Collaborative Experiences of Mental Health and Child Welfare Social Work Professionals in Providing Service to Parents with Mental Health Challenges

by

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Abstract

There are various points of intersection between child welfare and mental health systems. It is vital to understand how these two systems can collaborate to support parents who are experiencing mental health challenges or who have mental health diagnoses. This is of critical importance in the context of Manitoba, Canada, where there are high rates of children in care and an need for increased preventative services for families. Employing a phenomenological approach, this qualitative research aimed to explore the collaborative experiences of both mental health and child welfare social workers in providing services to parents who experience mental health challenges and who are involved with both systems. Twelve participants, all of whom were Registered Social Workers from either mental health or child welfare fields of practice, engaged in semi-structured interviews with the researcher about their collaborative practice experiences. The results conveyed a mixture of experiences and ideas about collaboration. Participants described a variety of collaborative mechanisms and daily practices, including clarification of respective roles and identification of common goals, as being beneficial to collaboration. Professional approaches such as transparency and flexibility were generally preferred by participants as opposed to more rigid or closed off approaches. Participants also described ways by which service mandates between systems can conflict with one another. Gaps in resource availability for parents experiencing mental health were also identified by participants. Factors related to professional knowledge and education were described as impacting participants' collaborative experiences as well. Many participants emphasized how parental motivation and participation to engage with collaborative services were central to their experiences. Additional social and contextual factors, including stigma and geographical considerations were also described as impacting participants' collaborative experiences. The

findings indicate a need for increased resource efficiency for parents receiving services from either system as well as stronger protocols surrounding interagency collaboration and ongoing professional education, particularly around adult mental health. These findings largely echoed that of past literature on this topic. Future research could benefit from including parents' experiences with interagency collaboration between mental health and child welfare systems.

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Chapter 1: Introduction

Mental health and child welfare practice have many points of intersection. According to one Canadian report, the presence of caregiver mental health concerns is among the most prevalent factors in child maltreatment investigations (Joh-Carnella et al., 2021). To effectively support families while minimizing risks to children, mental health and child welfare agencies must work collaboratively. Given Manitoba has had among the highest rate of children in care among all Canadian provinces (Government of Manitoba, 2018), there is an apparent need for preventative services, including mental health supports, aimed at keeping families together. The Manitoba Advocate for Children and Youth (2019) published a recommendation for improved coordination of services and information sharing between public health systems as it relates to children's mental health concerns. It can be argued that such efforts should extend to cases of adult and parental mental health where there are concerns for child protection or safety. As child welfare systems have a mandate to provide supportive services to improve the wellbeing of children *and* families (The Child and Family Services Act*,* 1985), agencies must work together with parents experiencing mental illness or mental health challenges to ensure they are supported in meeting the needs of their children. In 2011, the Manitoba Government released a report titled *Rising to the Challenge: A Strategic Plan for the Mental Health and Wellbeing of Manitobans*, which included goals of enhancing collaborative services with other government departments as well as increasing family participation in treatment planning (Manitoba Health, Seniors, and Active Living, 2011). As the Government of Manitoba undertakes such new and continued initiatives to improve both child welfare and mental health services, it is crucial to understand the nuances in experiences of effective collaboration.

To understand the collaboration between these services in Manitoba, it is essential to understand the experiences of both mental health and child welfare professionals in providing collaborative related services to parents experiencing mental illness or mental health challenges. Understanding workers' experiences in the context of their diverse professional knowledge is a critical first step in identifying a meaningful evaluation of collaborative. Listening to professionals' narratives and extracting themes can provide perspective as to what practices are working well and what areas of need and improvement may exist. This should be done with the goal of strengthening partnerships between child welfare and mental health systems to enhance coordinated services to families impacted by parental mental health challenges. While one in five Canadian adults will experience mental illness or a mental health challenge in any given year, there is a high capacity for functioning with a mental illness when proper supports are in place (Canadian Mental Health Association, 2021). This will be further evidenced in the literature review. Government funded mental health and child welfare services have a responsibility to provide the appropriate and timely supports for parents experiencing mental health challenges to thrive as caregivers and to provide care for their children. This research aims to answer the question of what the experiences of collaboration are like for mental health and child welfare professionals in providing services to parents experiencing mental health challenges in Manitoba.

Chapter 2: Literature Review

A variety of challenges exist at the interface of child welfare and mental health systems. While both systems share common goals in improving the wellbeing of individuals and families, ideas on how these goals should be met may diverge based on professional areas of focus. This can be exemplified in cases of parents who are experiencing mental health challenges, for which both clinical treatment and child protection efforts may be necessary. To successfully serve this population, it is crucial to examine professional accounts of interagency collaboration. One approach to begin to understand this is to explore the experiences of both mental health and child welfare professionals in serving parents who are dually involved with these systems.

Overview of Literature on Parental Mental Health Challenges

Parental mental health challenges are a widely researched topic. The broad array of diagnoses, approaches to treatment, cultural considerations, and potential impacts on children are ever-evolving in the literature. However, there are some central areas of consideration that can be helpful in setting the stage for understanding the issue as it pertains to the connections between the child welfare and the mental health systems.

The Mayo Clinic (2022) describes mental health concerns as being characterized by problematic thinking, behaviour, or emotion. This may amount to a diagnosable mental illness when these factors impact an individual's daily functioning (Mayo Clinic, 2022). As such, parents may require mental health support services without having a formal diagnosis. Elaborated in subsequent sections of this literature review, child welfare agencies intervene based on perceived risks to children and program staff may not be aware of existing diagnoses or

mental health concerns among parents. For these reasons, when exploring collaborative experiences between child welfare and mental health professionals, it is important to capture such experiences as they pertain to parents both with diagnosed mental illnesses and active mental health challenges.

While some of the literature discusses differences in child protection related concerns across parental mental health diagnoses (Sheehan, 2005; Sahanapriya et al., 2021; Ben David, 2021), others suggest that impacts may be similar regardless of the kind of mental illness that is present (Ben David, 2021; Dean et al., 2018). Ben David's (2021) research indicates that while the risk for child neglect may be similar across mental health diagnoses, the risk for abuse is greater among parents with personality disorders. Citing previous research, the author posits that this may be due to adults with personality disorders experiencing higher levels of stress associated with parenting responsibilities. As well, some personality disorders may result in difficulties for parents to remain attuned to the needs of their children (Newman et al., 2007; Simons et al., 1993; Walsh et al., 2002, as cited in Ben David, 2021). Further, diagnoses of depression and anxiety are found to be correlated with issues like truancy but are not associated with child abuse (Ben David, 2021). While Ben David's (2021) research provides a valuable overview of child protection issues where parental mental health diagnoses exist, it is important to note that it focuses solely on the analysis of court documents pertaining to loss of parental rights. As such, while the authors may speculate explanations based on their findings and empirical research on mental health diagnoses, the findings do not account for causality. Another study done by Kaasbøll & Storhaug (2025) found that depression and anxiety were associated with inconsistent parenting practices. Some of the literature focuses on schizophrenia as a diagnosis associated with more serious impacts on children (Sahanapriya et al., 2021; Sheehan,

2005). In Sheehan's (2005) review of child protection court cases involving parental mental illnesses, it was found that diagnoses of schizophrenia and borderline personality disorder were most associated with loss of parental rights when compared with other mental health diagnoses. Factors related to mental health symptoms including impulsivity and skewed perceptions of reality were identified as being at the basis of some of the child protection concerns in these cases. Issues with lack of insight and difficulty in following through with case planning further impacted parents' ability to work towards successfully retaining or regaining their parental rights (Sheehan, 2005). Sahanapriya et al.'s (2021) study also suggested that children of parents with schizophrenia were more likely to have internet addiction that children of parents with other mental health diagnoses. While lack of follow through in case planning efforts may easily be attributed to ones' mental health challenges, it is also important to note that other factors such as general distrust of child welfare systems may also contribute to a parents' poor engagement. It is also important to be mindful of how certain mental illnesses, such as personality disorders or schizophrenia, are characterized within the literature. It may be posited that some mental illnesses carry more stigma than others, which may translate both in the literature as well as how practitioners relate to individuals with certain diagnoses. It is important to bear in mind that literature based on court records, such as Sheehan's (2005) and Ben David's (2021), partially reflect subjective assessments made by mental health and child welfare professionals. It is also important to note that child protection court records likely reflect the most severe of cases involving parental mental illnesses.

Along with diagnostic differences, the severity and duration of parental mental illness is another factor which contributes to the overall impact on children's welfare (Radley et al., 2021; Sahanapriya et al., 2021). Radley et al.'s (2021) research on parental psychosis suggests that

parents with chronic psychosis may be more likely to experience child welfare intervention including removal of children than those who experience acute psychosis. The authors also note that antipsychotic drugs can lead to a variety of side effects including weight gain and fatigue which can pose further difficulties with parenting (Radley et al., 2021).

Research conducted in Canada suggests that child welfare interventions are often initiated in response to suspected or identified child protection concerns associated with parental mental health (Joh-Carnella et al., 2021). However, parents involved with child welfare agencies primarily for other reasons may also be more likely to experience mental health challenges. Recent research highlights how parents who experience mental health challenges and are involved with child welfare systems are more likely to have cooccurring risk factors such as domestic violence, substance abuse, social isolation, or housing insecurity. (Kaasbøll & Storhaug, 2025). Another study suggests parents involved with child welfare agencies primarily due to child behavioral challenges are also more likely to meet the clinical threshold for mental health diagnoses compared to non-child welfare involved parents of children with similar behavioral challenges (Acri et al., 2015). Such findings demonstrate the complexities of familial experiences with mental health challenges and the important considerations that child welfare and mental health professionals must factor into their treatment or case planning.

The impacts of the COVID19 pandemic, including lockdown measures, added additional complexities to the issue of parental mental health (Johnson et al., 2021; Russell et al., 2020). This may be due to isolation and increased tensions between household family members during the pandemic (Russell et al., 2020). Johnson et al.'s (2021) research found that parents with pre-existing mental health diagnoses were particularly vulnerable to experiencing psychological distress associated with parenting during the COVID19 pandemic, particularly those who

reported carefully following lockdown procedures. The issue of parental mental wellness during the pandemic may be further complicated by issues of accessibility to adequate mental health resources during mandatory lockdowns (Johnson et al., 2021). This research highlights the importance of social and community supports in sustaining healthy familial functioning. It also underlines the complex issue of balancing between physical and emotional aspects of health and wellness. Overall, it is evident that the social impact of the COVID19 pandemic has taken a complex toll on the mental health and wellness of families (Johnson et al., 2021; Russell et al., 2020).

The literature also suggests that children of parents with mental health challenges are at a greater risk of experiencing poor psychosocial functioning themselves (Dalgaard et al., 2016; Dean et al., 2018; Radicke et al., 2021). Specifically, Dean et al. (2018) found that children of parents with mental illness were more likely to exhibit both internalizing and externalizing traits of emerging psychopathology. This may be due to the hereditary nature of some mental illness, potential environmental stressors and trauma related to having a parent with a mental illness, or a combination of both. Along with psychological deficits, children's overall physical wellbeing can take a toll (Radicke et al., 2021). In cases of parents experiencing paranoia, children may be excessively sheltered and develop fearful worldviews (Radley et al., 2021). One study indicates an association between parental mental illness and child internet addiction, which the authors speculate may be a way of comfort seeking when parents are not meeting the emotional needs of a child (Sahanapriya et al., 2021). Such findings may also elicit further curiosity about the impacts that parental mental illness may have on a child's social development. A Norwegian study suggests that in cases involving parental mental illness, nearly one third of children live alone with the parent and lack additional adult supports (Reedtz et al., 2019). Radicke et al.'s

(2021) research shows that the presence of social supports may be one of the strongest indicators of positive outcomes for children of parents with mental illnesses. Interventions for children should include psychoeducation and the building of supportive networks (Radicke et al., 2021). Such findings not only further highlight the significance of social and familial networks in supporting families impacted by parental mental illness, but also point to the importance of mental health and child welfare professionals to work with the entire family unit in mitigating risks and supporting positive outcomes for both children and parents.

Capacity for Effective Parenting

Despite the well-documented impacts on children, much of the literature also points to the fact that parents with a wide range of mental health challenges have the capacity to provide quality care to their children (Friedman & McEwan, 2018; Jones et al., 2016). Sheehan (2005) found that successful parenting was often hindered by a parent's' lack of ability to recognize or address their mental health concerns. There is further research which indicates that, with appropriate treatment in place, parents with mental illnesses do not pose any higher risk of harming their children than do parents without mental illness (Friedman & McEwan, 2018). As noted by Radley et al. (2021), even ill-conceived parenting decisions associated with mental illnesses are often made in a perceived effort to protect children. For example, a parent experiencing paranoia may excessively shelter their child with the intentions of keeping the child out of harm's way (Radley et al., 2021). While potentially harmful, this exemplifies the possible loving intentions that may inform questionable parenting decisions. It also underscores the importance of professionals seeking to understand the reasoning behind actions rather than making assumptions about a parent's intentions. Many parents demonstrate knowledge and insight into the risks that mental illness can pose to their children and take actions to protect their

children and educate them about mental health (Jones et al., 2016; Radley et al., 2021). Research has also repeatedly identified that parents with mental illnesses may be more likely to prioritize educating their children about mental health and engaging in emotional identification (Jones et al., 2016; Kaasbøll & Storhaug, 2025; Kedzior et al., 2024). Research also indicates that having children can serve as a motivator for parents to ensure that they were adequately tending to their own mental health and wellness (Hanson et al., 2019; Jones et al., 2016; Kedzior et al., 2024). This drive can be powerful in effecting positive change, given that motivation is a key predictor of intervention success (Van Dongen, Sabbe & Glazemakers, 2018).

It is also important to note that the presence of a supportive extended family network can play a significant role in enhancing the child wellbeing and mitigating risks for children of parents with mental health challenges (Reedtz, et al., 2019). As such, it is important for professionals providing services to these families to explore the existence of such support networks and whether involving them in ongoing supportive planning would be helpful. Similarly, supportive parenting programs specifically tailored to parents experiencing mental health challenges may also be valuable. One Australian study demonstrates the efficacy of a positive parenting program designed for parents with mental health challenges (Phelan et al., 2013). This program, which was adapted from the Triple P model, entailed parents engaging in reflection on their parenting responses in the context of their mental health. Following engagement in the program, parents demonstrated improved communication skills as well as an increase in motivation and preparedness to respond to child behavioural issues (Phelan et al., 2013). Such findings are significant, as they highlight the strength and capacity of parents experiencing mental health challenges. This puts further onus on professionals, particularly those in the child welfare field, to work patiently and collaboratively with parents throughout their

mental health treatment process. It also highlights the value of interventions that provide empowering tools to service users.

Despite the abundance of evidence supporting the capacity for parenting with mental health challenges, many parents remain reluctant to seek out appropriate supports in managing their mental health due to the fear of stigma and reactive interventions (Jones et al., 2016; Kedzior et al, 2024; Lever Taylor et al., 2019; Radley et al., 2021). For child welfare professionals, this points to the need for caregiver encouragement for those who are not already seeking mental health supports to do so in a non-shaming or non-threatening manner. Of course, such conversations require established rapport and trust.

Early Intervention and Shared Responsibility

The importance of early intervention in cases of parental mental illness where there are child protection concerns is highlighted in the literature. Reedtz et al.'s (2019) research underlines the vulnerability of younger children, particularly those under the age of five, whose parents are experiencing mental health challenges. This is echoed by Dean et al. (2018), whose research indicates the need for supports at a young age in such cases due to the increased risk of poor psychosocial development. While there is nearly a 15-year gap between Darlington et al.'s (2005) research and Ben David's (2021), both authors recommend that improved preventive supports be in place for parents who are dually involved in mental health and child welfare systems. Clear and meaningful planning needs to be in place between agencies and families to provide necessary supports for parents to succeed while minimizing risks to children.

A review of the literature also notes the significance of shared responsibility between systems and families in monitoring the wellbeing of children. The idea of shared responsibility between systems in serving families is highlighted by Webber et al. (2013), who examined the

effectiveness of policies implemented in the United Kingdom which put the onus on mental health and child welfare systems to work collaboratively to maximize protection efforts for children whose parents are experiencing mental health challenges. This involved providing clear guidelines for interagency collaboration. Practitioners reported both an increase in accessibility of program referrals for clients as well as an improvement in overall collaboration following the implementation of such protocols. Mason et al.'s (2018) research reiterates this notion in a Canadian context, as the authors identified a need for shared responsibility between Ontario public systems in identifying and intervening in child protection concerns where parents are experiencing mental illness. More recently, Kedzior et al.'s (2024) research found that parents expressed a desire for better coordination across services, finding many services difficult to navigate due to operating in silos. This further emphasizes how interagency collaboration can make services more accessible to families. As neither families nor systems can flourish in isolation, collaborative community efforts are critical in supporting children and families impacted by parental mental health challenges.

Systemic Inequality and Cross-Cultural Considerations

In exploring health and social service professionals' experiences in relation to parental mental illness, it is important to recognize both systemic and cross-cultural factors that may play a role in working with parents and families. One notably referenced issue in the literature is that of gender, as professionals are often focused on mothers as the primary caregiver. Mothers experiencing mental health challenges are often subject to heightened judgement by professionals, while fathers are largely ignored and disregarded (Ben David, 2021; Jones et al., 2016; Lever Taylor et al., 2019). Radley et al.'s (2021) research indicates that among parents

experiencing psychosis, mental health professionals report that single mothers appear to be most vulnerable and often subject to child welfare involvement.

Issues of poverty and unemployment also cannot be ignored with respect to parents experiencing mental health challenges and child welfare involvement. This is again exemplified by Radley et al.'s (2021) research, which indicates that low-income parents may be more likely to be met with social service intervention than wealthy parents, regardless of symptomology. Poor mental health may also increase a parent's risk for experiencing poverty and unemployment (Sheehan, 2005). As such, it is crucial for professionals to be mindful of the mutually reinforcing relationship between poverty and mental illness. Ben David (2021) contends that the nature of such factors should be addressed by human service professionals when working with parents.

It is also crucial to examine the cross-cultural experiences of mental health and child welfare service users. Wylie et al. (2018) highlight the importance of being mindful of cultural biases that exist in the Diagnostic and Statistical Manual of Mental Disorders, the dominant tool used by Western mental health professionals to assess mental illness. While the most recent edition of the manual contains guidelines for cross-cultural practice such as considering impacts of war and community trauma, Wylie et al.'s (2018) research indicates that many professionals are unaware of this and avoid conversations about culture altogether in the context of mental health services.

Along with being mindful of cross-cultural belief systems, it is also important to be cognizant of personal experiences of trauma. In cases of refugee parents, the literature strongly suggests that such trauma can be intergenerational in nature and can also lead to parent-child attachment disruption that may result in child welfare concerns (Dalgaard et al., 2016; Wylie et al., 2018). This reality is also evident among Indigenous Peoples in Canada, which is

exemplified in one scoping review of the detrimental impacts of residential schools on the physical and mental health, including substance abusing behaviours, depression, and suicidality among residential school survivors as well as descendants of survivors (Wilke, Maltby & Cooke, 2017). These findings further affirm the intergenerational nature of the legacies of colonization, war, and trauma. As well, such experiences of community trauma emphasize the value of non-Western, Eurocentric approaches to treatment and healing. For instance, research supports the effectiveness of land-based traditions and Elders' guidance in enhancing Indigenous mental wellness (Walsh, Danto & Sommerfeld, 2020).

