



NCOSS Conference Paper

## **Working Together for Mental Health**

### **Children ,Young people, Child Protection and Mental Health**



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This presentation will briefly examine 2 intervention models for children and young people whose parents might have a mental illness or who may be at risk themselves of developing a mental health problem. It will also explore a couple of initiatives that have been implemented and pose some questions in regard to more effective interagency practice.

Imagine that it is 1993. John Fahey is the premier, we've just won the bid for the Olympics and you are probably listening to Nirvana or Pearl Jam, driving a Mazda 121 bubble car. On a Saturday night you will be watching Hey Hey its Saturday before you go to the movies to see the Bodyguard. If you are a woman (or transgendered) you might be wearing leggings and a big shirt. The Brisbane Broncos have just won the Winfield Cup.

You have contact with a family. There's a mum and two kids aged 10 and 4. They have two different dads. The mum, let's call her Sonja, has been struggling with depression for years. She has no contact with her own family (they've pretty much given up on her) and she lives in an area of Sydney that when people say the name of the suburb, they roll their eyes or think – "I wouldn't want to live there". Sonja and the kids live in one of those Department of Housing flats – you know, the ones that all face each other but people can come and go without any contact with each other. Mara (that's the 10 year old) doesn't get to school much – she tends to stay home to help her mum with Rachel (the 4 year old). They don't have a car and there is only a couple of buses in and out of the suburb, unless you want to catch the school bus at 8.30 in the morning. Sonja (the mum) has never been very good at mornings. Rachel sees her dad every now and then but Mara doesn't know where her dad is and hasn't seen him much at all.

Mara's pretty quiet. Her teacher gets a bit frustrated because Mara just won't participate, despite her attempts to help. She notices that when Mara is at school, she is often without her lunch and just doesn't connect with any other kids. The teacher has so many other kids in the class with problems that its hard to concentrate on any one child. She wonders whether she should talk to someone else about Mara, but worries that DoCS won't do anything about it or will make it worse.

Sonja does a pretty good job of avoiding people who might help. She hates busybodies and is constantly telling Mara and Rachel that they are to say nothing to anyone about their business – they can handle it themselves. Mara

and Rachel have had to go and stay with the welfare a couple of times when Sonja has been in hospital. They hated it, according to Sonja.

The mental health worker who sees Sonja from time to time has worked really hard to try to get Sonja's trust and can see that she tries really hard with the kids and knows it would kill Sonja to lose them (Sonja has a history of suicide attempts). She knows how Sonja reacted to the kids going into care last time, when Sonja went into hospital. The kids were placed on the other side of Sydney and she didn't get to see them for a couple of weeks. The mental health worker feels very frustrated with the way the system further discriminates against people with mental health problem.

Rachel, the youngest, is starting to be a bit of an "out there" kid – you know the sort – never shuts up and escapes from the house, usually through one of the windows. They live on the ground floor of one of the front flats on a busy road. She's one of those kids that is your best friend 2 seconds after meeting her – a bit weird. She should go to pre-school but Sonja would never be able to get her there regularly and they'd end up hassling her about it all the time.

### **Heard of a family like this? A recipe for disaster?**

Come back to 2003. We've learnt a lot in 10 years.

In this time, the Child Death Review team has been established, part of whose role is to address systemic issues that contribute to children's and young people's deaths. For a number of years, they have discovered a very strong link between a child's death and the chance that a parent has a mental health problem or disorder.

The NSW Child Death Review (CDR) 2001-2002, reported on 14 child deaths where parental mental disorder was present. In those 14 cases, only four of the families had contact with adult mental health services. Two major issues identified by the CDR related to parental mental health were that :

- Mental health professionals failed to understand the impact of the parents' illness on the child.
- Department of Community Services caseworkers failed to understand the effects of mental health problems on the parent's behaviour." (p. 116).

New child protection legislation was introduced in 2000 that has drawn many more workers into the net as mandatory reporters. The Children and Young Person's (Care and Protection) Act 1998:

- has enshrined a whole of government approach to child protection in legislation. It
- has identified the responsibilities of parents, workers and the community to ensure the safety, welfare and well being of children and young people.
- has prompted a shift in focus on the risk of harm to children and young people rather than only focussing on an incident. This is particularly

relevant in situations where the parent has a mental health problem as it is often ongoing neglect that has the most impact on the child, rather than an incident of physical abuse.

- has addressed some of the mistakes of the past, for example removal of children in the first instance rather than as the last resort, have also been addressed within the legislation by a range of factors which include participation of children, young people and adults in decisions that effect their lives and the capacity to share parental responsibilities.

We are also far more aware of the impact of a parent's mental health problem or disorder on both their ability to parent and the increased risks to the child.

Oates (1997) states “..there is little evidence that patients suffering from severe mental illness (schizophrenia and bipolar disorder ) are more at risk than the general population of physically abusing their children” ( p. 26). Parents with mental illnesses can care very appropriately for their children, however those with limited supports and/or untreated illness may abuse their children through acts of omission ie what they fail to provide, which is the main feature of neglect, rather than acts of commission. It is also recognised that emotional neglect, the failure to engage positively with a child has the most impact of all forms of neglect (Killen, 1994) and it is this that the child of a mentally ill parent may be most vulnerable to.

