

# IDEAS FOR APS ADVISORY GROUP ON JUSTICE ISSUES FOR PRODUCTIVITY COMMISSION

## 1 - Transmission of mental illness between generations

Delivery of early intervention therapy for families where a parent has a mental health condition including depression and anxiety is one effective way to prevent the transmission of mental health conditions between generations.

There is evidence of a pattern where domestic violence occurs in a family, parents separate, then one parent experiences an episode of mental illness and has difficulty managing their child who is distressed by the separation. These cases go to both the Commonwealth Family Courts and Child Protection Courts.

If cases are mishandled, then parental mental illness continues, and children are more likely to develop behavioural problems that develop into their own mental illness in adulthood.

If cases are managed well then parents recover from an episode of mental illness and return to being productive parents whose children are well. Evidence of this can be obtained from the group COPMI (children of parents with a mental illness).

Parents with mental illness would be classified as having moderate needs. Their needs can be met by a single skilled mental health clinician who can direct practical help that is provided by a disability support worker. These parents are not eligible for NDIS support.

## 2 – Attitudes about parents with a mental illness

Many members of society hold strong attitudes about parents who show signs of a mental health condition including depression. Many people presume that a parent with a mental health condition will automatically be a poor parent, and that there is no need to assess the parenting capacity of individual parents.

Family courts often do not express clear standards they look for when assessing the competence of parents with a mental illness. It would be very helpful if Child Protection Courts published findings about cases to establish thresholds of competence.

## 3 - Poor communication between Commonwealth and State Courts

Commonwealth Family Law and State Child Protection courts operate under different legislation, use different procedures, and can produce different judgments in similar cases.

Commonwealth Family Courts publish reports about their procedures and rulings, and they receive treatment reports from community psychologists. Summaries of decisions by Family Courts in the period 2006 to 2016 that are relevant to psychologists have been published in a website [complexfamilies.com.au](http://complexfamilies.com.au). Family Courts are operating in ways that facilitate provision of family-oriented therapy that is delivered at an early stage. Family Courts use reports from treating psychologists to make decisions about the balance of time a child spends in the care of each parent, in shared care or co-parenting arrangements.

#### 4 - Lack of an agreed policy framework

Work in this field would progress if a consistent policy framework was adopted.

In 2009 the Council of Australian Governments COAG adopted a National Framework for Protecting Australia's Children.

The National Framework recommended that families be classified into four categories:

- **Competent parents** who are supported by generic services that are available to the whole community.
- **Vulnerable families** where a child is exposed to adverse parenting practices that produce cumulative harm for a child over time. Adverse parenting practices cause concern but can be remedied by family-oriented therapy while the child remains in the care of their parent, while the family is subject to a monitoring order.
- **At-risk families** where a child is at an immediate risk of serious harm and needs to be removed from the care of parents.
- **Unfit parents** who spend no time with their child.

This policy framework has not been widely adopted by Child Protection Departments or Courts in Australia. If courts published rulings about families, this would assist clarifying thresholds between at-risk and vulnerable families.

Family-oriented therapy is most effective when provided to vulnerable families that are still intact. An example of a programme that delivered family-oriented therapy to vulnerable families where a parent had a severe mental illness is the Adaire programme that is described in **Appendix 1**.

The child protection CP system has not adopted the framework that distinguishes vulnerable families from at-risk families. As a result CP systems use the same approach with at-risk and vulnerable families. The approach is to remove all children from family care as a first intervention, even when young children have a strong attachment relationship to their parent. This approach does not facilitate reportable early intervention therapy for vulnerable families, and produces unnecessary trauma for children. Literature summarising the adverse effects of prolonged removal of a child from a parent where there is an attachment relationship is summarised in **Appendix 2**.

After a child has been removed from their parent, the Child Protection system considers reunification. No statistics are published about rates of trialled or successful reunification. Observations are that Child Protection systems are slow to commence any rehabilitation, and often increase thresholds making it more difficult for parents to persuade Child Protection staff they are now competent parents. Child Protection staff argue that stability for the child has become the most important consideration.

Departments then apply for a long term custody order until the child is aged 18 years. Parental contact is often very restricted during the custody order to encourage children to develop attachment relationships with alternative carers. This prolonged separation from birth parents adds to a child's trauma due to disrupted attachment. Some child protection staff doubt that children are able to form multiple attachments, and reduce time a child spends with their birth parent to facilitate attachment with a foster carer. This practice is not followed by Commonwealth Family

Courts who consider that a child spending time with two caring parents is a safety factor for a child. Family Courts make decisions about how much time a child will spend with both parents in shared care arrangements. It would be very beneficial if Child Protection systems negotiated shared care arrangements between birth parents and foster parents in suitable cases.