Exposure to Child Welfare and Mental Health Systems

While existing research that explores interagency collaboration between child welfare and mental health services specifically in relation to parental mental health is somewhat limited, there is a broad array of literature that examines either system's standalone services to parents. Before simply examining professional collaborative experiences, it is critical to explore parents' experiences of working with professionals in relation to their mental health.

While health and social services have the potential to act as supportive resources for families, the fear of experiencing stigma and losing parental rights can impact trust or ultimately prevent parents from initiating and seeking mental health supports (Jones et al., 2016; Kedzior et al, 2024). In one qualitative study, Lever Taylor et al. (2019) examined experiences of social work interventions for mothers who were having perinatal mental health concerns. Many of the mothers expressed feeling misunderstood and felt that social work intervention exacerbated their mental health symptoms. The mothers reported feeling more trusting of mental health professionals compared to child welfare workers, which speaks to the importance of improving mental health expertise and enhancing collaborative efforts within the child welfare system.

While most of the mothers who participated in this study had negative perceptions of child welfare, positive experiences were reported when mothers felt that social workers focused on getting to know them and building a relationship (Lever et al., 2019). In other research by Kedzior et al. (2024), parents described the value of child welfare agencies' willingness to connect them with practical supports, such as parenting programs or financial assistance, during crises. In another qualitative study, dually involved parents expressed concerns about the inefficiency of disjointed services and having to retell stories between mental health and social services (Jones et al., 2016). This highlights the need for professionals to establish a unified reporting protocol and support system for families involved in dual relationships. It also points to the need to develop an efficient, confidential, and ethical information-sharing protocol between health and child welfare systems.

Interagency Collaboration

Improving interagency collaboration between mental health and child welfare systems in relation to supporting families impacted by parental mental illness is listed as a recommendation in numerous articles (Acri et al., 2015; Colvin & Thompson, 2020; Darlington et al., 2005; Houlihan et al., 2013; Jones et al., 2016; Kaasbøll & Storhaug, 2025; McCartan et al., 2022; Reedtz et al., 2019; Riihimaki, 2015). As such, it is important to understand what factors influence the success of interagency collaboration. A variety of themes can be identified in the literature, including competing interests, clarity of policies and roles, educational initiatives, and the quality of interpersonal relationships.

Competing Interests

Although mental health and social service workers share a common goal in enhancing the wellbeing of individuals and families, there are a variety of ways in which their areas of focus

may conflict. Some of the literature points to inconsistent paradigms and professional identities between child welfare and mental health professionals (Coates, 2017; Darlington et al., 2005; Hanson et al., 2019). Although there is substantial evidence that the wellbeing of parents and their children is greatly interconnected (Dean et al., 2018; Radley et al., 2021; Wylie et al., 2018), mental health professionals may focus on upholding the rights of their parent patients (Sheehan, 2005). Conversely, child welfare workers may be more likely to maintain a child-centered approach while undermining the importance of supporting parents (Lever Taylor et al., 2019; Radley et al., 2021; Sheehan, 2005). This research indicates that while many mental health professionals favour using a holistic approach in practice, some also express using an approach which focusses solely on the patient's recovery in isolation from other factors. This is exemplified in one study by Krum et al. (2014) where many mental health professionals expressed a belief that patients' roles as parents are private in nature and denied having extensive conversations with patients about family and related responsibilities. This finding was echoed in Radley et al.'s (2021) qualitative study with mental health professionals, whereby many participants favoured an approach to practice which focuses on individual patient recovery, leaving all the family-related concerns for child welfare services. Houlihan et al. (2013) found that while mental health professionals reported they routinely asked patients about their families upon the initial assessment, many admitted that ongoing collaborative work with and consideration of the patients' families was lacking. Krumm et al.'s (2014) work suggests that mental health professionals are mindful of past issues, such as forced sterilization, where human rights have been infringed upon in relation to parental mental illness. As such, mental health professionals tread a fine line in balancing the rights of patients with those of patients' children (Krumm et al, 2014). Some research has also referenced mental health professionals' concerns

for the decline in patient recovery due to stress and trauma associated with child welfare interventions (Coates, 2017).

In contrast, child welfare professionals' focus on risk mitigation in cases of parental mental illness may undermine the importance of collaborative work and relationship building with parents. Many parents find it difficult to work with child welfare professionals when they maintain an excessive focus on potential risks to children without taking the time to get to know parents as people (Jones et al., 2016; Lever Taylor et al, 2019). Research indicates that many mental health professionals agree with this sentiment and feel that often child welfare workers operate off fear, without having an accurate understanding of the actual risks of parental mental illnesses (Coates, 2017; Darlington et al., 2004). Some mental health workers even express apprehensiveness around communicating with child welfare to protect families from excessive and potentially harmful interventions (Radley et al., 2021). Darlington et al. (2004) report differing views of risks as being a major barrier in interagency collaboration between mental health and child welfare services. Collaborative and holistic approaches by both child welfare and mental health professionals are favoured in the literature (Darlington et al, 2005; Hanson et al, 2019; Radley et al., 2021). Radley et al. (2021) even suggests value in bringing older children into planning meetings with professionals. The practice of identifying common goals between the two systems is also favoured in the literature on interagency collaboration (Coates, 2017; McCartan et al., 2022). Concerns about the possible negative impacts of child welfare interventions highlight the need for child welfare professionals to be cognizant of existing power relations in the work they do with families. While these findings illustrate the potential for competing interests between professions, they also highlight the opportunity for establishing common ground in interagency collaboration. Further, there is evidently a need for both child

welfare and mental health systems to move towards more holistic approaches that appreciate the interconnected nature of parent and child wellness.

Clarity of Policies, Practices, and Roles

Clear guidelines on policies, practices, and roles are also a foundational component of successful interagency collaboration. Mental health practitioners' understanding of procedures for making child protection reports is one example of this. In one European survey given to psychiatric nurses, close to half of the participants reported that they were not aware of processes or expectations surrounding making child protection reports (Houlihan et al., 2013). This process can be further complicated by mental health workers' need to maintain transparent and supportive relationships with families. As such, mental health professionals may find it beneficial to clearly communicate their duty to report child protection concerns to parents at the outset of their working relationship with families, thereby setting clear expectations (Hanson et al., 2019; Radley et al., 2021). Further, mental health professionals may find it helpful to clarify to parents that child welfare services are not strictly punitive and can potentially play a supportive role in their lives (Radley et al., 2021). These findings highlight the importance of clear policies surrounding child protection reporting among human service professionals. As well, further initiatives should be taken to educate both the public and professionals alike about the scope of services offered by child welfare agencies.

Policies surrounding confidentiality can pose yet another barrier in interagency collaboration (Coates, 2017; Colvin & Thompson, 2020; Darlington, 2005; Webber et al., 2013). While some research emphasizes the value of open communication and information sharing between the systems (Martins & Tucker, 2023), mental health professionals often tread a fine line between reporting child protection concerns and respecting their patient or client's

confidentiality. While parents may provide written consent for professionals to communicate with agencies about treatment plans, this additional step can impact the efficiency of collaborative practice (Colvin & Thompson, 2020; Webber et al., 2013). In one Canadian study child welfare professionals reported having trouble obtaining information about parents from mental health professionals for case planning purposes, which participants felt was likely due to a lack of clear policies and protocols on information sharing in such cases (Mason et al., 2018). Mental health professionals who are contracted to do therapy and assessments for families may also be apprehensive about collaborating with child welfare agencies due to the potential of being roped into legal processes or being subpoenaed (Colvin & Thompson, 2020). This underscores the importance of clarity of roles and communication about potentially conflicting practices at the outset of collaboration involvement between systems. The literature suggests that limited understandings of one another's policies present a hindrance in successful interagency collaboration between mental health and child welfare systems to the detriment of children and families (Coates, 2017; Colvin, 2020; Darlington, 2005). Similarly, Acri et al (2015) emphasize the need to critically examine how policies between mental health and child welfare systems impact service delivery to parents.

Clarity in roles and expectations for both agencies and families are also a vital component in effective interagency collaboration (Darlington et al., 2005; Radley et al., 2021; Mason et al., 2018; Van Dongen et al., 2018). Houlihan et al. (2013) recommend that professionals be given clear policies and procedures related to working with other agencies in instances of parental mental illness. The expectations between agencies should be clearly defined at the outset of the collaborative process (Van Dongen et al., 2018). This process is exemplified by two different successful interagency collaborative initiatives discussed in the literature. One study by Hanson

et al. (2019) evaluates a collaborative model between mental health clinicians and child welfare professionals in working with parents who are recovering from substance abuse. This model begins with an open and honest discussion between clinicians, families, and child welfare professionals about the expectations of all parties involved including what will and will not be shared between professionals. This step proved to be a vital component in successful case planning which ultimately benefited families involved by mitigating risks to children while keeping families together (Hanson et al., 2019). Another study by Webber et al. (2013) in the UK evaluated the effectiveness of inter-agency protocols that were implemented between mental health and child welfare professionals. These protocols, which entail education between agencies about policies and expectations, were found to enhance the collaborative process through reducing role ambiguity (Webber et al., 2013).

Education

The need for ongoing educational initiatives between mental health and child welfare professionals is another overarching theme in the literature. Darlington et al.'s (2004) research indicated that neither child welfare nor mental health professionals were adequately educated on the complex issue of parental mental illness and could both benefit from one another's expertise. While this research may be outdated, recent literature continues to echo this theme.

More recently, the need for continued education and improved knowledge of mental health related issues among child welfare professionals is emphasized in the literature (Lever et al., 2019; Martins & Tucker, 2023). In one study that explored the views of parent participants, they expressed feeling that child welfare professionals did not adequately understand their mental health experiences (Lever et al., 2019). This notion is supported by other studies whereby mental health professionals expressed concerns to researchers about child welfare workers' lack

of knowledge about parental mental illness (Coates, 2017; Radley et al., 2021). Without sufficient knowledge and education about the complexity and diversity of mental illnesses, child welfare professionals cannot adequately assess risks that parents experiencing mental health issues pose to their children (Coates, 2017; Kaasbøll & Storhaug, 2025; Radley et al., 2021; Sheehan, 2005). Mental health professionals have also expressed a desire to researchers that they be consulted with about mental health issues by child welfare workers before decisions are made based solely on a parents' mental illness (Coates, 2017; Sheehan, 2005). Interestingly, this sentiment is echoed by child welfare professionals. Mason et al's (2018) research indicates that child welfare professionals desire more opportunities to consult with mental health professionals and increase their own awareness of adult mental health issues.

Along with knowledge about mental health challenges, the literature suggests that child welfare workers may benefit from increased education about clinical treatment processes. In one American study, clinicians working with child welfare involved families voiced feeling pressured by case managers to meet therapy objectives with families in a rushed manner. In this study, clinicians reported feeling that child welfare professionals were often overly focused on achieving specific case-planning objectives and meeting deadlines, which were thought to undermine the value of the therapeutic process (Colvin et al., 2017). Further, mental health professionals participating in Radley et al.'s (2021) study discussed experiencing pressure from child welfare professionals to remain involved with parents with mental health challenges longer than deemed beneficial from a mental health treatment perspective. Participants noted that this pressure was likely founded in fear associated with a lack of education around mental illnesses rather than an actual need for extended clinical involvement (Radley et al., 2021).

Similarly, there is also an apparent need for increased education among mental health professionals about child protection issues. Mental health professionals admit that they are likely not regarded by child welfare professionals as being knowledgeable enough in child protection related domains (Coates, 2017). The literature suggests that mental health professionals often feel insufficiently prepared to deal with the complexity of child protection issues as they arise and some even report being undereducated about the impacts of parental mental illness on children (Colvin et al., 2020; Houlihan et al., 2013). In Houlihan et al.'s (2013) research, many psychiatric nurses reported feeling that they lacked training in communicating with younger children and stated that they would benefit from increased education on assessing parent-child relationships in cases of parental mental illness. Mental health professionals also reported feeling unprepared to talk with patients about having children and may avoid conversations about it altogether (Krumm et al., 2014).

Together, these findings indicate a need for further education and professional development among both child welfare and mental health professionals. The value of interagency training efforts is largely favoured in the literature (Colvin et al., 2020; Darlington et al., 2004; Hanson et al., 2019; Mason et al., 2018; McCartan et al., 2022). Interagency trainings with mental health and child welfare professionals provide an opportunity to create common goals and improve understanding of one another's practices, professional lenses, and jargon. They also provide opportunities for relationship building among professionals and increased knowledge of supports and resources that can be offered across agencies (Colvin et al., 2020; Hanson et al., 2019). The issue of differing professional values and paradigms between mental health and child welfare workers may also point to the value in exercising professional reflexivity. Reflecting on and openly discussing personal views and biases is an aspect of

professional development that is supported in the literature (Coates, 2017; Krumm et al., 2014; Wylie et al., 2017).

Interpersonal Relationships Between Agencies

The quality of interpersonal relationships between professionals is a critical component contributing to the effectiveness of interagency collaboration. The need for improved communication between agencies is cited widely in the literature (Colvin & Thompson, 2020; Coates, 2017; Hanson et al., 2019; Houlihan et al., 2013; Webber et al., 2013). Interpersonal relationships between agency professionals may be improved through establishing common goals and clearly outlining each other's roles and responsibilities (Hanson et al., 2019). The issue of overburdening caseloads and high turnover within child welfare agencies can make regular communication with child welfare professionals particularly difficult (Colvin & Thompson, 2020). This also highlights the need for increased systemic initiatives around employee retention and manageable workloads within child welfare agencies. Improved communication and interpersonal relationships between professionals can benefit clients in that the delivery of services are made more efficient. As well, conflicting messages about treatment or intervention plans from different professionals can be avoided through ongoing communication (Coates, 2017; Colvin & Thompson, 2020; Jones et al., 2016).

Along with interagency trainings, communication and interpersonal relationships can be strengthened between agencies through the increased use of systems meetings and wraparound approaches. Such methods of interagency collaboration to meet client needs are regarded favourably in the literature (Coates, 2017; Jones et al., 2016; Mason et al., 2018; Van Dongen et al., 2018). Van Dongen et al. (2018) notes that bringing in a wide array of professional expertise is not only beneficial to clients but also enhances the knowledge of professionals. In Van

Dongen's (2018) research professionals reported that, while practices can be time consuming, clear protocols for interagency collaboration result in a sense of shared responsibility among professionals.

Implications for Research

There is an abundance of literature that is relevant and valuable to the topic of interagency collaboration between child welfare and mental health services with regards to parental mental illness. Recent literature pertaining to this topic echoes many of the findings and recommendations of earlier research. For instance, Darlington et al. (2004) found that there was a need for improved role clarity, clarity of relevant policies, and increased educational efforts among workers in both systems. Mason et al.'s (2018) research suggests that these hindrances to interagency collaboration continue to be present. This brings into question how effectively the literature is utilized in making policy changes.

The literature indicates that parental health and wellness plays a crucial role in supporting the overall wellbeing of children and families. As the literature suggests, parental mental health challenges can be associated with a variety of child protection issues when the proper supports are not in place. This highlights the value in effective collaboration between systems in fostering familial wellness. The literature reviewed suggests that factors such as education, interpersonal relationships, role clarity, and potential competing interests influence the quality of professional collaborative experiences. Future studies in this area may benefit mental health clinicians and child protection workers alike. Darlington et al's (2004), research provided a rich exploration of the experiences and perspectives of both mental health and child welfare professionals. In examining the effectiveness of such collaborative efforts in serving families, revisiting the

experiences of professionals from both systems may be a valuable approach to explore in the Manitoba context.

Conclusions

It is evident that there is a need for continued efforts to effectively serve parents experiencing mental illnesses or mental health challenges. Effective interagency collaboration between child welfare and mental health services is crucial in meeting this need. As such, examining professionals' collaborative experiences is an essential step toward understanding how services can be optimized. The literature indicates that there is a need for improved professional knowledge of issues related to parental mental illness. Child welfare professionals may benefit from enhanced education in areas of mental illness, while mental health professionals may require further training on child protection matters. Clarity of professional roles and relevant policies, such as those surrounding confidentiality, is important to establish at the onset of collaborative relationships. Competing interests and differing professional values may hinder successful collaborative relationships. This highlights the value of establishing common goals while recognizing and appreciating the differences among professionals. As such, opportunities for interagency trainings and consultative processes between professionals may be beneficial in overcoming many of the barriers identified and ultimately improving interagency relations. Efforts to form strong collaborative relationships between mental health and child welfare agencies must be addressed by establishing strong policies and initiatives that will ultimately enable professionals to best serve children and families.

Chapter 3: Methodology

Research Design

This study was qualitative in nature and used semi-structured interviews to examine the experiences of mental health and child welfare professionals in providing services to parents who experience mental health challenges and who are involved with both systems. As the aim was to explore the nuanced experiences of participants without excluding context, this was best achieved through a qualitative rather than a quantitative approach. The interview questions (see Appendix C) were intended to provide a template for providing data to inform the research questions and serve as a starting point for participants to share their experiences. The semi-structured nature of the interview allowed participants to deviate from the initial questions and to provide further experiential context relevant to the research question. Participants completed a brief, one-page basic demographic survey, including information such as gender and years in the field (see Appendix B), prior to the interviews. This served to identify variation in participant characteristics, including potential limitations in diversity, when interpreting the research. The demographic survey questions were optional for participants.

Phenomenology

This research employed a phenomenological approach. Creswell & Creswell (2018) describe phenomenological research as an exploration of participants' experiences in relation to a certain phenomenon. In the context of this research, the phenomena of interest were the experiences of participants in relation to collaborative professional practice in serving parents who are dually involved with mental health and child welfare systems. Gill (2014) describes a variety of approaches to phenomenological research, namely descriptive and interpretive phenomenology. The former focuses on in-depth descriptions of participants' experiences, while the latter allows for more analytical interpretation, acknowledging that everyone has their own

subjective reality. While this research is primarily descriptive in nature, there will be analyses with acknowledgement of researcher's positionality and an acknowledgement that the researcher's interpretation of participants' words may deviate from the participants' intended meaning. As Newberry (2012) contends, it is also important for the researcher to acknowledge their own social standpoint and factors which may impact their interpretive analysis throughout the research process. This reflexive process on the part of the researcher, known as bracketing, is a critical step in phenomenological research. The goal is for the researcher to set aside past knowledge and experiences in relation to the topic being explored to make room for new information brought forward by participants. While it may not be possible to separate oneself from one's experiences and knowledge, at the very least the researcher should make a list of their own knowledge, assumptions, and experiences in relation to the topic (Giorgi, 1997). This may help the researcher to critically acknowledge their own views as a product of their standpoint, which cannot be indicative of the whole truth. This critical attitude is central to phenomenology (Giorgi, 1997). In this research, the researcher engaged in ongoing critical reflexivity regarding personal interpretations and biases. This will be further discussed in the positionality statement. Newberry (2012) argues that attention to structural and individual factors that impact experiences makes phenomenology a desirable approach within the context of social work research.

Philosophical and Theoretical Considerations

This research has aimed to operate from an anti-oppressive lens. Brown & Strega (2016) describe anti-oppressive research as entailing critical reflection on positionality and power differentials. This means seeking to employ an approach that both challenges assumptions and recognizes social positions including those which intersect. Additionally, this perspective

involves recognizing that access to knowledge can be treated as something that is privileged and profitable (Brown & Strega, 2016).

As such, it is important to remain critical of forces that maintain power differentials between service users and those we consider to be experts. Tosone et al. (2025) contend that anti-oppressive practice in the context of mental health services means evaluating how experiences of oppression and poverty impact overall wellness. Following principles of empowerment and employing minimal intervention to achieve desired outcomes are essential steps in practicing from this approach (Tosone et al., 2025).