“Children of concurrently depressed mothers are at greater risk for development of behavioural disturbance, poorer cognitive functioning, more insecure attachment (Foreman, 1998).”

A study conducted on 512 undergraduate students examined the relationship between reported childhood neglect and physical abuse, and current symptoms such as anxiety, depression or paranoia and attachment styles. The authors found that neglect was significantly related to both increased psychological problems and difficulties in relationships with others. (Gauthier, Stollack, Messe, Aronoff, 1996.)

Again, it is recognised that children whose parents suffer from mental ill health may experience few or no effects as a result, these children and young people may be very resourceful, competent, able to cope with a range of difficulties, have a good understanding that their parents mental health problem is separate to themselves and have a warm, loving relationship with their parent.

However for some children, we now recognise that there can be a significant impact on children, such as:

- Insecurity
- Embarrassment
- Over-responsibility
- Difficulties in forming/maintaining relationships
- Isolation
- Guilt
- Sharing in the parents delusion

For young people (ie over 12 years) the effects can become more magnified as their cognitive abilities and awareness have improved, so the implications of their parent 's disorder come starkly into view.

- Fears of developing a mental illness themselves
- Rejection of family , responsibilities
- Development of maladaptive coping strategies
- Developing a similar or different mental illness themselves

One significant factor for children and young people of all ages is the increased vulnerability to abuse by others. Perpetrators of child sexual assault deliberately prey upon children whose parents may be less able to care for them or be available to them and also prey upon children who are vulnerable (Conte, Smith and Wolfe, 1989).

A case example to illustrate this point involves a woman struggling with depression had a neighbour who befriended her and her children, and offered to help with child care and to assist her. She had very limited supports and was very grateful to the neighbour, and eventually agreed to allow him to help. He started to care for the children regularly, eg take them to school and picked them up etc. He exploited both the vulnerability of the children (due to the difficulties their mother was facing and their need for attention and affection) by sexually abusing them, as well as exploiting the vulnerability of the mother. If a child experiences this trauma and the compound effect of unavailability of their parent, they are far more vulnerable to the development of a range of mental health problems.

The mental health, child protection, education and community sectors have demonstrated both a willingness and ability to adapt to changing community expectations and respond to research and practice messages in regards to the inter-connected issues of children, young people, child protection and mental health.

The following two initiatives demonstrate this:

**The Children of Mentally Ill Parents program (COPMI)**

- worker based in each Area health Service
- specifically working on projects to assist families affected by mental illness, or
- working directly with parents with a mental health problem and their children
- assisting those families to get access to other services
- ensuring the children's needs are met and not subsumed by the needs of the adults

Ideally, these workers can act as the interface between Mental Health, DoCS, other support services and the family.

### **Relevant training for Mental Health and DoCS**

- Mental Health workers have received training on both the recognition of risk of harm and their responsibilities under the new legislation, as well as some more specific training such as training on the impact of abuse on children and the links between mental health and abuse.
- A Mental health training program specifically developed for DoCS caseworkers. The content explores:
  - the mental health field within the child protection context.
  - the consequences of the parent's mental health issue on the child / young person.
  - And applies the knowledge gained about mental health issues to assessing risk of harm to children and young people.

### **If we transport Sonja, Mara and Rachel to 2003, what would need to happen to ensure that this situation is no longer a “recipe for disaster”?**

- Both the teacher and the mental health worker would be required to report. If a report was made this could access early assistance for the girls and their mum, rather than waiting until Sonja is re-hospitalised and the girls need out of home care.
- the mental health worker would more likely to inform Sonja early on in their relationship about her reporting responsibilities and work to negotiate with Sonja about how to best support her through this process.
- This worker could also provide a supportive structure to assist Sonja such as providing assistance for parenting.
- All workers involved would have a much better idea of the risks to the girls and the difficulties Sonja may experience as a parent (through School link and other combined departmental initiatives).
- Mara and Rachel would receive age – appropriate education about their mum's illness.

### **So what could these strategies mean for the family?**

- Mara meets the daughter of a neighbour who goes to dancing classes at the local community centre and Mara has always wanted to do this, but has been too scared and shy to ask. Mara starts to attend with the girl.
- Rachel goes to child care 4 days a week.
- Sonja gets linked in to other support services such as the local COPMI worker (but not too many to avoid the cast of thousands!)
- The school offers after school care programs and Sonja is eventually convinced that this is good for Mara to go one day a week
- Further down the track, Mara and Rachel regularly go to respite care offered by one of the non government services. Negotiations take place for these carers to take the girls if their mum requires hospitalisation.

**All of this may sound like a “Pollyanna” solution, however, if services start to work together, exchange appropriate information and look to providing manageable and appropriate supports to families where a parent experiences a mental health problem, we may have “discovered the missing ingredient” to make a difference for this family.**