mental illness who have children in the house

Appendix Six. Summary of the Panel Discussion at the
Advancing Agency Sharing Forum

Notes from the Advancing Agency Sharing Forum

Held by Aberfoyle Park DC CYFS on the 16th August, 2005

Summary of the panel discussion

Chaired by Professor Dorothy Scott, Director,
Australian Centre for Child Protection, UniSA

Panel members: Mike Ahern, Solicitor, Crown Solicitor's Office
Ms Mary Ann Carver, Project Manager, Child Protection Planning, DFC
Dr Don Tustin, Team Leader, Noarlunga Early Intervention Service, Adaire
Clinic
Mr Michael McKenzie, Privacy Liaison Officer,
Social Inclusion, Strategy and Research Unit, CYFS
Ms Cate Braham, Regional Manager, CAMHS Onkaparinga Regional
Services,
Ms Sue Ellershaw, Nursing Unit Head, Helen Mayo House
(Comments from the floor:
Ms Wendy Thiele, Perinatal and Infant Mental Health in the Community,
Project Manager, Helen Mayo House
Ms Sue McDonald, Clinical Services Co-ordinator, Child Protection Service,
women's and Children's at Flinders Medical Centre)

**Please note: these notes were taken to the best of our ability
Ruth Lange & Elizabeth Fudge**

Q Has any mental health worker ever been fined for breaching confidentiality?

A Daryl Watson: Not to my knowledge

Don Tustin: Past staff training material from Glenside explicitly stated that staff could lose their job if they breached confidentiality. Breach of confidentiality can be both a civil matter and a criminal matter. Be mindful that some staff have been given very strong messages that they cannot share information with other agencies/people.

Mike Ahern: There is a duty of confidence as outlined in Section 64 of the Health Commission Act (1976) and Section 58 of the Children's Protection Act. It is a criminal offence to breach confidentiality. One does not breach confidentiality by disclosing information as a legitimate part of your work, eg if you are investigating child abuse allegations or assisting such as part of your job requirements. To his knowledge no-one has been charged under those Sections. There is a common law duty of confidentiality which could result in civil action (although this action is rarely taken). Duty of confidence exempts certain kinds of information sharing –

for anything undertaken in the course of someone's duties (where they are abiding by relevant protocols) there is no question of breaching confidentiality

Q What about an Act of Omission - failure to disclose information that was important to decision making?

A Mike Ahern: people who work in CP owe a duty of care to the child not to the parents. Failure to disclose might constitute negligence. Mandated notifiers/Mental Health Workers if failing to disclose -there is an industrial and common law aspect. It is far more common to sue if information isn't disclosed.

Q Is it okay to delay the reporting of child abuse while the mental health worker puts safety mechanisms in place for the child?

A Mike Ahern: There is no time-line attached to notification – just that it be within a reasonable time – at the first reasonable opportunity. It is always the safety of the child (based on clinical judgement) which is the first consideration.

Mary Ann Carver: We are aware that we need to think differently about how we train mandated notifiers and provide them with more opportunity to consult CYFS around the question of child safety. Also discussed was a consideration of diverting children/families elsewhere – other than to the investigative role of CYFS

Q What happens to the accessing of information over time? What is the legal status when consent runs out for access to information?

A Michael McKenzie: Government keeps information – if nothing happens to the client (e.g. after 12 months) – then the information goes nowhere except to archive after 3 years. The information only becomes a 'live' issue again if and when concerns are raised again. Under FOI only edited information is given out – and only given to the person who the information directly relates to.

Don: People become ill for a short period of time and then Mental Health staff are asked to write about their illness when they are unwell and that creates a permanent record → that provides a biased picture of the person's ability.

Q&A Wendy Thiele: *Who makes the decision about mother's capacity to parent?* – the clinical team does not know what the course of the person's illness will be, etc., CYFS asks us (Helen Mayo House) to assess parenting. If parents have lost 3 children to CYFS, and they can't look after themselves, then it is unlikely that the mother is going to be able to care for the new baby.

Mary Ann Carver: The Youth Court makes the decisions regarding parenting capacity based upon information and recommendations put to it by CYFS. It is up to all of us to ensure that the best information possible is provided from each information "pot" in the sector. This means that we all need to talk and communicate about what we have seen, what we have assessed and what we are concerned about to ensure the court is fully informed as it makes its decisions and, in turn, to ensure that the best decisions possible are made for children in trouble. This means that CYFS needs to ask mental health for all the information and the best information about the parent. The over-riding principle is about the child's safety and this should not be overridden by issues of privacy and confidentiality. It is not about the child's rights nor the parents' rights. Field workers/clinicians need

to apply principles of good practice each time (e.g. first seeking consent from the parent for information).

Sue McDonald: information sharing gets in the way sometimes, such as in the Family Court. For example, the mother has good interventions put in place and makes progress but the courts have access to the information which may be very negative about the mother for her initial interactions presentations which are no longer relevant to her situation.

Michael McKenzie: it is important to always contextualise the information which you record.

Mike Ahern: With a Family Court subpoena you have to provide everything.

Michael McKenzie: Be prepared that whatever you write the person you are writing about will see - if subpoenaed.

Mary Ann Carver: That is why if you have a case review – and clear recommendations are agreed upon – write them down and continually update and ‘tidy-up’ the file.

Q *It is mentioned in the policies that information sharing is permissible if there is an imminent threat to the child. Could the panel discuss that please.*

A Mary Ann Carver: Policies talk about significant risk of serious harm. Can’t stipulate rigid words round them.

Mike Ahern: It does talk about ‘imminent threat’ in the Cabinet Privacy Principles written by the Bannan Government, 1989, Section 4.10. However once you are working under a protocol – that will over-ride that policy – the MOU will operate as an exemption to the Privacy Principles ‘Imminence’ is a red herring in this context as disclosure about child abuse is authorised by law and therefore you don’t have to worry about the concept of ‘imminence’.

Margaret Nippert: The MOU working party is developing a protocol now and is aware that they need to get this out quickly – they expect a protocol on information sharing to be out in about 6 weeks.

Don Tustin: discussed the importance of service development to further develop capabilities of providing a service for parents. For example, using HACC money to establish a parenting support service which can monitor patients’ parenting abilities after discharge from hospital while they are recuperating from a mental illness, and might be on sedating medication.