In the context of Manitoba, this approach also entails acknowledging the overrepresentation of marginalized and systemically disadvantaged individuals (Indigenous and racialized peoples) within the child welfare system. As can be exemplified by Wilke et al.'s (2017) review on the impacts of residential schools on Indigenous populations, it is crucial to consider social determinants of mental health. Employing an anti-oppressive lens in the context of this research has entailed critical consideration for forces that marginalize service users while maintaining a central focus on the importance of empowerment. Practicing reflexivity throughout the data analysis process was also integral to the anti-oppressive approach.

This researcher has operated from a constructivist worldview, in that the subjective experiences and realities of participants were examined (Creswell & Creswell, 2018). In the context of this research, this has entailed understanding how the participants' knowledge and views may relate to their professional experiences and standpoints. Through conversations and open-ended questioning, the researcher has sought to gain as much context as possible about participants' collaborative experiences and views. In keeping with the constructivist research paradigm, the author acknowledges how these experiences may shape the trajectory of the

research process. In the context of child welfare-related research, the principle of keeping families together and addressing protection concerns through increased supportive services is central to the author's practice and educational pursuits. Understanding the powerful reciprocal nature of parent and child wellbeing is at the basis of this principle and has been kept at the forefront of this research.

Positionality Statement

This researcher acknowledges that positionality matters in the context of research. There are aspects of the researcher's personal and professional identity that may have impacted how data was conceptualized or delivered. Firstly, the author's professional background is in child welfare and biases may result from having experiential knowledge in this area. The author has also had a variety of experiences, both positive and negative, working collaboratively with mental health professionals to service both adults and children. This may have influenced how information is interpreted or make the researcher prone to making assumptions about meaning. As first-hand knowledge of the mental health system is limited to such collaborative experiences, additional research and clarification may be required to fully grasp data related to working within such systems.

The author is Canadian born and English speaking. As such, conceptualizations of issues surrounding mental health have been rooted in Western ideological beliefs. While the author aimed to operate from an anti-oppressive lens, first-hand experiences of marginalization are limited. In the context of this research, the author has been mindful of how workplace experiences of identity-based marginalization may shape one's professional collaborative practice. The author has aimed to be attentive to others' experiences, recognizing that they may differ based on their varying standpoints. In the context of this research process, the author has

practiced reflexivity through journalling and challenging assumptions that may have been derived from the author's standpoint.

Sampling and Recruitment

After obtaining approval by the University of Manitoba Research and Ethics Board, participant recruitment was primarily accomplished through advertisements shared in the Manitoba College of Social Worker's monthly E-Bulletin. A recruitment poster (See Appendix F) was shared with a brief synopsis of the research and the contact emails for the principal investigator and research supervisor. The researcher also shared the recruitment poster with individuals who were known to the researcher through the professional community and who were willing to share the poster with other social workers. Prospective participants who reached out to the researcher via email were provided with the consent forms as well as the optional participant demographic information form. Upon completion and receipt of the consent form, the researcher was able to schedule interviews with prospective participants. As such, participants were given the option between an in-person or a virtual interview. Participants were also asked to share the poster with other social workers they knew in either field of practice. A small honorarium was given to each participant following the interview.

All participants who completed interviews were Registered Social Workers in Manitoba at the time of the interview, which was verified through the public register. (See Table 1 for full demographic details) While not a part of the information requested on the demographic forms, a few participants did make note that they had experience doing social work in other provinces prior to their current roles working in Manitoba.

Table 1

Characteristic	Category	N=	%
Age (In years)	18-29	2	16.7
	30-39	6	50
	40-49	3	25
	50+	1	8.3
Racial Identity	White	8	66.6
	Black	1	8.3
	Indigenous	2	16.7
	Metis		
	Southeast Asian	1	8.3
Gender Identity	Male	3	25
	Female	9	75
Education Level	Bachelors Level	6	50
	Masters Level	6	50
Current Professional Role	Mental Health	6	50
	Child Welfare	5	41.6
	Other	1	8.3
Number of Years in Role	0-2	4	33.3
	2-5	3	25
	5+	5	41.6
Experience in Other Field	Yes	8	66.6
	No	4	33.3

Note. One participant had recent experience working in an adult psychiatric setting but recently moved departments. This participant's current role is listed as Other.

Data Collection

Once participants completed the consent forms, interviews were scheduled via email. Eleven out of twelve interviews were virtual, two of which were video calls using UManitoba Zoom and the remainder were audio calls. One participant chose to meet in person at the University of Manitoba to complete the interview. As previously indicated, preliminary

demographic data was provided through a written form which was exchanged via email. However, this portion was optional, and not all participants completed these forms in their entirety.

The interviews were scheduled to be one hour long; all fell within the fifteen-minute range of the scheduled time. To be mindful of the participants' time, they were advised when the one-hour mark was nearing. All interviews were recorded and transcribed verbatim. The researcher used Microsoft Word to do the auto-transcription of the interviews as a starting point. However, due to the program's tendency for inaccuracies, the researcher then listened to each recorded interview and made manual changes as needed.

Ethics

Prior to recruiting participants, this research was approved by the University of Manitoba Research and Ethics Board (Certificate #HE2022-0224). Since the initial approval, the ethics application was renewed annually throughout the duration of this research. The consent forms provided by participants (see Appendix A) reviewed the limits of confidentiality and information about how the data would be used. Participants were also advised that they could withdraw from the research process at any time. Limits of confidentiality (e.g. responsibility to report child abuse or neglect and harm to oneself or others) were verbally reviewed at the beginning of the interviews, and participants were advised of the researcher's efforts to make their information non-identifying within the research. Participants were informed that the researcher is working under a supervising researcher who would be the only other person who may see their directly identifiable information. Participants were provided with a form listing supportive resources (see Appendix E) and advised that it may be used if the interviews cause any distress.

The data collected was stored on the researcher's University of Manitoba OneDrive. Participants were given pseudonyms to protect their identities. Further, the researcher was careful not to disclose too many identifiable traits when discussing individual participants and redacted potentially identifiable information in quotations presented below.

Data Analysis

The researcher utilized steps for thematic analysis, beginning with transcribing and becoming familiar with the data, as described by Braun & Clarke (2006). Throughout the initial manual transcription of the data, the researcher made notes including keywords, initial impressions, and personal biases. The researcher then utilized NVivo software for qualitative data analysis. All transcriptions were uploaded to NVivo on a password-protected file. The researcher then used codes based on keywords and important concepts to organize the data. In the early stages of the research, the researcher was coding liberally and using an analytical approach that was largely inductive in nature. However, as the data began to build and concepts were formed, the researcher did begin to categorize information into larger categories that were most pertinent to the research question. For example, codes related to "confidentiality" would initially be placed under several larger categories such as policies or ethics. As the research developed, conscious choices were made about which categories best suited the code within the context of this research question. This entailed principles of thematic mapping and the review of codes and themes, as described by Braun & Clarke (2006). As the coding developed, the researcher's biases about the meanings of data likely increased to fit initially developing themes and ideas. However, the researcher attempted to counter such biases by exploring alternative meanings and reflecting on experiential biases. This was done through practices such as making notes with personal commentary following interviews and alongside the initial transcriptions.

Once codes were placed into larger categories, the researcher placed them under larger themes that fit within the context of the research question. For instance, the code for "experience working in the other field" had a parent code of "knowledge or education" which was placed under a larger category of "Professional Knowledge and Education". Many statements made by participants could fit under a variety of larger themes. As the researcher was able to share work with the supervising researcher, critical feedback on meaning-making was provided to enhance rigour. For further credibility, the researcher re-read and reconsidered these data at various points throughout the process. To enhance reliability, the interviewer regularly paraphrased participants' interview responses and asked for their feedback on the researcher's understanding of what they were saying throughout the interviews. A summary of the research results, excluding any identifying information, was shared with three professional peers working in either area of practice for initial feedback and debriefing. Feedback indicated that the findings were relatable, and no changes were recommended. Participant quotations were included in the results section described below to demonstrate interpretations of the data and to allow readers to critically interpret and challenge these data for themselves.

Chapter 4: Results

Daily Facets of Collaboration: Mechanisms, Approaches, and Communication

Many participants identified everyday practice mechanisms or approaches that affected the nature of their collaborative service delivery to parents experiencing mental health challenges. Identifying shared goals and establishing role clarity were described as practices that were conducive to building collaborative cohesion. Joint meetings were described as a valuable avenue for achieving such ideals. Clear and direct communication, as well as a willingness to be flexible, were described as professional approaches that may also enhance collaborative services and ultimately better support parents and their children. In contrast, a few participants described experiences of interpersonal challenges or hostility in daily collaboration. The accessibility of communication and the exchange of information were widely discussed as factors shaping participants' experiences of collaborative practice.

Establishing Cohesion Through Shared Goals and Identified Roles

Identifying common goals and respective roles was described as a vital step in establishing collaborative cohesion. One participant, Gina, who had experience working in both mental health and child welfare, described how ongoing collaborative efforts where there were shared goals, namely a positive outcome for families, were often more successful. Speaking of parent-child reunification, she said,

> Their investment to see the same outcome as me would be what led to that- like the return- because we're both doing the same, working towards the same goal, we're collaborating and not working in the same way but I guess moving forward as like a team (Participant Gina).

Another participant, Dale, described an experience in which a meeting facilitator clearly laid out the shared goals in the meeting minutes and articulated them with all parties involved, including the client. The participant describes how this helped establish collaborative unity:

> She would write out the minutes and everyone got it. The client got it, the mom got it, like everyone got it. So it was like very transparent. So I think that would be another thing that I think lent to good collaboration (Participant Dale).

Dale went on to describe:

> I think everyone knew we were there for the benefit of the child, but also the benefit of, the well-being of the whole family right? So I think having those shared stated goals is important (Participant Dale).

Aidan, another participant working in an adult psychiatric setting, echoed this notion. This participant specified that even when commonalities exist between goals, role clarity is important in achieving such efforts: “I think there needs to be a fair amount of work to ensure that both systems are aware of one another's responsibilities” (Participant Aidan).

Several other participants discussed the significance of role clarity in day-to-day professional collaboration. One participant, Gina, described the importance of role clarity in maximizing the quality of services to parent clients,

> I think each of us understanding our roles better would strengthen our collaboration. I think sometimes we're not always on the same page. If someone doesn't know what my role is with the family and it can breakdown communication for sure. If there's an expectation that I'd be doing something or vice versa and it's not happening and then our relationship working relationships isn't as strong as it should be (Participant Gina).

Another participant, Olena, who had experience working in both professional areas further emphasized the importance of communication around clarity of roles in maximizing the quality of support for parents when working collaboratively.

> That's what parents' need. You know, they need to have folks that are in their corner and, you know, helping them navigate these real challenges of parenting and mental health. And be able to kind of work together systemically to say, yeah, what can we do to kind of provide some ongoing support to this? You know, what's my role? What's your role? (Participant Olena).

A few participants working in child welfare at the time of the interviews discussed experiences whereby they believed adult mental health professionals had demonstrated a possible lack of understanding of the roles and responsibilities f child welfare workers. Tina described experiences in which such collaterals have provided clients with incorrect information about the duties within a child welfare agency's scope of work. For example,

> They provide really like really unrealistic expectations to the clients. So when the clients show up, they, they don't have the real image of like really the work that they actually have to do and what can be provided by either child welfare or even other agencies as well (Participant Tina).

Tina went on to suggest that if collaterals are unaware of what services child welfare can provide it would be best to just advise the mutual client to speak directly with the worker about this first, rather than setting that expectation.

Another participant, Betty, who was working as a supervisor in child welfare at the time of the interview, described a similar experience in which collaterals were requesting services from child welfare agencies outside the roles they were intended to fulfill.

> Whenever a resource, a source of referral contacts, the agency to report or to, you know, advocate for someone's mental health, they tend to illustrate it as a child protection concern because they're trying to motivate the child welfare system to undertake the process (Participant Betty).

Betty went on to describe the impact that such unrealistic expectations can have on workers and the system: “My experience has just been more about, you know, overwhelming workers and child welfare being the catch-all for these services” (Participant Betty).

Joint Meetings

Some participants discussed professional joint meetings as part of their collaborative experiences and identified core factors that contributed to the quality of those meetings. For instance, a few participants described their preference for in-person meetings over virtual ones. As an example, Gina described her belief in the value of in-person meetings for establishing professional collaborative relationships:

> I think when somebody hasn't met you and they hear all these negative things about you, there's a preconceived idea of who you are as a professional. And then people carry that with them. And then if they hear your name, you've already got that in your mind. So I think doing that intermingling face to name and getting a feel for who you are and how you practice might break some of that down too (Participant Gina).

Similarly, Aidan, who was working in an adult psychiatric setting at the time of the interview, described an incident in which he believed that the child welfare worker had not communicated the agency safety plan with a parent-client, and the overall communication between services was lacking. The participant conceptualized how an in-person meeting would have been helpful in this situation, particularly as it pertained to planning with the parent and family.

> If the worker or the agency had reached out to the unit to explore the opportunity to have in-person meetings to discuss you know the concerns and the safety plan I think- I think that would have been beneficial for everyone (Participant Aidan).

Olena, who had experience working in both systems and felt confident collaborating effectively with either field of professionals, discussed in-person hospital visits as a critical part of her practice as a child welfare worker.

> If you're a CFS worker or [redacted Intake agency] worker and suddenly find out somebody has been hospitalized and the first thing I did with my files is I would be all over the hospital and then go visit them and talk to the social worker (Participant Olena).

Dale, who had been employed in adult mental health at the time of the interview, discussed an experience whereby he participated in regular meetings between a child welfare agency and a parents' mental health team. In this instance, the child welfare agency assigned a meeting facilitator, which the participant described as an asset to the meeting quality. Dale described how having a meeting facilitator present was, in his view, an effective way of managing power differentials between the two systems and the parent-client. Referring to the facilitator, who was assigned through the child welfare agency, Dale described, "She was very

much a facilitator of good dialogue, relevant dialogue -like it never felt like it was a waste of meeting" (Participant Dale).

A few participants discussed systems approaches to meetings, in which family members and the systems through which they are receiving services come together to discuss plans and interventions. This approach was described as a meaningful and effective tool for collaboration. One participant, Melanie, who was a supervisor working in child welfare at the time of the interview, described the value of systems approaches from her experience.

> The ones that I've worked with where we've had maybe monthly systems meetings where we're all kind of collaborating together, we're connecting on a regular basis to talk about where things are at and some of our goals and next steps and kind of able to have those open conversations, especially with the parents involved in those discussions. Those have been the best (Participant Melanie).

Mara, who had experience working both in adult crisis services as well as child welfare, discussed her belief in the value of systems approaches for supporting parents who are experiencing ongoing mental health challenges.

> I think when it comes to, like, ongoing mental health, I can see, like, CFS being a role and then also other professionals maybe having like a systems meeting once in a while with the parents to kind of talk about what's been going on. Like what's been helpful, what hasn't been helpful? (Participant Mara).

Openness, Flexibility, and Inclusion

Many participants discussed how different professional approaches may have influenced their collaborative experiences. Several participants discussed how flexibility in professional

approaches can foster a positive collaborative experience. Some described the importance of professionals being open and willing to engage relevant parties in the planning process. Graeme, a participant with experience in both child welfare and adult mental health, discussed how such approaches can benefit collaboration between the systems. Graeme described the importance, in his view, of "Having that- that willingness of a broader dialogue, learning from one another and being able to meet in the middle when necessary". Conversely, the same participant described what a more challenging approach to collaboration may look like.

> The professional or the agency that they represent are coming in guns-a-blazing saying like 'this is what needs to get done now and this is our priorities and this is what needs to get done' right? It's that being closed off to the other professionals and the input that they're bringing to the table (Participant Graeme).

Aidan, who had been working in an adult psychiatric unit at the time of the interview, offered similar insight. Aidan described a collaborative experience where he appreciated the flexibility in approach by the child welfare worker as well as the inclusion of all parties in the planning process.

> I definitely appreciated that approach, it was more collaborative in terms of professional-to-professional. It included both the patient as well as the patient's partner and you know they were afforded the opportunity to speak to the concerns, to discuss the safety-plan to kind of- for lack of a better term- you know, negotiate the safety planning (Participant Aidan).

Dale, a participant who had been working in community mental health at the time of the interview, also recalled an experience where joint planning and flexibility were beneficial to collaboration. The participant shared that the agency was willing to include people important to

the parent client and all systems involved in the mother's life. He described, "Like everything got addressed, but the way it was accomplished felt like a very collaborative thing rather than a 'you shall, you shall, you shall' (Participant Dale)." The participant went on to describe experiencing willingness by the child welfare agency to include all parties in the collaborative process: "I think anyone probably conceivably could have been invited to the table " (Participant Dale).

Another participant, Jasmine, who worked in outpatient mental health at the time of the interview, described the importance of openness and inclusion in collaborative approaches between child welfare, mental health services, and parents.

> When there's good collaboration between all three, case planning can happen in a much more dynamic way. People can participate and offer solutions. Patients, social workers, and the CFS worker can all work together to come up with solutions that are the least intervention - with the balance between safety and intervention kind of come together (Participant Jasmine).

Participant Melanie further described the importance of flexibility in collaboration, particularly when creating case or treatment plans for parents experiencing mental health challenges. Drawing on her experience as a child welfare supervisor, she discussed how such approaches can shape the quality of collaborative services.

> Those are the ones that work out because then you have kind of like a safety plan or a care plan tailored to that person and their needs as opposed to just that cookie cutter kind of approach. So I think sometimes just kind of the willingness of both parties, both CFS and the mental health workers, to just, you know, create something unique to that parent (Participant Melanie),.

Another participant Eliza, who worked for child welfare at the time of the interview, described how one clinician's flexible approach was beneficial to the collaborative experience when providing services to a parent client. Eliza recalled the clinician's approach, "I remember the therapist being really flexible and eager to meet the parent where she was at." (Participant Eliza).

Daily Communication and Interpersonal Factors

Participants described a variety of aspects of daily communication that played into their overall collaborative experiences. Transparency and directness of communication, both between professionals and towards parent-clients, were frequently described as contributing to the quality of collaboration. Some participants also discussed how reciprocal versus one-sided communication impacted their collaborative experiences. Participants had differing views on information sharing in collaborative practice.

Transparency and Directness. Several participants discussed how direct communication between professionals can be beneficial in collaboration, particularly in overcoming challenges that may arise. Participant Aidan summarized how principles of communication, transparency, and advocacy can interact to enhance the quality of collaborative experiences.

> I think transparency and communication are two really big things. And then I guess too, as well just having the ability to have advocacy, you know whether that's a family friend, whether that's the mental health clinician, you know, CFS can act as an advocate as well (Participant Aiden).

Jasmine, who worked in both inpatient and outpatient mental health settings, described valuing transparency by child welfare agencies in communicating plans, as it allows space for emotional reactions in difficult situations.

> When the collaboration goes well, patients are informed, they're not surprised, they may not like the outcome, but at the very least, they have been given the right to their own information, the right to understand the plan and ask questions and the right to have, like their own kind of response or reactions to it (Participant Jasmine).

Some participants also described the importance of directness of communication between collaborative partners. Recollecting his experience working in child welfare, participant Graeme described how speaking up amidst disagreements or miscommunications in meetings has benefited his collaborative experience with mental health professionals.

> There were times right when I would speak up in meetings and and the professional was very apologetic. They're like ‘Oh yes- you're certainly- you're correct’, right? Like and ‘I didn't mean this’ right? And there were genuine apologies (Participant Graeme)..

