Researchers from a number of countries of the European Union agreed to work together as the Icarus Project, guided by the Centre for Comparative Social Work Studies, Brunel University, to investigate the nature and level of support in the community for children and parents in families where there is parental mental illness (Hetherington et al., 1997). The problem of providing satisfactory responses for such families is recognised not only across Europe but also in Australia as an issue of widespread concern (Hetherington, Baistow, Johanson & Mesie, 2000). At various intervals throughout the project, the Brunel team (led by the indefatigable Rachael Hetherington) gathered the researchers together to compare the different approaches taken by the participating countries' mental health and child welfare services to a case scenario concerning a family in which there were child welfare and adult mental health concerns. The final research meeting was held in London, 9-10 November, 2000.

Unlike Icarus, whose wings of wax failed, with tragic consequences, I was successfully carried by wings of steel from Australia to London to this final Icarus Project meeting. Over the two days of the meeting, we had the opportunity to meet the researchers and fellow participants in what has been a ground breaking project. Despite the Republican tendencies of Down Under, we Australians were delighted to be invited by the English team at Brunel to join the project. The tyranny of distance between the continents of Europe and Australia is overcome by opportunities such as these. Whilst the final report of the project looks to building a European model of professional intervention for mentally ill parents and their children, the practical applications of such a model offer Australia the opportunity to re-define how adult mental health and child welfare services can work together with vulnerable families.

The Icarus meeting: at the Tavistock

With this in mind we came to the final meeting in London. We spent our first day at the Tavistock Clinic, where Dr. Judith Trowell, consultant to the Icarus project, gathered together the responses of the participating countries to the case vignette and compared the functioning of their child welfare and mental health structures. What Australia shared with other countries was a level of free health care, and mental health care, and legislation ensuring the protection of children from harm. What was also shared was a commitment to maintaining children in the care of their parents, as much as possible, and to the provision of community based services that support vulnerable families; children growing up in families where there is parental mental illness are recognised as one such group. When the Australian groups met for the second time in Melbourne, whilst participating in the study, they had discussed how the Australian participants’ responses to the child welfare and adult mental health issues, depicted in the case vignette, compared with those of Germany and England - the countries assigned to us for comparison. Members of the Australian adult group expressed surprise and interest that, generally, the services in England and Germany were more similar to ours than they would have expected:

“Apart from the exotic pedagogues... in many ways I felt that both of them (English and German services) actually felt very familiar, it was reassuring actually. Some workers had statutory responsibility for the protection of children, while other workers had statutory responsibility for looking at issues about involuntary admission, and there were community supports such as midwives. Furthermore, in some ways they experienced the same difficulties that we do about boundaries and communication and how we actually collaborate and work effectively together and whose interests we are serving.”

The significance of the primary care system as the likely first port of call for help by a family, that is a visit to the General Practitioner, was an outstanding similarity between England, Germany and Australia:

“It is interesting that in three different countries, the first thing people said is that they would go to their GP”; “They’re normalised, you don’t have to walk into a building and be stigmatised”.

Rosemary Sheehan

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System differences and similarities

Whilst we found similarities in the service structure of each country: each had the formal, statutory services and the less formal support services, often provided by non-Government organisations; it was apparent that the way child welfare and adult mental health services are structured in Australia is markedly different from other countries, in particular the Scandinavian and continental European countries. In Australia, there is a structural separation between health and child welfare services, each with separate governing authorities, although both are government funded. Although there are often protocols for collaboration between the two services, the services function as autonomous units. This organisation of the different professional functions and structures is shared with England, Scotland, Ireland: Northern Ireland reported that the recent amalgamation of Health and Social Services Trusts and the co-location of services had played an important part in improving the functioning of their system.

What Australia also shared with the Anglophone countries was a reluctance to intervene in family situations such as the one described in the case scenario; reluctance based on a lack of services that could meet both child welfare and adult mental health needs and differing views on when parental mental illness constituted a risk to a child. The Scandinavian and continental European countries said they would provide intensive family support and primary care services and intervene earlier to avoid the crisis that emerged in the later stages of the case scenario. There is a wide range of services for both child welfare and adult mental health clients within the Australian system. In particular, the mobile support and treatment teams, the community based crisis team, assessment and treatment teams (CATT), the in-patient Mother and Baby Units (for mothers with psychiatric illness who have an infant less than twelve months in age), are impressive. The wide range of family support and family preservation services available in the community impressed other countries’ participants. However, what was clear about the Australian system, from the first day of the Icarus meeting, was the lack of a shared discourse, and authority to cross service boundaries, between child welfare and adult mental services. This hinders the development of practices that are both child-centred and family-focused and thus able to meet the needs of both children and their parents.