Another participant Sabrina, who had experience working in both areas of practice, expressed a similar view. Sabrina described how directly addressing each other as professionals when issues arise can be helpful both for professional growth and overcoming practical issues amidst collaboration.

> No social worker is perfect, and you're going to miss things and we have to rely on each other to like help each other out. So if someone calls me out for like missing something or like not returning a phone call or something like that's just helpful for me. Like if I forget, please like, tell me. Like we all just have to want to do better and we have to just

> think about the impact that it has on people, it‘s so serious of a role I think (Participant Sabrina).

Both Sabrina and Jasmine, who had worked in adult psychiatric hospital settings, mentioned similar experiences whereby child welfare agencies have expected hospital social workers to relay plans for apprehensions to take place, without directly speaking to the parents themselves. Sabrina described her response to this scenario.

> ‘I will not be telling them that you are planning on apprehending like their child- like you have to talk to them’. It's like they are not even like talking to them directly and giving them this information is almost not even like a consideration or like a requirement (Participant Sabrina).

Such experiences may exemplify how collaborative service delivery can be negatively impacted when principles of transparency and role clarity are absent.

Accessibility of Communication. Many participants discussed the impact of daily communication accessibility between systems and families on successful collaboration. This was frequently mentioned in relation to reaching professionals, particularly child welfare workers, on the phone. A few participants attributed this to workload, while one participant identified the possibility that workers may not make adequate efforts to reach parents who are experiencing mental health challenges while in the psychiatric unit.

Mara, who worked for an adult crisis service at the time of the interview, described how child welfare response times can affect services to parents when they are required to report.

> It's been really difficult to get a hold of workers and oftentimes, like we're not able to get in touch with them right away. So usually our files are staying open for longer than they should because we need to, like, make that contact with CFS still (Participant Mara).

Jasmine, who worked in psychiatric outpatient and inpatient hospital settings at the time of the interview, expressed empathy for the workload that child welfare workers may experience while also describing how it impacts response times and overall services to families.

> They wanna be good stewards. But when you don't have the time to call somebody back that's just gonna just crush you over time. Huge caseloads that are causing people to be not observed enough (Participant Jasmine)

Another participant, Sabrina, described assisting clients when they have difficulties reaching child welfare workers while working in an adult psychiatric setting.

> They often are like not responsive to their calls or attempts to get in contact. So I mean we'll help connect them and like make calls, leave messages, share like our work lines to connect to (Participant Sabrina).

Melanie, who worked as a child welfare supervisor at the time of the interview, discussed experiencing difficulties with accessibility of communication between child welfare and mental health services in the collaborative process.

> Sometimes just playing telephone tag and chasing information and you're just not getting it and it takes three months before you even get anywhere- those ones are the most frustrating (Participant Melanie).

Interpersonal Challenges. A few participants described interactions with the other service professional that were affected by perceived disrespect or hostility. Reflecting on an experience as a child welfare supervisor collaborating with a community health service, Betty described an instance whereby the collaborative process was challenged by animosity from a mental health professional.

> I had recently where the community mental health worker came with such a level of hostility that I had to overcome the hostility every single time we met and it became to the point where it's like, this is not helpful and you're not seeing everything that we're seeing (Participant Betty).

Melanie, a child welfare supervisor, described how respectful communication can improve collaboration quality in her experience.

> When we are all kind of working well together, we're all communicating in a positive way about you know, how to kind of propel things towards change, a positive change- I think it's easy for everybody to get on board. If you're talking about it in a negative way, or if you're kind of like crapping on the other party and saying, you know, 'they're not doing their part and how dare they take this long to get back to us?' you know? If you're just kind of not positive in even the way that you're discussing the services that the family should be receiving, I think everybody feels that. Everybody feels either the positive or the negative, and I think the collaboration, as long as we ourselves are kind of viewing it as a positive thing for the family- the family will start to view it that way as well (Participant Melanie).

Aidan described an instance whereby he experienced an interpersonal challenge with a child welfare professional while he was working in an adult psychiatric setting.

> And then, you know, we're asking questions, and unfortunately, the worker was rather short, you know, with, with us and saying, you know, like, 'This is all the information I can share at this point. And you know, I have another matter to attend to and I need to go. I'll follow up upon discharge'. So that kind left a sour, you know, taste in my mouth (Participant Aidan).

Information Sharing. Participants expressed different views about how much information sharing between systems is appropriate when collaborating to serve parents with mental health challenges. Some participants described being more conservative with information sharing, limiting it to their duty to report safety concerns. Conversely, some participants described beliefs that more liberal information sharing between systems is beneficial for families.

Jasmine described her experience with exchanging information with child welfare agencies in her role as an outpatient mental health clinician.

> So in terms of the collaboration, I think it's there, but it tends to be more one sided. I'm asking CFS for information with the patients' consent so that we can include those things in our therapy setting, I don't think that there's very much of my stuff going back to CFS, unless there's a duty to report (Participant Jasmine).

Reflecting on her experience working for an adult mental health crisis service, Mara described receiving limited information from child welfare agencies about parent-clients and how she believes this could impact services to families.

> When we do like have those conversations with CFS, there's also not a lot of information that gets like shared back with us either. Like we kind of just make the report and that's it. But it like, even for us to know a bit of information might be helpful just so we have something on file that in the future if we have another contact with this family or this adult, then we can kind of reference back to this phone call and or like the communication with the CFS worker and kind of know- have like a bigger perspective of the situation as well (Participant Mara).

Drawing on his experience working in community mental health, Dale also described his views on information sharing for the benefit of the parent-client and how he discusses this with parents.

> I think there's real benefit in the two services working together or at least communicating together...and you know I guess my pitch to the to the parent would be 'You know, having us in a corner can help inform this process so that you know we can offer some real helpful information to CFS so they know how to, you know, how to support you' (Participant Dale).

Another participant, Olena, described how gathering and relaying information from mental health services benefited her practice as a child welfare worker and in determining case planning for families.

> I'd say in my work as a CFS worker and my ability to gather information from the key players from mental health teams that it's probably been really helpful in my assessment- whether we're going to close the file and not have further contact with the parent, or are we going to transfer the parent? (Participant Olena)

Aidan, who worked in an adult psychiatric setting at the time of the interview, discussed how he believes information sharing can play a crucial role in ensuring families receive appropriate services when parents are experiencing mental health challenges. In these instances, Aidan highlighted the importance of identifying strengths when making reports to child welfare agencies.

> I feel more comfortable perhaps than others to share, maybe a bit more information with the intent to again to make sure that you know, CFS, that those workers can do the most accurate assessment possible while also identifying- if these things are out there- you know the strengths of the individual, the mitigating factors right- while, you know, reporting the concern right? Making sure that those strengths are identified as well (Participant Aidan).

When asked for recommendations on optimizing collaborative services between adult mental health and child welfare agencies, Sabrina shared her views on how improved processes for information sharing and communication accessibility can enhance services for parents navigating both child welfare and adult mental health systems.

> There's so many issues with just getting a hold of people that like some sort of formalized committee and better processes in place for information sharing could be really beneficial. It seems- it could also be kind of scary to think about because you don't want information to be used improperly but it doesn't need to be. I think it could be very beneficial for... It's so hard for them to get these services and to get in touch with people- it doesn't need to be that hard, and I think that we have a responsibility to make it easier for them (Participant Sabrina).

Melanie described how, as a child welfare supervisor, she finds balance in exchanging information with adult mental health professionals.

> I think sometimes it's like discretionary what we both can share. Like what we can share about the case planning and the family situation and what they can share about you know how much or how, you know, little a parent is maybe participating in their treatment planning. And I mean, of course, we're not going to share like nitty gritty details that are not really relevant, but specific to their treatment plan or specific to their interactions with their children and how we can improve access arrangements or how we can improve the quality of the visit times and things like that- those things we can share freely (Participant Melanie).

Service Mandates, Priorities, and Resource Allocation

Participants described a variety of aspects of collaboration related to service mandates, prioritization, and resource allocation in their collaborative experiences. The involuntary element of child protective services was described by participants as conflicting with adult mental health services, which are most often voluntary in nature. Some participants discussed how a lack of accessible mental health resources for parents may limit opportunities for collaboration between the two systems. Specifically, a few participants noted that child welfare agencies' funding models are not conducive to preventative practice. A few participants shared ideas and experiences around having internal mental health resources within child welfare agencies.

Service Objectives and Priorities

Consistent with Darlington et al.'s (2004) research, participants cited the differing service objectives between mental health and child welfare systems as adding complexity to their collaborative experiences. Drawing on her experience as a child welfare supervisor, Betty

discussed the importance of child welfare agencies staying within the scope of their role as agents of child protection. She described the value of maintaining clear service objectives between systems, saying, “I think it would be really objective to keep everybody within their boundaries so that we're all doing our pieces and then our systems will all work better” (Participant Betty).

Another participant, Jasmine, who was working in a hospital setting for both inpatient and outpatient adult mental health services at the time of the interview, described how patient-centred advocacy is at the foundation of hospital social work services. “They think of the patients in hospital as having like a tether to the social worker here” (participant Jasmine). Jasmine went on to describe how adherence to this service objective can shape interactions with child welfare agencies.

> Sure, we follow our duty to report. But ultimately, we are not agents of CFS. In fact, we're often agents against CFS because we are connected- that tether is to the patient. So we're always looking at what does the patient need? What barriers, what obstacles? What kind of forces that are acting against that patient? (Participant Jasmine).

Participant Olena discussed how child welfare agencies’ emphasis on child protection may be at odds with other social workers’ philosophy of maintaining parent-child attachments. Drawing on experience from working in both fields, Olena described such differences in objectives as “child protection versus, you know, maintaining the parent-child relationship" (Participant Olena).

Voluntary and Involuntary Service Expectations. Another principal difference in services highlighted by several participants was the distinction between voluntary and

involuntary services. One participant, Eliza, who worked for a child welfare agency at the time of the interview, discussed how the involuntary role of child welfare agencies can be at odds with the often-voluntary nature of adult mental health services. Eliza described how these differing approaches can complicate collaboration in supporting parents.

> I don't think parents can be expected to change if they're not ready... But it just created some, I think challenges in how we how we navigate that. Like here I'm saying like you need to go get mental health support and then the mental health therapist is saying well only come when you're ready (Participant Eliza).

Melanie, who was also working in child welfare at the time of the interview, had similar reflections on these service differences. The participant describes the ethical complications of balancing a parent's right to free will while upholding an emphasis on child protection.

> I think my biggest struggle or I mean even frustration in terms of planning comes down to how there's often, like everything is voluntary it seems... So when it comes down to making safety plans or coordinating, just planning around a family, it's like nobody can really enforce anything it feels. So when someone's struggling with their mental health we can't had forced them to seek treatment, we can't force them to be on medication, we can't force them to go to therapy or counseling or whatever else other supports they might be requiring. And I think that frustration is probably shared. As much as we're frustrated with that- [mental health professionals] also are probably not able to force anybody to do anything that they don't want to do. And that their consent is important, and all of those things. So there's kind of that ethical sort of dilemma I think (Participant Melanie).

Melanie went on to discuss the safety implications that are sometimes present with unaddressed parental mental health challenges. In discussing how this influences safety-planning decisions in child protection, Melanie explained, “At the end of the day we have to respect their decisions. But their decisions come with consequences on our end, unfortunately.”

Another participant, Mara, who was working for an adult mental health crisis service at the time of the interview, described how their duty to report and the involuntary nature of child welfare services may impact a parent's willingness to participate in voluntary supportive services for fear of then being obligated to deal with CFS.

> It kind of gets a little complicated when there are child protection concerns that come up because our role is to really support the client- that would be the parent- but if they make comments that have, that are reportable to CFS then we have like an obligation to report that to CFS. But then there's that worry that OK, you were supposed to be here as a support, but now they've made this disclosure and we have to report it to CFS. So how is that going to impact our working relationship with this person in the future? Like, are they likely to give us a call in the future if they're going through something similar, or are they just going to say like, no, I don't want to talk to you guys because last time you called us on me? That's one of the biggest barriers that I deal with in terms of, like the overlap (Participant Mara).

Competing Timelines and Priorities. A few participants described how timelines, including the level of acuity associated with the service, can impact collaborative experiences. For instance, Mara noted that the acute nature of her work for an adult crisis service may align more with after-hours child welfare agencies, thereby creating a simpler collaborative experience.

> I think it's because [After Hours Child Welfare] are very much like crisis oriented and whatever is happening in the moment too. Whereas with like ongoing agencies, they just have so much on their workload that I think they probably don't have the capacity to respond as efficiently as after hours does because at after hours like you have to have your work done by the end of the day, right? Like you can't put it off until tomorrow because your whole goal is doing what you need to in the moment. I think when I contact after hours workers, I know that they're working on it right away versus like an ongoing worker where like chances are it's just one thing on their To-Do-List for the day or the week or month honestly (Participant Mara).

Melanie also described how constricting timelines imposed by child welfare agencies may shape service objectives and interact with parents' healing processes, highlighting how the involuntary nature of CFS' court requirements can impact a parent's path to healing.

> We are often kind of pushed by these like kind of really stringent timelines. Like I think you know, when you look at, OK, well maybe your kids have to come into care. You have this many months to, you know, kind of pull it together and make this drastic life change. Now that you're even kind of worse off because now you don't even have your kids with you, and now you're struggling even more and your mental health is probably even lower than it was when the kids came into care at the first place. And now you're kind of combating depression and anxiety and all of those things on top of it, plus having kind of this black cloud of CFS walking over you, so you have all of that. And then we're here telling the family you have six months to, you know, turn around. And I think when it comes to mental health, I don't think we can be that black and white (Participant Melanie).

Another participant, Gina, described how priorities may shift in an instant. Gina, who had experience working in both fields of practice, reflected on how factors such as workload and attending to crisis situations may shift social workers' priorities in either field, impacting their ability to deliver quality and collaborative service delivery.

> If we're just putting out fires and running- and you know, we could be collaborating in those pieces, but it's not going to work. We're not going to be successful if we're not fully invested because we've got burnout or other things happening in the background. Because in child welfare, you do have scenarios where you got to drop everything and you're going to the other family or, you know, in mental health well, we drop some families for the day and be like we'll pick you up when we get there (Participant Gina).

Prevention and Aftercare. Some participants discussed the importance of prevention work in providing collaborative services to parents experiencing mental health challenges. This aligns with recommendations in the literature (Darlington et al., 2005; Ben David, 2021). Shifting priorities amidst crises and limited resource availability were described as potential barriers to achieving this. Addressing concrete child safety concerns, as opposed to the underlying cause of such concerns, was described as a focus of service among a few participants.

When asked about families' needs regarding how the two systems collaborate, participant Gina emphasized the importance of prevention work for child welfare services. Gina reflected on an experience working for a child welfare agency, where she was frequently pulled into child protection work, despite her role being intended to focus on preventive services for family enhancement. Gina described how this could impact the way that mental health and child welfare services collaborate.

> It was disheartening because it's like we're trying to do prevention instead of reactive work and the higher ups aren't- it's all lip service is what it felt like- are saying that we want to do this, but we're not actually doing it. And so I feel that would have been a stronger way to even collaborate with mental health, so prevention services and mental health are working together and it's not- we're not at the place where we're having to even consider apprehension yet. It's just prevention and family enhancement as teamwork (Participant Gina)

Several participants discussed the importance of collaboration among services in building a strong aftercare system. A few participants working in the field of child welfare at the time of the interviews expressed concerns about the lack of continuity of mental health care for parents experiencing mental health challenges.

In her role as an adult crisis clinician, Mara described how her value for strong aftercare plays in her decision to communicate with child welfare agencies.

> I think my hope usually is that, ok, there's another agency that's involved and they can provide follow-up support when it comes to that parent. And I think especially when it comes to like the mental health of a parent and how that can impact a child as well, I would hope that's like a really big priority for them as well (Participant Mara).

When discussing the optimization of collaborative services, Mara elaborated further on the importance of continuity of care for parent-clients following mental health crises.

> I would like for there to be something that connects the bridge from, like, crisis work to ongoing work as well, and I don't know what that would look like, to be honest. But I

> think just to ensure that there is like that continuity of care and that information isn't being missed between either agency is really important (Participant Mara).

Reflecting on her role as a child welfare supervisor, participant Betty also discussed the value of a strong mental health aftercare system for parents who are experiencing mental health challenges.

> When I have had an opportunity to work with somebody who does have the aftercare system attached to them, it does go very well and they not only help in terms of managing the case plan strategies within the agency, but they also provide a network for their clients and it is a very empowering (Participant Betty).

Betty also expressed the belief that the aftercare system for parents experiencing mental health challenges is often lacking. Betty observed, “It doesn't seem that there's like a very strong aftercare for multiple people. So I'm seeing a lot, a lot of like admissions to [Redacted Mental Health Unit] but then nothing”.

Tina, who was also working in child welfare at the time of the interview, echoed Betty’s concern around the lack of follow-up care in the community for parents experiencing mental health challenges. Tina shared one example of a parent who had been discharged from a psychiatric setting following a lengthy hospital admission. She described how the parent waited months for community mental health services to reach out and ultimately had little to no aftercare services, “[The Mother] was like ‘Ohh I. I feel like I'm doing fine’ and the community mental health worker never saw her after that conversation, like the file was closed” (Participant Betty).

Drawing on her perspective as a child welfare supervisor, Melanie expressed a sentiment similar to Tina's and Betty's. Melanie described an experience whereby she believed a community mental health team closed aftercare services to a parent-client prematurely. The participant described how, in her view, the parent client was displaying symptoms of significant mental health challenges in the presence of the child welfare agency but was able to display enough stability for her community mental health team to decide to terminate services.

> I've experienced situations like that where we just view the situation very differently. But again the parent is entitled to you know, being involved as much as or as little as they want to in their planning and at that point they felt that they didn't need any support (Participant Melanie).

Primary Versus Secondary Concerns. A few participants discussed how addressing concrete protection concerns often takes precedence over treating underlying mental health issues. Sabrina, who had experience working in both fields, discussed how the priority of child safety may dictate goals and priorities when child welfare agencies are working with parents experiencing mental health challenges. The participant used the example of hoarding to illustrate this.

> There's quite a few people- like families where there would be like a hoarding issue which would create an unsafe environment so they would participate in like a program that would assist them with addressing the physical environment of the home- and then that would be good enough for us if it was like a safe situation physically, but wouldn't really necessarily address their disorder, underlying things that are causing the hoarding Participant Sabrina).

Tina also described how interim solutions put in place by child welfare agencies for families affected by parental mental health challenges may create the illusion that the parent is not in need of further mental health services and aftercare.

> The client was referred to community mental health services, but because like nothing was done collaboratively, mental health services, community mental health services closed the file after receiving the file, after a couple of days. So the client really never got the services that they actually needed. And the client is getting like a support worker from CFS and from [Third Party Service]. But really that's for the for the children. It's really not for the clients or whatever related to the clients really being in that space will never really be addressed and the client is very reserved- doesn't really talk to anybody. So really like the client might get better or like might seem better because the client will now be able to function to be able to care for the child... But it never really addressed what leads to the situation that lead to her doing what she did (Participant Tina).

Jasmine, a participant who worked for an outpatient adult mental health service at the time of the interview, provided further perspective on how collaboration between the systems can inform her in identifying primary and secondary therapeutic objectives. The participant used the example of how knowledge of an agency's case plan could inform a decision to prioritize addressing an addiction issue in therapy before addressing depression, for instance.

> They need to be clean from meth because when they're on meth they go into psychosis and they become violent. So let's put off working on depression for now, even though that's a really great therapeutic goal. Let's spend all of our energy here, because now I know you as a patient want this. And now I know from CFS what they are asking for (Participant Jasmine).

Resource Allocation and Service Integration

Several participants discussed how their opportunities to collaborate between systems to provide services to parents experiencing mental health challenges have been limited by the scarce nature of mental health resources. Some participants highlighted how funding for child welfare models is limited in terms of preventative resources, particularly those that support parents. The inaccessibility of affordable and timely mental health care for adults was discussed by several participants. A few participants expressed their belief in the value of integrating child welfare and mental health services, while one participant shared her experience with such integration.

Agency Resource Allocation. Some participants identified the apparent prioritization of resources allocated to children by child welfare agencies, as opposed to parents. These participants, all of whom had experience working for child welfare agencies, expressed the belief that child welfare agencies should financially support parents in accessing mental health resources when they are unable to do so through the public system. Participants pointed out that child welfare agencies typically only fund mental health services when they are are for children in care, which is not consistent with a preventative child welfare funding model.

One participant, Sabrina, discussed her belief in the value of child welfare agencies stepping in to provide such supports, ideally before any need for child removal. Sabrina noted, “It would just be really great if child welfare agencies- they fund therapy for children in care, it's very expensive- and I think that it would be critical if they funded therapy for parents.”. Sabrina went on to describe the importance of assessments in supporting parents to access appropriate mental health services.

> Like children shouldn't need to be apprehended for an agency to provide financial support for a psychologist or like a really good assessment so that you know where you're going with mental health services. Like a really good initial assessment is critical to a person or family receiving proper mental health services and so just that would be so helpful (Participant Sabrina).

Another participant, Melanie, who worked in child welfare as a supervisor at the time of the interview, echoed this sentiment: “Unfortunately, your kid has to come into care to be able to kind of unlock some of those budgets which is not fair" (Participant Melanie).

One other participant, Eliza, who was also working in front-line child protection services at the time of the interview, discussed an experience in which she was afforded the opportunity to work collaboratively with an agency-funded private clinician for a parent preparing to have their child reunified. She described this experience as beneficial to her case planning but shared her views about the child welfare funding model when it comes to connecting parents with private mental health services.

> I think it was available because the kids were in care. Which is kind of unfortunate, I think. My personal opinion would be that it would be beneficial to get them- get parent support like before their kids come into care. And that the money would be well spent at that point (Participant Eliza).

Waitlists. Participants also discussed how opportunities for collaboration may be limited, in part, by the sheer unavailability of affordable, timely adult mental health services.

One participant, Eliza, described how few of her clients have successfully accessed community resources for adult mental health services. She reported, “I'm just trying to think if

there's anyone else I worked I've worked with in my Family Services roles- that has actually worked with a like a community resource, and I think I think the answer might be no, that it was all waitlists" (Participant Eliza).

Eliza also described her experience of encouraging parents to access such resources, only to be met with a discouraging level of inaccessibility. She described this saying, "It's like, like I'm finally ready, but now you're telling me it's gonna' be like six months or a year or something"(Participant Eliza).

Similarly, participant Tina described attempting to connect parents with mental health services in her role as a child welfare social worker. Tina explained, "The wait list is very long right? So the people might need mental health services right now, but they will have to wait like six months or even 6 to 12 months" (Participant Tina).

Betty, who worked as a child welfare supervisor at the time of the interview, described how she believes the inaccessibility of adult mental health services can trickle down to overwhelm the child welfare system. She described how child welfare workers often end up attempting to fulfill multiple roles for underserved families.

> I do believe that it is one of the services that unfortunately has fallen in the laps of child welfare and I think that it is definitely draining the Child welfare system. It's definitely overwhelming the child welfare system. So the wait lists and the intake process, the referral processes are all fairly extreme and time consuming (Participant Betty).

Integrating Mental Health and Child Welfare Services. While discussing participant recommendations to enhance collaborative services between child welfare and mental health systems for parents, some participants shared the belief that child welfare services may benefit

from internal mental health resources or expedited access to services for parent-clients. Dale, who worked in community mental health at the time of the interview, shared his views on this:

> It just makes sense that there be some sort of embedded service with agencies to, if truly addictions and mental health are some of the things getting in the way, like that's a worthwhile investment (Participant Dale).

Melanie, who worked as a child welfare supervisor at the time of the interview, shared this idea:

> I think that having things in-house would be easier. Like if we have like a mental health department within our own system- that way it would maybe fast track some of those, like lengthy wait lists or the referral times (Participant Melanie).

One participant, Eliza, had experience working for a child welfare team with an in-house mental health clinician and shared this experience. The participant described how, while the on-site therapist was able to provide valuable insight to case managers and was effectively utilized by some families, some parents expressed discomfort with the idea of accessing therapy services connected with child welfare agencies.

> I feel there were challenges around parents like being possibly interested in mental health support, but like, do they want their notes ending up on my desk? And there were some rules that they had to be available to me and that, I think was a deterrent. Never mind that they had to meet with the therapist in our offices. So that was not like, I don't think it felt safe to many parents to come to the office based on previous experiences or even current experiences (Participant Eliza).

Professional Competency, Education, and Knowledge of Either System

Nearly all participants described professional knowledge or education as areas that they either believe have factored into their collaborative experiences or could play a role in the quality of collaboration between the two systems going forward. This was discussed in a variety of capacities, including one's knowledge of either system and its related issues, the value of seeking and sharing knowledge between systems, and the importance of social work as a unifying professional entity. Many participants shared the belief that the overall quality of collaboration between adult mental health and child welfare services could be improved through initiatives, such as training or outreach, aimed at enhancing knowledge about either system.

Experience and Knowledge in Either System

Eight of the twelve participants had experience working in the other field, most of whom were working in adult mental health at the time of the interview, but had worked for a child welfare agency in the past. This likely factored into some valuable perspectives about the importance of increased knowledge of mental health-related issues among child welfare workers. Some participants who had worked in both fields believed that their knowledge of the other field benefited their collaborative experiences in their current positions. Such knowledge was specifically described as beneficial in professional assessment and response, as well as in client advocacy. A few participants, working in adult mental health at the time of the interview, also reflected on their own lack of knowledge of mental health-related topics when they had worked in child welfare.

Assessment and Response. Several participants discussed how their knowledge and experience of the other field have benefited their assessments and responses in providing services to parents with mental health challenges and collaborating with the other system. For

instance, Aidan, who worked in an adult psychiatric setting, described how his experience working for a child welfare agency in the past impacts his current approach to determining when to report concerns to child welfare agencies.

> I try to be a little more judicious, I guess with following up and making sure that if I am going to call that there is more of that greater concern. So like I said, I kind of do a bit of pre-screening right? Connect with the patients themselves, I'm trying to connect with collaterals, family. Kind of figure out what's going on so that I can be sure that one: the information that I have is accurate, and two: whether it actually is a necessity to report (Participant Aidan).

Another participant, Mara, who worked for an adult crisis response service at the time of the interview, also discussed how her experience as a child welfare worker may influence whether she reports incidents to child welfare agencies. This participant described her knowledge of the child welfare system and its resources as a reason she may be more likely to contact agencies when it would be beneficial to the family.

> One of the factors is like my previous experience as a CFS worker and knowing kind of what needs to be communicated to CFS as well. I think sometimes [others] don't make that phone call to CFS because they feel that like if it doesn't have anything to do with like immediate child safety or child abuse, then it's not something that's reportable. Whereas I kind of think that if a family has a CFS worker involved, it's still important for that worker to know that we had some sort of involvement with the family so that they're able to offer better follow up than we are. Usually, we're only in their lives for maybe like two to three days after we do an assessment with families or parents. Whereas if they

> have an ongoing CFS worker, then that person is able to kind of know that this is something that happened and then provide them support moving forward as well. So I think having that idea is something that influences like my collaboration with CFS (Participant Mara).

Participant Olena, who had worked both in an adult psychiatric setting as well as for a child welfare agency, discussed a scenario where a healthcare professional on the unit called child welfare about a mother when the participant did not believe it was necessary. The participant described how her knowledge of the child welfare screening protocols, as well as her comfort in communicating with agencies, factored into her decision to make a follow-up call to provide further perspective to the agency. The participant described how she felt it was important to provide the agency with context about the mother's strengths and protective factors to prevent unwarranted interventions by child and family services. Olena also shared that her knowledge from working in the mental health field has enhanced her ability to gather pertinent information from mental health services during child protection assessments in her role as a child welfare worker. She described the importance of obtaining such information to produce comprehensive assessments and reports.

> What I like doing and I'm really good at it- is getting the information from say the doctor or the social workers. We relate to a lot of like [redacted hospital], social worker calls us lots and [redacted child welfare agency] right? But we, our capacity is to have a- or my capacity is to kind of get more information. So that is clear to a CFS worker as I'm writing out my notes, what the diagnosis is, what the prognosis is- you know, as much as possible. Like even explaining medication and things like that.

Advocacy. Two participants who both worked in adult psychiatric settings, and both had experience working for child welfare agencies in the past, described how their experience as child welfare professionals lent to their ability to advocate for parents involved with the child welfare system. Participant Aidan described:

> Having that understanding of the CFS system, that I think is great it -it allows me to facilitate that process. You know, share information that CFS needs but also to be able to protect the – or be a [*sic]* be a strong advocate for the for the clients as well, right? You know if I believe that you know the agency may not be sharing information that they're privy to or that you know- that they may not be doing things in the quote unquote best practice, right- you know, I can kind of bring that up and make sure that they're well informed so that they can be the best advocate for themselves (Participant Aidan).

Another participant, Sabrina, further highlighted this idea using the example of scenarios where patients in psychiatric settings have difficulty reaching child welfare workers, saying:

> I think that just having an awareness of how the system operates and what to do when you can't get a hold of another worker – like you collaborate a lot with other CFS workers when you work in CFS so I know like when I need to reach someone, if I can't do it like how I can get around that and who else I can talk to. So that's good experience that just helps- when you otherwise would just feel like you've hit a wall and there's nothing else you can do. Like people often just give up (Participant Sabrina).

Reflection of Knowledge Growth. A few participants reflected on how their current roles as mental health professionals have enabled them to reflect on their own lack of knowledge of mental health-related topics in their past roles as child welfare workers. Aidan shared, "When

I was in CFS, my personal knowledge of the mental health system as well as my peers in CFS- the knowledge of the mental health system was lacking". Another participant, Dale, had a similar reflection: "As someone that worked as a child welfare worker and should have, should have got a lot more training in mental health before I was a CFS worker".

Sharing Insight with Colleagues. A few participants discussed how their knowledge from working in the other field has enabled them to offer insights to colleagues who may be collaborating with the other systems to provide services to parents. In her role working for an adult crisis service, participant Mara reflected on this: "It comes in to be handy when I'm making consults with other colleagues as well, and they don't always know exactly when to report to CFS". Olena, who also had experience working in both fields, described providing informal mentorship to child welfare workers around mental health related issues.

Professional Knowledge Seeking or Sharing

Several participants discussed the value of seeking or sharing knowledge and expertise in professional collaborative experiences. Consistent with the findings of Lever et al. (2019), this was primarily discussed in terms of child welfare agencies consulting with mental health professionals to make informed decisions. Participant Dale, who worked for an outpatient mental health service at the time of the interview, recalls an experience whereby a child welfare agency consulted with him and a psychiatrist in the program in response to a mother's mental health concerns:

> At one time the worker had come and met with ourselves and the psychiatrist and the participant to talk about- like really this individual had some or, you know, unwanted voices that would tell her to do things like harm her daughter or those kinds of things right? And so, of course, that makes CFS very concerned and upset, for good reason

> right? Because sometimes command hallucinations have very bad outcomes. But like in that case like I really, I feel like there was a receptiveness by the CFS worker to hear what the psychiatrist's view was on these unwanted kind of voices that she would hear (Participant Dale).

Dale went on to share how the psychiatrist was able to explain to the child welfare agency how, in this scenario, there was a low risk of harm because the mother's intrusive thoughts were not consistent with her actions or desires: "Their commitment is the exact opposite of these thoughts". Dale described how this interagency consultation impacted the outcome of services for a family: "I think it helped the plan for that woman and her daughter to keep moving in the right direction instead of being stalled or, you know, changed in a very restrictive and reactive way."

Olena also described an experience whereby a child welfare agency was insistent that a mother, who was a patient on the psychiatric unit where she worked, needed to be on a specific medication. From a psychiatric perspective, Olena described how that medication was unlikely to result in any improvement for the nature of the patients' mental health challenges. In this scenario, Olena described how she believes the child welfare agency could have benefited from a consultation with the mental health professionals on their unit.

> I think back and I wish I'd been a little bit more verbal about that- just to say I'm not really understanding what this means. Come down, we're going to meet with the doctor and the doctor can explain this to you (Participant Olena).

Participant Sabrina reflected on how consulting with mental health professionals, namely contracted psychologists, helped inform her case management when she was working for a child

welfare agency. This participant described how sometimes child welfare case plans in relation to parental mental health challenges may not provide a realistic avenue for targeting whatever the concern may be. She describes how having an appropriate mental health assessment can be important in such cases:

> You can't just put something on a case plan about therapy or some sort of following a treatment plan when it's actually difficult for them to, like, get to appointments on time where there's a lot of barriers in place related to what would look like typical progress for someone else- it looks like maybe defiance for that client, but it's actually just ADHD. Or maybe it's depression or something like that. So those [assessments] are really helpful because you really trust an assessment by a psychologist (Participant Sabrina).

Another participant, Melanie, who was a supervisor for a child welfare agency at the time of the interview, further highlighted how consultations with mental health teams can inform child welfare practice with parents experiencing mental health challenges. The participant describes, "It's us reaching out saying this is what we're seeing in the home, this is what we're seeing like behaviourally from that parent. Do you have any suggestions on how we can work with them differently?"

Another participant, Eliza, who worked on a child welfare team that had an on-site mental health professional, described how access to such expertise was helpful in her case management role:

> The therapist's knowledge and expertise was really helpful for me in in terms of understanding family or parents'... Like new perspectives regarding their- like their mental health. How they're doing, what their like- what's motivating them or making

> them frustrated or anxious or, you know, just explain like attachments, you know? Like all these different things that I sometimes feel like I don't have enough, like, knowledge on (Participant Eliza).

A few participants discussed how knowing what one does not know is an important quality that can influence one's willingness to engage with other professionals to acquire appropriate knowledge. Dale discussed this idea in reference to his experience where the child welfare agency was willing to consult their mental health team on a mother's intrusive thoughts: "With the CFS worker who came down to our office to meet with the doctor- like that's reception, that's being open and I think knowing what you don't know which is kind of important when you're a child welfare worker". Participant Graeme also discussed the importance of being willing to seek out other perspectives in partnership with parents and families.

> There needs to be such- there needs to be an openness of dialogue and sharing. And I'm not saying that's not already happening, because certainly I've shared my experience in that there is- that is happening. But there just needs to get that extra step of we, you know, we all don't know everything. We're never going to know everything. And so to be mindful and acknowledge that saying, 'Hey, I don't know this. So let's go find out together, Let's go learn this together'. And then hearing from another professional when appropriate (Participant Graeme).

While consultation between professionals was described as valuable among participants, Sabrina discussed setting boundaries in an instance where unrealistic feedback was sought from a child welfare agency. When working in an adult psychiatric setting, the participant describes a scenario whereby a child welfare agency asked for her opinion on whether a patient was fit to parent her children. She reflects, "That is like not my job to assess. I can tell you like how they're

doing with respect to their mental health. But I'm not going to comment on whether or not they could parent".

Social Work as a Profession

Several participants discussed how social work as a professional entity relates to their collaborative experiences. One participant, Gina, discussed the unifying role that social work education can play in the overall quality of collaboration:

> If we're not all on the same page and understand, you know, all of the things that we learn in our social work degrees and whatnot it's not... Like if we just hire [non-social workers] they're not going to have knowledge of like, anything like in relation to 60s scoop and like residential schools and why we see what we see today, then our collaboration is just not going to be the same (Participant Gina).

Graeme also discussed his awareness of his role as a social work professional and the unique skillset that comes with that, particularly in instances where he may be collaborating with mental health professionals in medicalized settings who do not have social work backgrounds:

> If you're not coming from social work, education or background, you don't get that training right? You don't get that- it's much more medicalized, it's much more focused on the diagnosis and how we can perhaps find a recovery for that... And that's great right? I'm thankful for those professionals, but it's just a reminder that I'm so thankful for what we learn as social workers, that we're there for our clients, that we can remind them of their strengths (Participant Graeme).

Similarly, Olena described how her role as a social worker in a mental health setting contrasts with other professionals with medical backgrounds: "It's that you know, person and

environment is like, so part of our social work identity". Olena went on to describe how clinical interventions by medical professionals may differ from social work intervention: "It's so based on the individual and not necessarily the individual and the environment of their family."

While participants emphasized the professional skill set of social workers, a few who worked in mental health settings at the time of the interview noted that child welfare agencies in Manitoba often do not require their case managers to be Registered Social Workers. One participant reflected on this:

> The agencies that sneak the wording differently, right 'family service worker' rather than 'social worker'- it's it creates that loophole for people that- and I'm not looping everyone in that hole- but I'm saying like it loops people in that maybe have a degree in business or something right? (Participant Gina).

Another participant, Jasmine, discussed this: "To be a social worker in the child welfare system if you are a registered social worker, it's because you've decided that it's important to you. But it's not a requirement of the job."

Discussing her belief in the importance of mental health professionals understanding the child welfare system, Tina described how she appreciates the presence of social workers in mental health settings. Tina, who was employed as a child welfare social worker at the time of interview, described this.

> I think it would be good for them to know how the child welfare system works. And thankfully a lot of mental health services like now have a lot of social workers that have some kind of some- some idea about the child welfare. Some who have actually worked previously for child welfare in the past (Participant Tina).

In contrast, Betty, who was also employed for a child welfare agency at the time of the interview, described her appreciation for collaborating with non-social work professionals who specialize in mental health:

> Mental health workers hold a certain skill set, social workers have more of a general skill set, but I do believe mental health and addictions need experts. They don't need people that have general information (Participant Betty).

While some participants discussed seeking expertise from non-social work professionals, the perspectives of non-social work professionals were not included in this research.

Education, Outreach, and Trainings

Several participants discussed their belief that collaborative services for parents experiencing mental health challenges can be enhanced by increasing education and outreach for social work professionals. Gina, who worked rurally in a mental health capacity at the time of the interview, discussed her belief in the need for increased outreach efforts between professionals, particularly in rural areas:

> I would love to like bring the professionals in the community together and do like- even if it was once a year- a little gathering and just intermingling of each other and getting to know each other and understand what our roles are (Participant Gina).

A few participants discussed the potential value of holding interagency educational and outreach efforts between the child welfare and mental health systems. Aidan, who had experience working in both fields, discussed how there is limited information in either system about one another's policies, legislation, and other relevant information related to mental health and child protection. He described the idea of incorporating presentations from either field as a

part of professional development: “Whatever their education plans are you know, making a point to provide education to their employees about the other system right? And that probably should involve, you know, professionals from other fields” (Participant Aidan).

Sabrina, who also had experience working in both fields, brought forward an idea for interagency outreach efforts in the form of a committee aimed at improving collaborative practice: “A committee dedicated to just providing really good support to patients and families, parents would be critical because communication is essential”.

A few participants described how they believe continued education efforts may alleviate burnout. Gina discussed how increased continued educational efforts among social workers can help professionals to maintain a focus on supporting families, particularly those who come from marginalized communities or have experienced intergenerational trauma. She described how, without a continued education about things such as systemic harms towards Indigenous peoples of Canada, some social workers may cope with the overexposure of mental health and addiction issues by adopting a less empathetic attitude: “It is so hard to keep people that are burning out on the path that we need them to be on.”