Australian group members thought some service boundaries in England and Germany were preferable to those in Australia. It became clear at this first meeting day that France and Italy and the Scandinavian countries also did not have the problems with boundaries that are endemic in the Australian system. It was understood that both child and family services and the community mental health services in England comprised teams that were naturally connected by sharing the same region or catchment area. It was thought this kind of overlap would aid the development of good working relations. In Victoria, the boundaries for the child protection service and mental health services do not overlap in this way. Furthermore the services in both England and Germany seemed more localised than those in Victoria. The role of child protection services was also debated: in Victoria there is a view that the child protection service has become too focused on investigation and statutory proceedings. Their role in assisting families is minimised, to the detriment of the potential service available to families. Some members of the Australian groups felt that the English participants reported similar problems, i.e. cutbacks and under-resourcing resulting in an over-involvement in emergency assessment and an inability to engage in more valuable longer term work with clients. This did not appear to be the case in Germany, France, Luxembourg and the Scandinavian countries.

Adult mental health and child welfare: the need for common frameworks

The adult group in the Australian study confirmed that the mental health and child protection services are not well co-ordinated, that they have poor communication, have different points of view about what it is appropriate to do. They placed great emphasis on a mental state assessment of the mother and involving the child protection service only as a last resort, to avoid stigmatising and alienating the adult client. It was agreed, however, across both groups of participants that it was important to improve structures of service delivery for vulnerable families.

Multi-disciplinary teams, be they in child welfare or mental health, increased the potential for good communication (Hetherington et al., 1999). Where the professionals in the team could obtain and receive information about the whole family, then a
more complete understanding of a family’s functioning was possible. The high level of specialism in the organisation of child welfare and mental health services contributed to barriers between services, over access to resources, to information and to programmes. All the participating countries agreed that the child and adolescent mental health services are well positioned to negotiate such barriers; they can be an effective resource in child welfare, family functioning and mental health. The central role of child mental health services was mirrored in the number of participants, and individual countries’ project leaders, from child psychiatry and paediatrics, who are an important voice for ensuring adult mental health workers are better oriented to working with their adult clients who have dependent children. The Victorian child and adolescent mental health services make an important contribution to such children and provide consultation to child protection. However, they are also constrained by the same structural and system boundaries already discussed.

Australia’s National Mental Health Strategy emphasises the need to provide services that focus on prevention and early intervention, programmes that maintain adults, and adult parents, with mental illness in the community. In Victoria, a number of programmes have been introduced that focus on universal prevention (e.g. strengthening parent-child bonds), or targeted prevention and early intervention aimed at symptom reduction and coping skills (for example: the Parent Project, Maroondah Adult Mental Health Service (Melbourne), the Mothers Support Programme, Prahan Mission (Non-Government agency in Melbourne), Keeping Kidz in Mind, Hidden Children Hard Words, (videos produced by the Mental Health Branch about the experiences of children in families where there is parental mental illness). Of particular interest to us was the Danish response to the Australian Mother and Baby Unit facilities. The Danish participants in the group did not think that a child should be admitted to a facility for psychiatric patients, even though it was explained that they are special units where staff are experienced in dealing with mothers and babies. They believed that the mother’s needs were being placed above those of the child in advocating for such services.

The child’s needs seemed to be more of a priority in the continental and Scandinavian systems. What that meant was that there did not seem to be “competition” between parent and child when there were established parental mental health problems that were impacting on the child. The multi-professional teams of Luxembourg, France, Italy and Germany appeared able to make decisions about risk to a child in a more straightforward manner than in Australia. They appeared to have common legislative or service definitions about what constitutes a mental health concern or a child protection concern for families in which there is a child whose parent has a mental illness. Even if there were structural separations between child welfare and mental health services, there did appear to be more a shared discourse and thus child-centred yet family-focused practice.