Olena also discussed the importance of educating social work students about their roles and responsibilities in multidisciplinary settings, such as hospitals. As she had been employed in both child welfare and adult psychiatry settings, she discussed how medical professionals may route all child welfare correspondence through the social worker, even when it may not be appropriate. For instance, concerns related to child abuse should be directly reported by whichever employee witnessed the abuse or received the disclosure. Olena describes this, saying:

> I think that's something that should be really and like for social work classes like field focus or whatever it is. To focus on- to talk about like those interdisciplinary roles. If you're on an interdisciplinary team, just because you're the social worker you're not the one the go to for CFS every time (Participant Olena).

Contextual and Social Factors Influencing Collaborative Experiences

This section focuses on the social and contextual factors that shape participants' experience of collaboration. Participants described a variety of contextual, practical, and social variables that they said impacted their collaborative experiences. Unsurprisingly, parent and family-specific contexts were central to the collaborative experiences described by participants. Factors such as parental motivation and participation were cited by several participants as central to collaborative experiences and as influencing overall opportunities for collaboration. Geographical context and other practical considerations were also cited by participants as influencing collaborative experiences. Many participants also outlined social forces, notably stigma surrounding parental mental health and social perceptions of child welfare systems, as being present and influential in their collaborative experiences.

Contextual and Practical Factors

While this research is primarily centred on direct collaboration between child welfare and mental health professionals, key contextual and practical factors were repeatedly described as central or influential aspects of collaborative experiences. Family-specific and practical factors such as geography, transportation, and childcare were described by some participants as critical elements in the collaborative experience.

Family Specific Context. Family-specific factors were largely cited as being at the core of the collaborative experiences described by participants. For clarity, the term family may relate

to the individual patient or client central to the collaborative experience as well as members of their family or others with whom they are personally connected.

Familial factors were discussed by several participants as shaping collaborative outcomes as they relate to how motivated or willing a parent is to receive services in a way that elicits positive change. Melanie, who worked as a child welfare supervisor at the time of the interview, described how a parent's willingness to receive and engage with collaborative services is central to the outcome.

> If they're willing and like wanting to engage with all of us at the table at once and, you know, having these joint conversations, things just are so much better. When they're in denial, when they're saying "no, absolutely not, you can't talk to them" or "you guys all think I'm crazy"- you know, like that type of other conversation then I mean it, it takes a lot longer (Participant Melanie).

Another participant, Jasmine, discussed how parent motivation impacted her collaborative experiences in her role as an outpatient mental health clinician. Jasmine described how this is also related to the timing and stage at which she typically becomes involved with patients for outpatient clinical supports.

> I'm coming in at a time when patients are generally pretty motivated to work with CFS because plans have already been in place and they're just seeking the support that they need to get to those end goals. So I think that's, I think, the fact that the patients that I'm working with are already very well established in the system makes for a little bit better collaboration. They've developed a relationship with their caseworker. It's not a surprise (Participant Jasmine).

A few participants discussed how motivating factors such as reunification or other specific parenting goals played a role in a parent's willingness to engage in the collaborative process. This is consistent with the literature on parenting as a motivating factor for engagement with mental health and family support services (Hanson et al., 2019; Jones et al., 2016). In her role as a child welfare social worker, Eliza discussed how a parent's engagement in collaborative services between the agency and a contracted clinician contributed to a positive collaborative experience: "Reunification was on the table and that was such a huge motivator". Eliza went on to also describe the importance of a parents' readiness to receive services: "I feel like parents were often not quite ready for mental health support. And that made it challenging to end up with like positive outcomes or like any real change."

Reflecting on his role working in a community mental health team, Dale described how parental motivation is integral to meaningful collaboration. Dale also highlighted how ongoing engagement with professionals towards goals may help maintain parents' motivation. He described an experience whereby a mother's participation in ongoing joint meetings with child welfare and a community mental health team may have played a role in renewing her engagement with her parenting goals, despite previously stating she felt like giving up. Reflecting on this experience, he described:

> I feel like it engaged her in meaningful involvement for a pretty... like for... Cause at one time she just kind of cut out and was like, "I don't wanna do anything about my [child]. I don't wanna do it". And so [at that time], it had been [an extended period] in the going and it was- there was no sign that she was kind of quitting or throwing in the towel or saying "I don't wanna do this anymore". So I feel like ongoing dialogue with the CFS

> agency when they have your child in care, it's a very important piece to build hope. And so I feel like that meeting kept her going and kept everyone on board" (Participant Dale).

Graeme, who had experience working in both child welfare and providing clinical services to adults, described the importance of professionals encouraging parents in their journey to seek support and heal:

> We are sometimes the only cheerleader this family or these parents ever receive, because how many times have they been written off by their family or by other professionals? And in this, we're going to be that one professional that actually gives them the time of day that can make a tremendous difference (Participant Graeme).

A few participants described how parents may be hesitant to engage with mental health and child welfare services collaboratively due to the fear of experiencing stigma or punitive interventions by child welfare agencies. This is also something that has been repeatedly identified in the existing literature (Jones et al., 2016; Lever Taylor et al., 2019; Radley et al., 2021). Tina, a participant working in child welfare at the time, described factors that may play into parental hesitation to engage in service collaboration between child welfare and adult mental health.

> If your CFS worker is telling you to go to get a mental health assessment, you're probably not wanting to go there because you feel like if you're going there and then they discover that you're like, you have a diagnosis, then they won't really, they will actually use it against you, so that's what you'll be thinking, right? So you're less likely to want to do it, knowing fully well that maybe that will also help you maybe get the treatment that you need and might be helpful as well (Participant Tina).

Tina went on to describe how in her experience parents often carve their own paths to healing, independent of collaborative service engagement.

> Overall the clients are very resilient, right? So they've always found a way to overcome or to even rely on their informal support. So usually it turns out that they'll find a way to just, you know, find support somewhere...It is not the best. It takes more time than it should have, but more often than not they just try to find alternative ways to just to figure out whatever the issue or the concern is that you know led them to maybe require mental health services (Participant Tina).

Mara, a crisis clinician who had also worked in child welfare, echoed Tina's idea about parental hesitation.

> I've also noticed that sometimes like parents can just be a bit more guarded about what they're sharing with us because they know like information that they share, may be reportable to CFS, and then they come back to bite them in the butt (Participant Mara).

When discussing parents' needs regarding collaboration between mental health and child welfare services, Mara also shared her thoughts.

> For parents to know that if I'm really struggling, I need to know that I can call my worker and ask for help and for this to not be used against me in, in my case file right? To know that this is actually a person that will support me with what I'm going through and tell me like some resources that I can access to get better (Participant Mara).

Sabrina, who had experience in both child welfare and adult psychiatric inpatient settings, described how some parents actually encourage information sharing between systems. Reflecting

on her role as a child welfare worker, Sabrina discussed how parents may view engagement between mental health and child welfare services as a helpful tool in demonstrating their efforts.

> Parents would want you to call and they would want you to have information about what they did or the services that they used and like how they're doing because it would be, they believe, to their benefit which it usually was because just showing an ability to reach out to use support that's in the community is just a huge strength. We would see that as something really great. Just the willingness to call- because I'm thinking about like stages of change- just engaging in any kind of help seeking behavior is great (Participant Sabrina).

Geographical Context and Practical Considerations. Some participants discussed how geographical context played a role in their collaboration. Participants also discussed practical considerations such as transportation and childcare as part of the collaborative process.

A few participants described their experiences working in rural settings and how that impacted collaboration between systems and the clients they served. Gina, who had experience working in both mental health and child welfare roles in rural and urban settings in Manitoba, discussed the significance of this.

> Rural mental health and child welfare is so different from like larger cities like we have, they have to travel to where they're going. Maybe they don't have access to a vehicle. Maybe they don't have access to internet. To, you know, to access both of those professionals poses an entire different set of challenges for those families as opposed to the ones that live in the city that could take a taxi or let's say that child welfare could pick up the mom and take her to the mental health worker. And I think we need researchers

> and higher ups and governments to really focus on, yeah, these two are so different based on where you live. How do we support those people that are living rurally? (Participant Gina).

Gina went on to describe how, as a mental health social worker in a rural setting, bridging geographic gaps to support parents and families has become part of her practice.

> When I was supporting that one mom who had all those agencies involved bringing all of them together- I did eventually get them all in one room- was such a relief for her that she didn't have to do all that chasing and tracking down on her own. But I pathed that and ran the meeting and we worked together and it was- it ended up being successful but also encouraging. It encouraged those other professionals, "OK, it is important that I come out to [redacted rural Manitoba town]". I do feel like they did feel that once they were there and understood why they were being brought to the table, it's certainly benefited that family (Participant Gina).

Participant Mara also discussed how, in her experience, the connection between services differs between rural and urban settings, despite closer proximity between agencies in the rural setting where she worked. Drawing on her experience in working in both fields, both rurally and in the city, she described this.

> Like when I worked at [redacted child welfare agency in urban setting] it felt like there was more communication and more collaboration that would happen even through like the [child welfare] role versus being in like the [redacted rural region] role. I feel like there's a little bit more disconnection there, which is kind of bizarre in a sense because

> the [child welfare team] are [redacted rural region] like their office is located closer to where ours would be, too (Participant Mara).

A few participants discussed how, sometimes the extent of their collaboration was simply helping to eliminate practical barriers for parents who wished to access the other service. Reflecting on her role as a child welfare worker, Sabrina described assisting parents with accessing community mental health programs.

> Different community-based services, you have to attend in person, they'd have to attend regularly. If they missed appointments, you know, they kind of wouldn't really be allowed to keep attending if you miss a certain amount of appointments. They'd have to find childcare- we would often have to like assist them with that through maybe arranging transportation for them or providing like respite workers (Participant Sabrina).

Mara also discussed how a lack of childcare can be a barrier for parents accessing mental health supports. Reflecting on her experience working for a child welfare agency, she highlighted the importance of informing parents when respite services can be offered.

> When I worked at [Redacted CFS agency], that was the pattern I noticed, was that parents were not as willing to go to hospital to get support because they had kids in their care and they didn't have anyone that could watch their kids and at [Redacted CFS agency] like we're able to provide like an in home like support worker at times. I think knowing that that's an option could be you know- if it makes things more accessible for parents to be able to access the resources that they need to access help and to know that their kids are going to be safe as well- like I think that's really beneficial (Participant Mara).

Melanie, a child welfare supervisor at the time of the interview, similarly described an experience in which collaboration did not involve in-depth professional interaction but instead focused solely on practical planning for parental attendance: “It was just kind of like the coordinating of like transportation and like that was kind of the extent of our involvement.”

Participant Jasmine reflected on how policy can sometimes prevent social workers from helping clients overcome practical barriers. She discussed how this connects to her experience providing outpatient mental health services to parents involved with child welfare systems.

> I still do home visits but it's so far and in between. And that is super sad. One of the restrictions is my time because I have to always be doing kind of the most acute situation at the time. But the other is policy has made it very difficult for me to leave. And yet, how much benefit could I have? Is it really the patients’ fault if they can't come into their appointment? And CFS really needs them to attend these appointments. But they don't have a car. They have to bus, they have three kids, they don't have a job like, I can't like go to them. That would be social work’s true value, removing that barrier. If they can't come to me, I go to them. That's a removable barrier. But policy has made that very difficult (Participant Jasmine).

Stigma and Social Perceptions

Many participants described social forces at play in their collaborative experiences, including stigma associated with parental mental health challenges as well as social perceptions of child welfare agencies. It is important to note that while participants’ experiences regarding social perceptions are valid, some involve speculation about the thoughts or experiences of others who did not participate in the research and therefore cannot explain the reasoning behind their words or actions.

Perceptions of Child Welfare. Several participants described how perceptions of child welfare systems, held by parents and other services, shaped their collaborative experiences. While negative perceptions and fear of child welfare agencies were discussed by several participants, this same notion did not come forward about mental health services. This is consistent with Lever et al.'s (2019) research, whereby mothers experiencing perinatal mental health challenges described feeling more trusting of mental health professionals than of child welfare agencies. Participant Gina, who had experience working in both fields, described how mental health services may be hesitant to align with child welfare services if it is something that could impact their relationship with a parent.

> Even if you have consent, I think there's still a lot of- because once you build a relationship with someone and then child welfare is in the picture, it's hard for them to figure out.... "Well, I don't want to be looped in with that person" who, like for lack of a better word is demonized in the parents eyes, right? "I don't want to be a part of that". So that can be really tricky (Participant Gina).

Gina went on to describe her belief in the value of face-to-face meetings between professionals in overcoming such barriers to collaboration.

> I think when somebody hasn't met you and they hear all these negative things about you, there's a preconceived idea of who you are as a professional. And then people carry that with them. And then if they hear your name, you've already got that in your mind. So I think doing that intermingling face to name and getting a feel for who you are and how you practice might break some of that down too (Participant Gina).

Another participant Olena described how the child welfare system is viewed in the hospital settings where she had worked: “I think the hospital system does view- and again, need for collaboration- CFS as sometimes unduly punitive”. Participant Tina, who worked as a child welfare worker at the time of the interview, summed up how such views can impact collaboration: “Some systems believe that other systems are providing some type of harm, so it's really hard to work collaboratively together.”

Betty, who worked as a child welfare supervisor at the time of the interview, described how other systems’ perceptions of child welfare agencies can impact their collaborative efforts.

> When an adult is experiencing a mental health crisis, child welfare often is not viewed in a very trusting way, right? So they don't always want us to be a part of that and when we are a part of that there's a lot of hostility in the mix and we're not often able to collect information. We're able to give information, but we're not able to collect the information and that does pose a barrier for us (Participant Betty).

Betty went on to describe this, comparing perceptions of child welfare workers to those of police officers.

> When you're talking about child welfare- us workers are viewed in very negative ways, similar to you know how police officers are viewed-various authorities, very harmful, you know, to them. And so when a community mental health worker aligns with, with one of our parents in that way, it is very, very, very hard to overcome and very damaging (Participant Betty).

Mara, who has experience working in both fields, discussed how she works to overcome such negative perceptions in order to attempt to work collaboratively in her role as a mental health clinician.

> Like what I know of CFS and like the work that they're doing to keep families together is different than some of the stereotypes and narratives that are out there as well. I think it's also like making it a point to help shift that narrative from CFS being almost like the enemy, in a way, to being a support for families and doing things that need to be done to keep the family together as opposed to removing a child from care (Participant Mara).

Mara went on to describe how she might approach this in daily practice.

> Some kind of gauging like what their perception is about CFS as well. And if a person has a good relationship with their worker, then I'm like, "OK, like, let's talk about contacting them in the future. Like, what is that going to look like? Are you OK if we give them a call?". And even if it is like an obligation for us to call CFS to make any reports, I think just having that conversation with the parent is really important so they're aware of what's happening, right? (Participant Mara).

Perceptions of Parents and Experiences of Stigma. Many participants also discussed the social stigma associated with mental health challenges for parents and how that influences collaboration. Gina, who had experience in both fields, discussed how parents may face a dual stigma when involved in either system.

> I think society could do a better job of normalizing accessing help for mental health and child welfare. I think there's still- and that's a huge thing- but to tackle that there's still so much stigma attached to having child welfare involved and accessing mental health and

> needing all of those services. I think society could do a better job of normalizing that and destigmatizing it so that parents are not feeling like they need to hide all of this and feel that they can work more openly with those services (Participant Gina).

Betty described situations in which she wondered how a client's child welfare involvement might affect the other system's view of her client. She described this with an example of accompanying a parent client at a mental health agency in her role as a child welfare supervisor.

> For the clients- like I have in a number of occasions gone down and sat with somebody [at redacted mental health agency] while they're waiting to be seen. And I've often wondered, what are people thinking like, Why am I here? Are they viewing me as a family member? How are they viewing? And if they're viewing me as a social worker, are they, you know, approaching this person from that frame? I'm not included. Once I'm there, I'm only there to sit with the clients. I'm not included in the assessment that happens behind the doors. We don't get to be a part of that. So I don't know how that's framed. I wonder if they're perceiving things in a more serious way because I'm there, I don't know (Participant Betty).

Reflecting on her experience working in an adult psychiatric setting, Sabrina discussed experiences where she felt that child welfare workers may perceive or treat parents experiencing mental health challenges unfairly.

> I think it's just easy to ignore or not respond to people who are on a psych ward and you have to call and ask the nurse like to talk to the person, then they have to go find the person and transfer them. And I don't know- if they know that you're on a psych ward

> they probably they kind of like write you off, I think as a parent, even though we would- we arranged some visits with her and her children while she was there waiting to go to [redacted program], which was really great. And it's something that she's done before, but we definitely had to, like, fight for it (Participant Sabrina).

Dale, who worked for an adult mental health service at the time of the interview, discussed stigma associated with different mental health conditions and how it can impact practitioners' views of parents. He described how his collaborative experience with a child welfare agency allowed him to share positive information about a parent-client with his mental health team regarding their efforts and progress.

> So there was that meaningful participation. I guess, from the mental health side of things I think I guess my hope was in sharing outcomes related to those meetings to our bigger mental health team that people would not be so umm, would view this participant in a different light right? (Participant Dale).

Graeme, who had experience working in both fields, also described how bringing together service providers can play a role in breaking down the stigma associated with mental health challenges for parents. Consistent with Walsh, Danto & Sommerfeld's (2020) research, he emphasized the importance of ensuring that parents have access to non-Western healing practices, particularly in Indigenous communities. Graeme described this in the context of his past work with Indigenous agencies, where they had access to traditional healers.

> And then within our- the couple of agencies that I was employed in- we had elders that we would bring in. We had a knowledge keeper at one point because we did, we wanted to prioritize mental health. And I think if anything in the last several years we've seen how mental health has been impacted and so to bring that back to the forefront and

actually allow these clients and their families to explore it, not be afraid of it, because so long as a society we, you know.... Mental health has been something that you're confined for right? You're put into an institution for. And to bring in these collaborators to allow these families to feel safe with these collaborators that say that this is a priority and this is health (Participant Graeme).

Chapter 5: Discussion

Summary and Interpretation of Results

The purpose of this study was to explore the collaborative experiences of child welfare and mental health social work professionals in providing services to parents experiencing mental health challenges who are connected to both systems. A phenomenological methodological approach was utilized, in which participants' lived experiences were shared through individual semi-structured interviews. These experiences varied widely with a variety of factors at play. Participants' descriptions of their collaborative experiences ranged from concrete everyday examples, such as those surrounding collaborative mechanisms and approaches, to more abstract conceptualizations of collaboration, such as experiences and ideas related to education and professional identities. While many of the participants' experiences are consistent with themes identified in the existing literature, this research was valuable in providing insight into practitioner experiences specifically among social workers in the Manitoba context.

Collaborative Mechanisms and Approaches

Many participants discussed ways by which daily facets of collaboration, including tools or mechanisms for collaboration, professional approaches, and aspects of daily communication and information sharing, played into their collaborative experiences.

The importance of identifying collaborative goals and respective professional roles was highlighted through a variety of participant experiences described in the data, which was strongly consistent with existing literature (Darlington et al., 2004; Hanson et al., 2019; Mason et al., 2018; McCartan et al., 2022). Participant experiences pointed to the value of goal identification in optimizing collaborative outcomes as it relates to supporting families affected by parental mental health challenges. This was described as a powerful tool for establishing direction for

collaboration between the two systems to achieve positive outcomes. Role clarity was described as a useful tool for reducing service redundancy and for ensuring that collaborative partners are aware of the capacity and responsibilities of their respective roles. The importance of this was emphasized in participant examples, whereby unrealistic expectations for service were placed on collaborative partners due to a lack of understanding of one another's roles. Participants' experiences regarding role clarity and goal identification suggest that such tools are critical for establishing collaborative cohesion to support parents and families.

Participants described the characteristics of collaborative meetings, including the value of in-person meetings. Participants' preference for in-person collaboration raises the question of whether a post-pandemic push towards virtual meetings exists, particularly given the referenced literature on how the COVID-19 pandemic affected parental mental health challenges (Russell et al., 2020). It also raises interest in whether virtual meetings have any impact on quality of collaborative services. Some participants described the value of systems approaches in professional meetings, and one participant shared a positive experience in which a meeting facilitator through the child welfare agency was present. Some participants described ongoing meetings as a valuable tool for collaboration. These results support existing research emphasizing the importance of interagency meetings, specifically when using a systems approach, as a valuable collaborative tool (Coates, 2017; Jones et al., 2016; Mason et al., 2018; Van Dongen et al., 2018).

The research findings also suggested that professional approaches including openness, flexibility, and inclusion, were described as vital assets in effective collaboration. The vital role of interpersonal communication in professional interactions, as described by participants, reinforces previous findings in the literature (Colvin & Thompson, 2020; Coates, 2017; Hanson

et al., 2019; Houlihan et al., 2013; Martins & Tucker, 2023; Webber et al., 2013). This was illustrated through participant examples of whether these features were present or absent. Participants tended to describe collaborative experiences in which such characteristics were present in more positive terms than those in which collaborative partners were more closed off or inflexible. Factors associated with daily communication, including transparency and directness, as well as accessibility, were also central to several participants' collaborative experiences. Some participants described difficulties reaching child welfare workers in a timely manner, if at all, and emphasized how accessibility of communication impacts parents and families. A few participants working in psychiatric or hospital mental settings described experiencing issues with child welfare workers not directly communicating important interventions, including apprehensions, with clients. These examples highlight both the importance of transparency in communication with families, while reemphasizing the value of role clarity between mental health and child welfare professionals. A few participants described interpersonal challenges, including hostility, negative talk about other parties, and issues with respectful communication.

There were varying views on the appropriate level of information sharing between collaborative partners. Some participants pointed to the importance of information sharing for the benefit of the parent receiving services, while others described limiting information sharing to situations where there is a duty to report child abuse or neglect. A few participants described the importance of client empowerment in this area. These results demonstrate that establishing protocols for confidentiality and information sharing between the two systems may be useful, as highlighted in past research (Coates, 2017; Colvin & Thompson, 2020; Darlington, 2005; Webber et al., 2013). This might involve having a meeting with the family and professional

collaborative partners at the outset of the collaborative process to outline an agreed upon plan for information sharing, communication, and bounds of confidentiality.

The findings around collaborative mechanisms, communication, and professional approaches point to the significant role that the nature of daily interaction between mental health and child welfare professionals plays in collaborative experiences. Participant examples emphasize how this impacts the overall quality of collaborative services for parents experiencing mental health challenges. While many of the experiences described in this section highlight the importance of establishing useful tools for successful collaboration, others point to the significance of personal approaches and communication styles. This may suggest that collaborative experiences are impacted by both professional effort as well as individual ways of being. While a social worker's effort to establish clarity about roles or the frequency of joint meetings with a collaborative partner may lend to a more positive collaboration, one's perception of the other professional based on interpersonal communication may also factor into the experience. Practicing using helpful tools for collaboration, such as those described in this section, may seem more concrete and within one's control than, for example, altering one's communication style. However, the powerful role of factors such as communication style or approaches in professional collaborative experiences may point to the value of ongoing reflexivity for social workers or practitioners working in mental health and child welfare related fields. Every difficult collaborative experience may be an opportunity for social workers to challenge themselves to critically reflect on aspects of their professional approaches or interpersonal communication that may have contributed to it. It is also an opportunity to conceptualize what the experience may have been like for the other professional. Ultimately, the

hope is that effective collaboration with other professionals will translate into improved service outcomes for parent-client and their families.

Service Mandates, Priorities, and Resource Allocation

Service mandates, competing priorities, and resource optimization were frequently articulated by participants as factors that influenced their collaborative experiences. Participants commonly referenced conflicting service mandates and priorities, consistent with the literature on ongoing competing interests between the systems (Coates, 2017; Darlington et al., 2005; Hanson et al., 2019). Participants discussed how adherence to the service objectives within their respective roles might shape the nature of their collaboration. Participants' examples highlighted both the benefits and potential drawbacks of staying firmly within their respective professional mandates. For example, child welfare professionals may want to go above and beyond to provide supportive services to parents experiencing mental health challenges. This may both reflect positively on a collaborative experience and truly benefit the parent. However, as participant Betty explained, it may become problematic when time spent on duties outside their mandate begins to interfere with their primary role of protecting children. Professionals may experience pressure from collaborative partners, and while it is important to do one's best to carry one's weight in collaboration, it is also vital not to lose sight of respective service mandates. In this sense, it may be challenging to balance adherence to professional mandates with principles such as advocacy that are central to the social work profession. This, once again, points to the importance of role clarity in collaboration, which appears to be a cross-cutting theme.

Participants identified a few key conflicting aspects of service delivery between the systems. The often-voluntary nature of adult mental health services was described as at odds with the involuntary nature of child welfare services. Further, as participant Melanie pointed out,

strict timelines in child welfare court may conflict with realistic timelines for mental health treatment. This is consistent with Colvin et al.'s (2017) research whereby clinicians reported experiencing pressure by child welfare agencies to rush therapeutic support to meet case-related deadlines.

Balancing the prioritization of services and crisis response with the need for preventative support and a quality aftercare system for parents experiencing mental health challenges was identified as a challenge by participants. This is consistent with past research that emphasizes the key role that ongoing prevention work plays in supporting families where parents are experiencing mental health challenges (Ben David, 2021; Darlington et al., 2005).

A few participants described how, sometimes, treating the symptoms of mental health challenges, such as addressing whichever behaviour may be causing the direct risk to children, may take precedence over treating or diagnosing the underlying mental health condition. From a child protection standpoint, this could point to the importance of building capacity for support that addresses families' direct needs in instances where they are not prepared or able to access mental health services. The value of such practical supports by child welfare agencies, including parenting programs or supports that alleviate financial stress, has been regarded favourably by parents in past literature (Kedzior et al., 2024).

The results also identified how factors, including waitlists and resource allocation, impact parents' access to mental health services. Participants described lengthy wait lists for mental health services for parents as discouraging. Some participants also highlighted that child welfare agencies do not typically fund private mental health services for parents, while they often do so for children who are in care. This is at odds with principles of preventative care, which have

been recommended in the literature for providing services to parents experiencing mental health challenges (Darlington et al., 2005; Ben David, 2021). A few participants described their belief in the value of integrated mental health services within child welfare agencies, consistent with findings on improved service integration in the existing literature (Martins & Tucker, 2023). While one participant in this study had experience working in a child welfare setting with integrated mental health services, she described how some parents may have felt less inclined to trust mental health clinicians who are associated with child welfare agencies. This is a unique example that points to the importance of including parents' voices in planning initiatives related to optimizing services for this population.

The participants' experiences related to service objectives, prioritization, and resource allocation highlight the continued need for increased resource availability for parents involved with both child welfare and mental health systems. This recommendation has been emphasized in past literature (Martins & Tucker, 2023). To prevent unnecessary or harmful interventions by child welfare agencies, it is vital that parents experiencing mental health challenges have access to public mental health services when they are prepared to engage with such support. In instances where parents are unable or unwilling to engage with mental health professionals, access to other supportive services, such as respite or programming that assists in addressing concrete child welfare needs, may be helpful in preventing crises. While such services may appear to be band-aid solutions for parents who have underlying or undiagnosed mental illnesses, they may also be powerful tools for maintaining family functioning while respecting the timelines associated with organic healing.

Professional Knowledge and Education

Many participants described professional knowledge and education as factors in their collaborative experiences. This is consistent with existing literature, which points to the significant role of knowledge and education related to child welfare and mental health topics in providing competent services to parents experiencing mental health challenges (Coates, 2017; Darlington et al., 2004; Kaasbøll & Storhaug, 2025; Lever et al., 2019; Martins & Tucker, 2023; Radley et al., 2021).

Participants who had experience working in the other area of practice described this as benefiting them in terms of their assessment skills in either area, being able to advocate for parent-clients, and sharing knowledge with colleagues. In conceptualizing this, it is important to note that more participants had experience working in child welfare prior to becoming mental health professionals as opposed to the other way around.

Several participants described the importance of knowledge seeking or sharing between systems. This was primarily described in reference to the importance of child welfare agencies seeking expertise on mental health challenges in order to make informed decisions and avoid harmful or unnecessary interventions. Participants' experiences and ideas suggested that child welfare professionals value expert consultation with mental health professionals and similarly, social workers in mental health settings appreciate it when such expertise is sought out.

This is consistent with past research and demonstrates that collaboration remains important for providing services to parents experiencing mental health challenges (Coates, 2017; Sheehan, 2005; Mason et al., 2018). This is vital, as interventions by child welfare professionals based on presenting mental health concerns can have lasting and potentially harmful impacts. As evidenced in past research, there is a great capacity for parenting with various mental health

disorders (Friedman & McEwan, 2018; Jones et al., 2016). As such, it is critical that child welfare interventions based on presenting mental health challenges are made with feedback from mental health professionals when possible.

Participants' experiences and ideas related to this are suggestive of the need for extra support and expert knowledge for child welfare agencies when working in the arena of adult mental health challenges. This is consistent with the findings of Lever et al. (2019) and indicates that this may continue to be an area of need for child welfare professionals when considering how to optimally support parents experiencing mental health challenges.

While the current study focused on the collaborative experiences of registered social workers, it is important to understand how expert knowledge can be gained from mental health professionals of all educational backgrounds to inform child protective case plans. It is also important to differentiate between seeking feedback from other professionals and asking them to assess matters outside their scope of practice. This is exemplified by participant Sabrina's example of child welfare workers seeking feedback from mental health professionals on parenting abilities. This further underscores the importance of role clarity in collaboration, including consultation processes between professionals. Interestingly, the need for mental health professionals to seek expertise in child welfare matters was not a salient topic of discussion, despite its presence in the existing literature (Colvin et al., 2020; Houlihan et al., 2013).

Participants described the importance of continued education. Such reflections highlight the notion that, while social workers require a tremendous amount of knowledge to match their degree of responsibility, understaffing may interrupt their ability to obtain adequate professional education. Furthermore, failure to provide employees with ongoing education on issues relevant

to the populations they serve may contribute to waning empathy or burnout. This is of important consideration when conceptualizing how social workers can achieve an optimal level of knowledge and education related to supporting parents who are experiencing mental health challenges and the associated collaboration between the child welfare and mental health systems. As many participants discussed a belief that child welfare professionals are lacking in knowledge related to parental mental health challenges, it is imperative to consider how employees can be supported to maintain the pursuit of relevant knowledge while working in an unpredictable and often understaffed environment.

Participants emphasized the value of social work as a profession with a unique skill set and educational background, particularly in multidisciplinary settings. This adds further to the consideration of how social work professionals fit into multidisciplinary settings. As mental health treatment is largely medicalized in nature, there is an opportunity for Registerd Social Workers to bring unique perspectives and considerations to the table. Participants described the value of bringing more holistic approaches to supporting families. Such ideas of balancing individual treatment with holistic, family-centred care when it comes to supporting parents with mental health challenges have been brought forward in past literature (Krum et al., 2014; Radley et al., 2021).

Additionally, the professional title of Registered Social Worker may provide a unifying opportunity for collaboration between child welfare and mental health social workers that does not exist, for example, between hospital social workers and their colleagues with a medical background. These ideas may also indicate that some social work professionals see value in requiring child welfare agencies to require case managers to be Registered Social Workers. As noted by some participants, this is not currently a requirement for all child welfare agencies in

Manitoba. In considering these views, it is important to note that all participants in this study were Registered Social Workers in Manitoba at the time of the interviews.

The findings in this research further emphasize what the existing literature has identified regarding the important role that professional knowledge and education play in collaboration between the two systems (Coates, 2017; Darlington, 2004; Radley et al., 2021).

Contextual and Social Factors

Participants described a variety of contextual and social factors that influenced their collaborative experiences. Unsurprisingly, parental motivation and participation were cited by several participants as determining factors in collaborative opportunities and success. The views and experiences described by participants as it related to parental participation emphasized that there often is no collaboration without this central component. Some participants emphasized the importance of keeping parents' goals at the forefront of collaboration to maintain parental motivation. A few participants described how specific goals related to family reunification may create a unique opportunity for meaningful collaboration between mental health and child welfare systems. This is consistent with existing research findings around parenting as a motivating factor for healing (Hanson et al., 2019; Jones et al., 2016; Kedzior et al, 2024). This may also raise the question of how collaborative efforts can promote positive change for parents at a more preventive level.

The findings based on participant experiences point to the importance of supporting parents to be proactive in seeking treatment while making efforts to minimize fear and shame around experiencing mental health challenges. Participants' descriptions of goal-oriented work in maintaining motivation for parental engagement both highlight the significance of seizing

such opportunities for quality collaboration between systems while further pointing to the value of examining what creates a positive collaborative experience. While a parent's motivation to engage with professionals may be a key starting point for ongoing collaborative work, how those professionals actually band together to sustain meaningful engagement can be an important foundation for supporting a parent through challenging times while optimally eliciting positive change. This further emphasizes the importance of identifying goal commonalities between systems, as has been recommended in past research (Darlington et al., 2004; Hanson et al., 2019; Mason et al., 2018; McCartan et al., 2022). Arguably, parents may also be more likely to reach out for support in the future if they have an experience receiving services from a strong collaborative network.

Some participants discussed the role of geographical context for collaboration between systems. A few participants indicated that the context of living and working rurally poses unique barriers, including access to transportation and reliable technology, for families and professionals alike. Participants also described transportation and childcare as important factors for parents engaging with mental health professionals, regardless of geographical location. While some participants described their collaborative experiences as being limited to communication about arranging practical support for parents to access mental health services, these practical considerations should not be overlooked when conceptualizing meaningful collaboration between child welfare and mental health systems to support parents. Such practical supports have been identified in existing literature as an important need for families impacted by parental mental health challenges who are involved with child welfare agencies (Kedzior et al, 2024). Not only can factors like access to childcare or transportation determine whether a parent can comfortably access treatment supports in the first place, but they could arguably factor into

caregivers' stress levels and overall motivation. Participants' experiences also emphasized how parents' ability to demonstrate a willingness to access mental health services may factor into child welfare workers' assessment of parents' overall ability to keep their children safe.

Factors related to stigma and social perceptions were described as influencing collaborative experiences. Several participants discussed perceptions that child welfare agencies are a barrier to effective collaboration between the systems. Some participants attributed such social perceptions to being a result of past and current systemic harms. However, it is important to note that individuals or groups may also have negative views of child welfare due to their own personal or professional experiences. Such perceptions of child welfare agencies may also raise questions about how those working in child welfare view themselves as professionals and how these views may impact what they bring to the table as collaborators. One might wonder, as participant Betty described in one experience, whether they need to make efforts to overcome this in every collaborative interaction. While only one participant alluded to social perceptions of mental health systems, referencing fears of being institutionalized, it may be compelling to further explore how these systems compare in terms of social fears and perceptions. These results support past research that has identified an apparent lack of trust in child welfare systems (Lever et al., 2019).

Stigma surrounding parenting with mental health challenges was also described as creating a hindrance to collaborative opportunities. This was described in the context of both internalized stigma that parents may experience and access services, and how professionals may view or interact with parents. This finding is also consistent with existing literature (Jones et al., 2016; Martins & Tucker, 2023; Lever Taylor et al., 2019; Radley et al., 2021). The results point

to the importance of creating an emotionally safe, confidential, and nonjudgmental network for parents to seek support from either service, which was emphasized by some participants.

Participants' ideas and experiences around parental hesitation to seek support due to fear of child welfare interventions are consistent with previous literature (Jones et al., 2016; Kedzior et al, 2024; Lever Taylor et al., 2019; Radley et al., 2021). While some participants shared how parents may be apprehensive to seek mental health services for fear of repercussions from child welfare agencies, one participant described how parents may view communication between systems as advantageous in demonstrating to child welfare agencies that they are taking initiative to seek preventive supports as needed. This underscores the importance of professionals communicating with parents about the purpose of collaboration. It also further highlights the need for transparency and clear communication by child welfare workers about case-related expectations to parents.

Employing an Anti-Oppressive Lens

There are a variety of concepts from the data that should be considered from an anti-oppressive perspective. For instance, information sharing may be regarded by some participants as a tool for improved services that are in the interest of a client. While this may be viewed as anti-oppressive in the sense that it can prevent unnecessary or harmful interventions, truly employing an anti-oppressive approach would suggest the importance of allowing service users to share information with professionals at their own discretion. Rather than assuming what is in the best interest of a client, parents should ideally be empowered to determine for themselves what degree of information between professionals would truly benefit their service planning. Approaches that enable parents to pave their own path to wellness could arguably result in more

lasting and meaningful treatment plans. However, it is important to note that this principle can be applied only to situations where there is no imminent risk to children and no duty to report to child welfare agencies.

To elaborate, the client can and should be a collaborator in the decision to share information between systems as each system has a different mandate and not all information about a client and their experiences are similarly relevant within each respective system. The child welfare system requires information about the client's engagement and progress toward treatment goals within the mental health system (but only the treatment goals that are directly tied to the diminishment of identified risk to caregiving capacity); whereas, the mental health system requires information about how the client's mental health has been assessed as a risk to their caregiving capacity and any mitigating factors that may be present that moderate the perceived child welfare risks. This information helps with treatment planning. As situations and circumstances change during a client's engagement with both systems, regular timely updating can be helpful to the client and the helping systems.

Similarly, employing an anti-oppressive lens when examining voluntary and involuntary services means examining how professionals perceive what is a correct course of action in practice. While practitioners may believe a service or intervention is in the best interest of a parent or family, challenging one's assumptions behind one's expert perspective is a key component of anti-oppressive practice and theory (Brown & Strega, 2016). While child safety is paramount and warrants intervention when risk is evident, intervention is not always welcome and may transgress a client's wishes. Utilizing this approach may also entail engaging critically with notions of safety. This might involve considering whether safety is determined solely by

physical risk or if psychological considerations should be included alongside the mitigating factors that moderate risk.

Further, one might consider how definitions of safety might differ based on lived experiences or cultural norms. Seeking additional input and perspective serves clients and system well as we try to forge agreement and a shared understanding of both risk and protective factors contributing to a child and family's well-being. It is also important to consider that while practitioners may strive to operate from an anti-oppressive approach, systems and policies may thwart some efforts. For instance, meeting standards with heavy workloads and time constraints may hinder a practitioner from taking time to engage in processes such as self-reflection or social justice advocacy. When social workers document decisions to deviate from standards of practice, they are building an evidentiary framework for a possible expansion of practice standards toward a greater inclusion of beneficial practice.

Brown & Strega (2016) contend that the anti-oppressive approach aims to encourage practitioners to examine assumptions inherent in their practice-informed perspectives and encourages the recognition that systems do not value all knowers and all knowledge equally. This perspective can be applied to the ideas brought forward in this research about professional knowledge and education. This underscores the great value of practitioners recognizing when they may lack knowledge in an area and taking initiative to seek that knowledge when appropriate. In the context of working with parents where mental health challenges are suspected, this may entail being critical of the assumptions that underlay ideas about mental health. Arguably, professional expertise in mental health should be sought prior to child welfare agencies making decisions or implementing interventions to ensure that decisions are made with the best available information.