The legal system

In the Australian groups there was considerable interest in comparing the legal issues raised by the case vignette. The child protection aspects of the legal systems in the three countries varied, although there was some similarity between the English and German systems in terms of being less adversarial in their approach. In the Australian system the capacity to ‘make a successful case’ that would succeed in court appears to over-ride the best interests of the child and to seriously influence the child protection workers’ perspective. The role of the judge in the German reports was viewed with some interest. S/he seemed much more ‘interventionist’ than those in Australia. The judge seemed to have independent staff making investigations in the best interests of the children and to make a greater variety of judgements regarding the children’s futures. The same judge made decisions on involuntary hospitalisation. In Victoria, there is no such overlap and the Children and Young Persons Act (1989), the Mental Health Act (1986) and family law (private law) legislation function autonomously.

In the Australian study one of the child welfare group members, a child protection worker, said it is not uncommon for their service to work with a family over time where it becomes evident to them that the mother, for example, behaves abnormally and should receive psychiatric treatment. The mother is barely co-operative with their attempts to get her assessed and/or treated. However, when they are able to get her to a psychiatrist or get a community mental health outreach worker to visit, these professionals do not assess her as having a mental illness they can treat or merit assertive intervention. In such instances, the worker applies
to the court for a child protection order because they are certain the mother’s behaviour is damaging to the child. However, the magistrate very often returns the children home, without a child protection order, because there is either no psychiatric report available to the court, or the information provided fails to confirm the child protection worker’s assessment that child is at risk of harm. In these latter cases, where the mental health worker fails to acknowledge the parents’ mental health problems, or assesses that the parent’s disorder does not require treatment, child protection workers believe that these assessments are made because mental health workers underestimate the detrimental effects of parental behaviours on children.

The Icarus Seminar: Day Two

The Future Governance Programme of the ESRC kindly sponsored this seminar, introduced by its Director, Professor Edward Page from the University of Hull. Dr. Judith Trowell and Rachael Hetherington spoke about the study findings and the implications of these for developing a European approach to services for families with a mentally ill parent. Later, the seminar worked in four groups that combined national participants with government and policy representatives, to consider the possibility of a shared approach. What impressed me about the seminar was that the presence of Government officials from various parts of the UK indicated a level of Government attention to the co-ordination of services for families with a mentally ill parent. Clearly the ESRC believed in the same need for attention.

The seminar gave both study participants and Government officials the chance to consider: various national systems; the features of these that positively assist the child and parent with mental illness; and, what features could be combined to shape an approach that could be used across countries, albeit mindful of political, legal and socio-economic imperatives. The first debate was about the need to keep the child in mind when working with an adult client with mental illness who has dependent children. The tension between maintaining a balance between parents’ rights and children’s needs is keenly felt within the Australian child welfare system. German, French, Swedish and Danish participants were very clear that the child’s needs must come first. Italy and Greece believed a systemic view was more desirable, so long as the mental health and child welfare services were in agreement. The English participants were very mindful of the need to first ensure the child was not at risk, and had available to them, it seemed, a range of voluntary possibilities for working with the family. In Australia, the child protection service would usually have to seek a child protection order, to be able to work with the family. This creates an immediate tension between the child’s needs and the parent’s needs, and issues around individual liberties, discrimination against a family on the basis of parental disability or different parenting practices, family preservation and minimal intervention, addressed. The paradox is that Australia, overall, has good adult mental health, and child and adolescent mental health, services. Adult mental health workers however do not see it as their remit to carry out child welfare responsibilities.

The state-citizen relationship

The role that authorities play in family life was an area of significant difference. Australia takes the view, and this seemed also the case in England and Ireland, that statutory services are provided when problems are extreme and the family is unable to provide the necessary care for its dependent children. Whilst Australia does not have the sanctity of the family enshrined in its constitution, as does Ireland, reluctance to interfere in family life reflects community concern that children have, in Australia’s very recent past, too readily been removed from their parents (Sheehan, 2000). State intervention in family life is perceived as an undesirable activity. This also reflects the strong anti-authority streak in the Australian national character; what might also be called the Anzac spirit. The Australian participants envied the respect given to French, Italian, German, and Scandinavian social workers, and the professional autonomy they enjoyed. This typified the very different state/citizen relationship in these countries from that of Australia.

The continental and Scandinavian countries were more willing to assume some State responsibility for the emotional well being of their subject children (Hetherington et al 2000). What was clear from the study was that social workers are given the authority by the State (and the courts) to work with parents and children to address child protection problems. Statutory intervention in families in Australia has to be legally justified rather than based on social work discretion. There is considerable emphasis on the importance of due
process, attention to individual rights and legislative obligation. What this means in practice is a need to establish fault with parents, to permit the involvement of welfare services, rather than propose that need is the basis for the involvement of the child protection service in a family’s life. The Australian legal system is based on the Westminster system, yet in England and Scotland, statutory intervention in child protection is sought only when certain limits are reached and there is particular emphasis on voluntary measures. However, the English child protection system has found there is increasingly less room for voluntary intervention and more and more the courts are being asked, as in Australia, to regulate child welfare activity (Hunt & McLeod, 1997).

Hetherington, Cooper, Smith and Wilford (1997:86) reported that the continental European approaches establish the family as an object of social concern, rather than as a private domain as it is in the Australian approach. It prefers to concentrate more on identifying children’s needs and improving parental care rather than proving child abuse has occurred. There is a preference for the use of voluntary measures to protect children rather than turning to the legal system; even if the legal system is involved it emphasises informal discussions between parents and welfare and judicial decision-makers to resolve child protection concerns.

Notions of collective responsibility are notably absent in the Australian approach which places a high value on individual rights and less emphasis on social rights and responsibilities. It appeared that countries with an inquisitorial legal framework were better able to seek out, and give priority to, the child’s point of view about their family’s or parent’s problems. The area child protection committees in England also seemed to provide a framework for professionals to consider what welfare measures would be in a child’s best interests.

**Conceptualisations of mental illness and child protection**

Dr. Judith Trowell commented on the different conceptualisation of mental illness between professionals and countries, noting that European countries appeared to adopt a more psychodynamic and less medicalised approach, than that of the Anglophone countries. This is the case in Australia, in terms of public mental health services, where the individual adult needs to have diagnosis on DSM IV or ISD 10 to be eligible for treatment. The consequence is that a parent, who has significant life problems which include mental health problems, but who is deemed not to have a diagnosed psychological disorder, is not eligible for a public adult mental health service.

How child welfare/child protection is conceptualised appeared also to have a significant influence on service responses to families with a mentally ill parent. The requirements of the fault-based Australian legal system which requires child protection services to make a case against parents based on agreed principles of assessment focuses on the behaviour and intentions of adults rather than on what children are experiencing (Sheehan 2000). Moreover, the Australian child protection system looks for single incidents of child abuse, or for actions that have precipitated a crisis in a family, to confirm the need for intervention.

Parents with mental illness, and their dependent children, will often have problems that are ongoing in nature, parenting in ways that do not intend to harm the child but which nevertheless are actually or potentially harmful. Child protection workers are confronted by a system, and perhaps also by professionals from other disciplines, that minimises the severity of emotional harm such children may experience, because generally it is believed that parents love their children and it is hard to look for proof that challenges this (what Dingwall, Eekelaar and Murray (1983) refer to as the “rule of optimism”).

It seemed that the systemic view of the need to work with the family as a whole, emphasised by Italy, France and Luxembourg, would do much to challenge the separate and structurally different approaches of adult mental health and child protection services. Family problems do not always fit organisational categories; the long-term and chronic nature of problems confronting families with a mentally ill parent typify this. Australia has in place approaches for working with parents with disability (intellectual disability, physical health disability) and parents with psychiatric disability need to be included in this approach.

Adult mental health services from a number of the other countries did not seem to have difficulty identifying clients who were also parents; this also enabled them to identify high risk children and

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1. DSM IV - Diagnostic and Statistical Manual Version 4 - a mental illness classification.
2. ICD 10 - International Classification of Diseases a World Health Organisation classification system.
develop pathways of care for the children when alternative care is needed. It was accepted also that child welfare professionals had to be educated about mental illness and its effects on families. This emerged as a particular theme in the Australian study. Child protection workers commented that the right of a parent to maintain that information about a mental illness is confidential is a source of conflict for both mental health and child protection services. This made it difficult, in particular for child welfare professionals to discuss, and seek information about, the impact of mental illness on the parent and other family members.