While participants discussed the value of child welfare workers being awarded enhanced knowledge around mental health, it is also important to consider the barriers to knowledge that service users may experience. For example, psychoeducation and knowledge of how to navigate systems can be important and empowering tools for parents experiencing mental health challenges or who are receiving services from either system. This may entail exploring what barriers individuals and families face to accessing information about mental health challenges and steps to achieve wellness. Providing user-friendly reading materials, or information in other accessible formats, could be a powerful tool in psychoeducation for individuals and families. It would also be crucial for practitioners to explore community resources that are culturally appropriate in their approaches to sharing wellness tools and knowledge. For instance, some families may get more benefit from talking to an elder about how to achieve wellness than they would from western forms of psychoeducation.

Most critically, parental partnership is essential to employing an anti-oppressive lens. While this research is focused on exploring the experiences of practitioners, it is central to consider a parents' empowerment and agency in the collaborative process. As some participants described, this points to the importance of practicing from an approach that is transparent. While there may be instances where parents are displeased with professional interventions, being transparent about planning allows parents to process and prepare for next steps. Such transparency can also be a critical step in building trust and allowing space for parents' emotional outlet. While a parents' unwillingness to engage in the collaborative process may be considered a barrier to professional collaboration, viewing it in such a way infers that the goals of the professionals are more important than those of the parents. Such ideas may maintain or exacerbate power differentials between systems and families.

Implications and Recommendations

This research was unique in that it generated qualitative experiential data on what collaboration between mental health and child welfare systems for serving parents looks like in the context of Manitoba, Canada. While this research included views and experiences from social work professionals in both fields, it could be beneficial to examine experiences from each professional background more closely.

Strong Collaborative Protocols Needed

Participants' experiences and ideas around the use of collaborative tools and mechanisms, including role clarity, goal identification, and in-persona interagency meetings, may point to the value of agencies establishing protocols for strong collaboration in servicing families affected by parents with mental health challenges. The need for this is further emphasized by the different views and apparent uncertainties around information-sharing protocols between systems. This warrants further exploration in the context of Manitoba. As interpersonal communication and professional approaches factored largely into participants' collaborative experiences, this points to the continued value of practicing interpersonal communication and reflexivity in social work education and in ongoing competency initiatives.

Optimization of Resources and Service Knowledge

Given that resource allocation and service mandates were major areas of concern for participants, future researchers may benefit from examining this topic through a policy lens. Discrepancies in service objectives that were identified by participants may indicate a need for a better understanding of either system's mandates and policies. This could be accomplished

through interagency trainings or outreach. At a systemic level, it should be considered how strict child welfare timelines might conflict with realistic avenues for adult mental health treatment. As well, further exploration of how resources can be optimized to improve service outcomes for parents experiencing mental health challenges would be valuable. The results also indicate the need for continued examination into how child welfare systems' funding models can support prevention work when it comes to serving families affected by parental mental health challenges. Further exploration into optimizing aftercare support for parents who have been hospitalized for psychiatric reasons may be warranted.

Continued Education and Professional Development

The results also indicate a need for ongoing professional development among social workers, as well as interagency training between systems, consistent with recommendations from past research (Colvin et al., 2020; Darlington et al., 2004; Hanson et al., 2019; Mason et al., 2018). This highlights the value of further inquiring into what access to ongoing professional development looks like for Registered Social Workers in either field. Specifically, it may be important to explore how professional development opportunities among social workers could include a collaborative focus. Professional development initiatives in this area may consider exploring how collaborative mechanisms and approaches, specifically those identified in existing, can be incorporated into training.

The findings also indicate a lack of professional knowledge of mental health-related issues among child welfare professionals, which is consistent with existing research findings (Coates, 2017; Radley et al., 2021). Such results are suggestive of the need for access to

professional expertise for child welfare professionals in parental mental health. Further exploration of how this can be navigated between the two systems would be beneficial.

Challenging Stigma and Taking a Supportive Stance

Lastly, the results of this research emphasize the continued need for Registered Social Workers to advocate for societal and systemic progress in the arena of wholistic familial mental health. In practice, this could be as simple as operating from a supportive, nonjudgmental stance that conveys to parents that mental health care is an essential aspect of caring for oneself and one's family. From a structural perspective, this could involve advocating for reducing stigma and increasing access to resources. Further examination into the perceptions of child and family services agencies and ways by which the system can continue to work towards being a supportive resource for families affected by parental mental health challenges may be warranted. The importance of supporting parents in practical, achievable ways, such as transportation and respite, should also not be overlooked. As such, it would also be valuable for future research to more closely explore practical barriers that parents face in seeking mental treatment.

Strengths and Limitations

There were a variety of strengths and limitations that are important to consider when examining this research. The sample size of twelve was a strength in that it included a range of views and experiences. While slightly more participants worked in mental health practice than in child welfare at the time of the interview, all but one of those working in the adult mental health field had experience in child welfare. It may be viewed as a strength that over half of the participants had experience working in both fields and were able to provide and compare perspectives from their experiences in either area of practice. However, this could also be viewed

as a limitation of the research, in that participants largely described their collaborative experiences as benefiting from their knowledge of the other system. As such, this research may be more likely to portray collaborative experiences in which professionals feel confident and well-versed in the area of practice of their collaborative partners, rather than those experiences in which professionals have to overcome challenges associated with not knowing the other system. While having a variety of mixed professional experiences among participants is a strength in some respects, future research may benefit from focusing solely on the experiences of professional for higher-quality insight. It is also important to consider that, in either area of practice, there are a variety of professional roles. This is particularly true of mental health professionals, who may have a range of roles from clinical outpatient work to inpatient psychiatric settings. As such, while the participant pool was broad in terms of professional experience, it may have lacked focus. It should also be noted that, while the findings in this research may align with the experiences of some social workers, they are not generalizable to all social workers employed in mental health and child welfare fields.

Another important limitation to consider is that the sample was largely female (n=9) and white identifying (n=10). It is critical to keep this in mind when considering how a social standpoint might play a role in collaborative experiences. Another limitation was that, while geography was cited by participants as being an important area of consideration for collaboration, few participants had experience working rurally. As such, many collaborative experiences depicted in this research are within an urban context. As noted by one participant as a central factor in their collaborative experiences, future research may examine how geography impacts interagency collaboration in social work practice.

Lastly, a central piece that was missing in this research was the experiences and views of parents and families who have received collaborative services from mental health and child welfare systems. It is vital that parents and families receiving collaborative services can provide perspective as to how such services impacted them and ways by which it can be improved upon. This would be a valuable area of continued exploration in social work research.

Conclusions

This research aimed to explore the collaborative experiences of Registered Social Workers currently practicing in either the mental health or child welfare fields as it relates to providing services to parents experiencing mental health challenges in the context of Manitoba. The results provide unique insight into the collaborative experiences of registered Social Workers from either field in the context of Manitoba, a province known for having among the highest rates of child apprehensions in Canada. Findings indicated mixed experiences, both positive and negative among participants from either field. Participants described how collaborative mechanisms, daily practices, and professional approaches influenced their collaborative experiences to better support parent-clients. Helpful collaborative practices described included goal identification and role clarity among professionals. Professional approaches that were favoured in collaboration included flexibility and transparency. In contrast, participants also described how resource allocation and service priorities negatively impacted their collaborative experiences. Competing service priorities between systems and a lack of resources in the arena of adult mental health were commonly identified by participants. Professional knowledge and education were another factor participants cited as affecting their collaborative experiences. The need for access to expertise in informing child welfare agencies' case planning as it relates to parental mental health challenges was identified. Participants who

had experience working in the other field generally deemed this as an asset in their collaborative experiences. Participants described parental motivation and participation as being central to collaborative experiences. Practical and social contextual factors such as geography, transportation, and social perceptions were also described as having impacted participants' collaborative experiences. Many of the results generated in this research echoed past literature relating to this topic.

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Appendix A: Consent To Participate

Research Project Title:

Collaborative Experiences of Mental Health and Child Welfare Professionals in Servicing Parents with Mental Health Challenges: A Thesis sin Partial Fulfillment of the Degree of Master in Social Work

Principal Investigator:

Frances Maiers ummaierf@umanitoba.ca

Graduate Student, Faculty of Social Work

Research Supervisor:

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Thesis Committee Members:

Dr. Ashley Stewart-Tufescu Ashley.Stewart-Tufescu@umanitoba.ca

Faculty of Social Work

Jennifer Hedges Jennifer.Hedges@umanitoba.ca

Faculty of Social Work

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to

ask. Please take the time to read this carefully and to understand any accompanying information.

Research Description:

This research aims to explore and describe the collaborative experiences of mental health and child welfare professionals in servicing parents who are experiencing mental health challenges and receiving services from both systems.

Participant Activities:

Participants will be asked to complete a preliminary one-page survey that provides basic demographic information, such as their age range and number of years in their profession. Subsequently, participants will be asked to engage in an 60-90 minute interview comprised of open-ended questions about their professional collaborative experiences. Participants will be offered the opportunity to review their transcribed interview.

Recording Procedures:

Interviews will be audio recorded and subsequently transcribed verbatim with the exception of identifying names of specific services, places and/or persons. Participants will be offered the opportunity to review their transcribed interview. Participants can indicate upon their review of the transcription if they prefer to have statements made in the interview retracted from the transcribed text. Audio-recording files will be maintained in a password protected and encrypted electronic file on a password protected and encrypted USB stick. All audio recording electronic files will be deleted upon the completion of all data analysis (estimated no later than December

30, 2022). All transcription files and electronic files containing simple demographic information will be similarly protectively secured and held for a similar length of time.

Benefits to Participants:

Participants may be able to include their time spent in this interview as a part of their professional development hours for their professional regulatory body (ie: Manitoba College of Social Workers). As well, participants will be given the opportunity to reflect on their professional collaborative practices and discuss these experiences in a non-judgmental space.

Potential Risks to Participants:

There are not expected to be any risks to participants engaging in this study. However, it is possible that participants may experience distress related to unpleasant memories while discussing potentially negative professional experiences. In revisiting their practices, some participants may experience some regret for their past actions. This interviewer is committed to taking a compassionate stance throughout the process. A list of supportive counselling resources will be provided to all participants, which can be utilized in the unlikely event that participants experience significant distress.

Confidentiality of Data:

All data used will be held confidential and as indicated above any personal identifiers will only be accessible to the researchers. The data will be confidentially stored using applications approved by the University of Manitoba Research and Ethics Board. No personal identifiers will be used in the publishing of the research. Rather, participants will be referred to with generic descriptors (ie: “some participants indicated” or “one participant indicated”). Data will be destroyed within a five year period from the successful completion and defense of the thesis

project (estimated to be no later than December 30, 2022, thus all data destruction will have occurred on or before December 30, 2027).

Limits of Confidentiality:

In certain cases, the researchers may have an obligation to report information shared should information provided indicate a child may be at risk of harm or should information provided indicate a risk of harm for a participant. Relevant child protection authorities or police will be informed of such perceived risk. Additionally, should information provided indicate a registered social worker participating in the study has engaged in an manner causing concern of an ethical violation, the Principal Investigator, their supervisor and the thesis committee have professional obligations as RSWs to report the concern and its corresponding supporting information. A similar obligation to report concerns applies should information be shared suggesting another regulated professional has acted in a harmful or unethical manner with an individual. Finally, the University's Research Ethics Board (REB) may elect to audit the researcher's files to ensure adherence to the approved ethics protocol.

Honorarium:

For their time spent, the participants will be given a small honorarium of $20.00 upon consenting to participate and prior to beginning the interview. Should the participant elect to stop their participation at any time, they will be able to keep the honorarium.

Participant Withdrawal:

Participants may withdraw from participating (and withdraw the data they have provided) in the research at any time up until the process of data analysis commences. A withdrawal cut off date will be provided to the participants once this research is approved by the ethics board and the

researchers have a better idea of the approximate timeline within which the research process will take place.

Debriefing:

Participants will have an opportunity to ask the researcher questions, provide any commentary, or bring forward further items that they wish to discuss at the end of the interview. No deception is used in the collection of data. Debriefing will be limited to inviting the participant to ask any questions or make any comments about the process. Participants will be welcomed to email the researcher following the interview, should they have questions arise which were not answered immediately following their interview.

Dissemination of Results:

This research is being completed in partial fulfillment of the Master of Social Work. As such, it will be subject to review by the above listed thesis committee. Should the research be published, it will be accessible to students and other academic professionals within online journals and university databases. Theses are typically stored within the University Library system and available through the University's library catalogue.

Summary of Results:

The participants will be offered a 1-3 page summary of the results upon completion of the research. Participants will be given the opportunity to share a preferred address or email for distribution of the results at the end of this form.

Destruction of Data:

All confidential data will be destructed within five years of the project's completion (estimated date for data destruction, anytime before October 01/2027.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Officer at 204-474-7122 or HumanEthics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

□ I, the undersigned, give you permission to use the above indicated email address to share any materials associated with my participation in this study

☐ I, the undersigned, would like a copy of the summary of results sent to me at the above indicated email address upon the completion of this study

☐ I, the undersigned, do not wish to receive a copy of the summary of results

☐ I, the undersigned, have received the $20 honorarium for my participation in this study.

Participant's Name_____

Participant's Signature: _____ Date: _____

Preferred Contact Email Address:_____

Researcher and/or Delegate's Name: _____

Researcher and/or Delegate's Signature: _____

Date: _____

Appendix B

Appendix B: Preliminary Demographic Survey

Student Researcher: Frances Maiers, Faculty of Social Work, University of Manitoba

Advisor: Dr. David Delay, Faculty of Social Work, University of Manitoba

You may leave blank any questions you do not want to answer

1) Age Group

☐ 18-29 ☐ 30-39 40-49 50+

2) Racial Identity (optional) Gender Identity (optional)

_____ _____

3) Highest Level of Education Completed

☐ Bachelor Degree ☐ Master Degree ☐ Doctorate Degree

☐ Other (Indicate)_____

4) Current Employment:

☐ Child Welfare Professional

☐ Mental Health Service Professional within a Regional Health Authority

☐ Mental Health Service Professional in Private Practice

If you are currently working within both categories of employment, please specify whether either is in a casual, part time, or full-time capacity in the space below.

_____

5) Number of years employed in current professional position

☐ Under 2 Years ☐ 2-5 years ☐ 5+ years

6) Do you have prior experience working within the other area of practice (ie: if you are currently working in Mental Health Services, do you have previous experience working for a child welfare agency)?

☐ Yes, I have been previously employed in the other area of practice

☐ No, I have not been previously employed in the other area of practice

7) If there is any other information you wish to share that you think should be known by the researcher prior to the interview process, please specify below:

_____

Appendix C: Interview Schedule

Central Question: What are the collaborative experiences of Child Welfare and Mental Health Professionals in Servicing parents who are involved with both systems?

1. Are there any aspects of your identity that you believe may play a role in your professional collaborative experiences (ie: race, gender)
2. Tell me a bit about yourself and the work that you do.
3. Describe your experience in collaborating with child welfare or mental health professionals (depending on which profession the participant is working in) in relation to a parent client or patient who is receiving both mental health and child welfare services.
4. What are some factors that you think may have played a role in your experiences of interagency collaboration between child welfare and mental health services?
5. In your opinion, how do you think that the nature of your collaborative experiences may have played a role (if at all) in the outcome of services for your parent patients/clients?
6. What is your perception of families' needs in relation to how mental health and child welfare services should collaborate to services parents who are dually involved?
7. What recommendations do you have for optimizing collaborative services between mental health and child welfare systems for parents who are involved with both systems?
8. What do you think is important for professionals and researchers to know about this topic?
9. Do you have any questions for me?

Appendix D: Recruitment Script

1. My name is Frances Maiers. I am a student in the Master of Social Work program at the University of Manitoba. For the completion of the thesis portion of my degree, I will be researching the collaborative experiences of mental health and child welfare professionals in servicing parents who are receiving services from both systems.
2. Dr. David Delay is my academic advisor and will be overseeing and guiding my research. Assistant Professor, Dr. Ashley Stewart Tofescu and PhD. Candidate and Lecturer Jennifer Hedges are both on this thesis committee and will assist Dr. Delay in guiding me throughout the research process.
3. This research has been approved by the University of Manitoba's Research and Ethics Board 1 (Fort Garry Campus). Approval Certificate #
4. I am looking to recruit voluntary participants who are registered social workers employed either as case managers for child welfare agencies or who provide adult mental health services for a regional health authority.
5. Your participation in this study would involve:
    a) Completing a preliminary one-page survey with for gathering basic demographic information
    b) Participating virtually (or in person if COVID19 protocols permit) in a 60-90 minute semi-structured interview comprised of open-ended questions related to your professional collaborative experiences in providing services to parents dually involved in child welfare and mental health systems
6. No identifying information will be revealed in the work. Participants will be referred to in a generic manner (ie: "One participant shared…"). Demographic data provided in the

preliminary survey will be used to give a broad description of the study sample. References to places and specific agencies will be rendered less identifying (eg. a social service agency in a large urban centre in Manitoba)

7. Your overall time commitment is anticipated to be approximately 60-90 minutes. I can accommodate interviews within evening and weekend time slots.
8. You will be given a 20-dollar honorarium for your time commitment at the beginning of our meeting.
9. Your participation in this study is completely voluntary and you can choose to withdraw your participation and the data you have provided at any time up until data analysis has begun.
10. If you are interested in participating in this research, please email me at ummaierf@myumanitoba.ca and I will send you the consent form which you will complete and return to this same email address, Upon receipt of your completed consent form, I can contact you to schedule your interview with time and date. If you have any questions, then feel free to contact me at the same email.
11. Thank you for your time and consideration

Appendix E: List of Supportive Services

If any of the topics discussed during your participation in this research have caused difficult emotions or stressful memories, please do not hesitate to reach out to any of the resources listed below for supports.

Crisis Supports in Winnipeg and Other Regions of Manitoba

Crisis Response Centre: 817 Bannatyne Avenue, Winnipeg MB, 204-940-1781

Klinic 24 Hour Crisis Line: 204-786-8686 or 1-888-322-3019

Manitoba 24 Hour Suicide Line: 1-877-435-7170

Manitoba Farm, Rural, and Northern Support Services: 1-866-367-3276

Mobile Crisis Unit: 204-940-1781

Interlake and North Eastman: 1-866-427-8628

South Eastman: 888-617-7715

Flin Flon: 204-689-9611

The Pas: 204-627-8224

Portage La Prairie and Winkler: 204-857-6369

Brandon: 888-379-7699

Appendix F: Recruitment Poster

Participants Needed for a Graduate Level Research Study in The Faculty of Social Work

We are looking for volunteers to be interviewed in a study exploring the collaborative experiences of social workers who practice as child welfare and mental health professionals and who serve parents who are receiving services from both systems. Participants must be registered social workers in the province of Manitoba and must work in either for a child welfare agency or a regional health authority in a department that provides adult mental health services

Participants will be asked to complete a one-page survey and a virtual or in-person one-on-one, conversational style, interview with the researcher. Your participation will only entail a single session and should take between 60-90 minutes to complete.

In appreciation for your time, you will receive a $20.00 honorarium in the form of a gift card

For more information about this study, please contact:

Frances Maiers

at

ummaierf@umanitoba.ca

This research has been approved by the University of Manitoba Research and Ethics Board