Inter-agency co-operation

The significance of developing services that will work together, and share knowledge frameworks and responsibility for children at risk, led to the development of the Working Together protocol, by the Department of Human Services, Victoria (1998). This strategy includes a range of approaches for service co-operation: introducing case practice review panels that meet regularly to review clients who require multiple service responses; implementing an intensive case management service that provides consultation to DHS staff about case specific issues. Mental health workers have been outposted to child protection regional offices, in some regions; in others, a specific mental health worker is available for worker consultation. The child and adolescent mental health services have played a pivotal role in supporting this strategy. Despite these innovations, however, there is often little communication between the mental health and child welfare fields. Thus, services to children of parents with mental illness have developed in an ad hoc manner, if they have developed at all. Sweden described how they had implemented new admission forms for in-patients and outpatients in a psychiatric hospital in West Stockholm, forms that included details about patient’s children. Groups for children and their parents were introduced, so too information folders for children. All this was done in consultation with social services. What was attractive to Australia about this was the combination of a formal structure, with the opportunity to develop informal networks, and that this is strengthened by the presence of interdisciplinary teams.

One of the difficulties for any system, and the English participants suggested this, occurs when there are multiple points of entry to the adult psychiatric system and poor co-ordination between the different branches of the system: hospital, out-patients, crisis-response teams and community teams. Certainly it is possible for a client in Australia to have two or three different workers on their case, most particularly when there is no formal liaison between adult psychiatric services and child welfare and they function as completely different areas. What currently bedevils Australian services, and system structures, is discussion over funding responsibility, especially between mental health and child and family services. Although Australia has much in common with England, in terms of professional approaches and the state-citizen interface, we do not have as good liaison and communication between members of the primary health care group: GPs, community health nurses, maternal and child health nurses, as in the UK. There seemed to be more of a tradition of exchanging information and following up on shared clients, arranging for records to follow clients when they move to different areas, for example. In Australia, many primary health carers would be reluctant to involve child protection services unless it was absolutely necessary, as social workers are regarded with some suspicion and closely identified with child removal.

Concluding comment

At the end of the project, and the seminar, Australia shared some similarities and observed a few distinct differences in approaches across Europe to families in which there is parental mental illness. Examples from Sweden, and other countries already mentioned, confirmed the need for Australia to better co-ordinate its mental health and child welfare systems. This would include an emphasis on preventive and pro-active programmes that recognise the long-term nature of problems such families experience, as in Sweden which ‘didn’t wait for things to happen’. This would require Australian authorities to play a different role in family life, one that gives priority to what is in the child’s best interests. Structural arrangements that encourage health and social services to share in the delivery of services, means information can be shared, and a common discourse developed about families, their needs and when intervention is necessary. The great strength of the Icarus Project, for the Australian participants, has been the opportunity to use comparison to advance understanding. The international discussion gave us the opportunity to explore insights into our system. Shared principles
and strategies must be developed around the identification of, and intervention in, child welfare and adult mental health problems. If we do not heed this, the experiences of children whose lives are subordinated to the needs of their parents, then we are not acting in the best interests of vulnerable families and the problems addressed by the Icarus Project will continue to exist.

At the end of the seminar I reluctantly left London and the Brunel team. We had been given a unique opportunity to participate in a project that challenged us to make a difference to child welfare and mental health policy in our home countries. Our great thanks to the Brunel team: to the vision and leadership of Rachael Hetherington, to the organisation skills of Philip Smith - who else could have guided us through he London Underground to our meetings, our accommodation and very importantly, our Icarus Dinner! Thanks to Dr Judith Trowell, Karen Baistow, Ilan Katz and Jeff Mesie for their commitment to the project. The Christmas lights were switched on in Regent Street; it was time to return down under to summer.

References

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Author’s notes

The Australian study was sited in Melbourne; comprised two groups of participants who met first, to discuss the Icarus project case scenario and second, to discuss how the Australian groups’ responses compared with those of Germany and England - the countries assigned to us for comparison. We met a third time to combine the two groups to discuss findings. There was a child welfare/child protection group; the nine members included social workers, psychologists, psychiatric nurses, the State child protection service, a family support agency, child residential services and the Mother and Baby inpatient unit. The second group, the adult and mental health focussed group, included a GP, psychiatrists, psychiatric nurse, occupational therapist, social workers, disability workers.

I would like to thank Anne McLoughlin, Senior Social Worker, Child and Adolescent Mental Health Service, Austin and Repatriation Medical Centre, Melbourne, who represented the Australian team at the Icarus workshop in Luxembourg, March 1999.