Literature about the ability of children to form multiple attachments is provided in **Appendix 3**.

A paper by Jenkins, Tilbury, Hayes & Mazerolle 2018 (Factors associated with child protection recurrence in Australia) reports that parental mental illness contributes to repeated referrals to child protection services.

## 5 - Poor coordination between mental health and legal services

There is poor coordination between mental health treatment services and legal services for parents and children who have been traumatised. This leads to re-traumatization by legal systems.

There are 6 difficulties involving this coordination:

- Many psychologists are not well trained to communicate with the legal system.
- Many people are not well informed about the adverse long term impacts on childrens' mental health when a child is subjected to prolonged removal from a parent they have an attachment relationship with.
- Some lawyers consider that mental health conditions in parents are untreatable.
- The current Family Law system promotes mediation between separated parents, but gives little emphasis to early intervention therapy. Mediation helps only 30% of separated parents.
- The Child Protection system removes decision making authority from parents and disempowers parents from demonstrating they are capable of making decisions in the best interests of their child.
- There is only a low level of legal aid for parents in the Child Protection system.

A paper by L Campbell 2015 (What characteristics are associated with good versus poor parenting outcomes amongst parents living with psychotic disorders? A confirmatory factor analysis) found that 75% of 1825 parents with mental illness were assessed as showing no parenting dysfunction in the previous year. Five modifiable factors were isolated that predicted parental competence or incompetence. The study recommended therapy that is targeted and flexible.

W Beardslee 2013 (Preventive interventions for children of parents with depression: international perspectives) gives information about effective therapies for parents who are depressed.

A study by Power, Goodyear, Maybery, Reupert, Cuff & Perlesz 2016 (Family resilience in families where one parent has a mental illness) interviewed adults whose parent had a mental illness. The study identifies a number of constructive practices in families where one parent has a mental illness.

## 6 – What treatment services to use

One recommended approach has been to improve coordination between state mental health and child protection services.

One successful initiative in South Australia placed an experienced mental health nurse in a local child protection office. The effectiveness of this project was evaluated by the Australian Centre for Child Protection (Evaluation of mental health liaison project 2006).

Another approach that worked well for a while was the Adaire programme where a state community mental health service in southern Adelaide provided family-oriented early intervention therapy for families where a parent with mental illness was at high risk of being hospitalised to treat their mental illness, resulting in their children being placed into alternative care. This occurred in a region where 30% of adult clients of the mental health services were parents of dependent children, making it viable to provide the programme in the region.

## 7 - Ethical concerns

There appear to be different ethical standards between lawyers and psychologists that impede the provision of family-oriented therapy for families before family law courts. Lawyers are prohibited from representing different members of one family as this introduces a conflict of interests. Lawyers who try to impose this principle on psychologists consider it a conflict of interests for psychologists to provide therapy for more than one member of a family, and this undermines both couple therapy and parenting therapy.

A paper by Tchernegovski, Reupert & Maybery 2017 (How do Australian adult mental health clinicians manage the challenges of working with parental mental illness? A phenomenological study) addresses topics where therapists struggle when a parent has a mental health difficulty and their case is being considered by a family court.

## 8 - Confidentiality

Psychologists are concerned about two confidentiality issues:

- Mandatory reporting - The shortcomings of parents who seek therapy to improve their parenting capacity are already known to courts, so there is no need for additional mandatory reporting.
- Subpoenas of confidential clinical notes – Rather than courts issuing a subpoena for confidential notes, it is preferable for lawyers to ask treating psychologists to provide an objective report about their therapy, with client consent, and an agreement about who pays for the report.

## 9 - Client's motivation for therapy

Reportable therapy can be made available to volunteer parents.

Reportable therapy is suitable for parents who appear before either a Family Court or a Child Protection Court, where the parent wants to improve their parenting on topics that have been criticised. The time these parents spend with their child has been restricted by a court order, and the parents are motivated to improve their parenting capacity to increase their time with their child. Family Courts have considerable experience in making decisions about allocating a child's time between two birth parents.

These parents are motivated to participate in therapy and they ask for a treatment report to be sent to court that describes their progress, together with recommendation about access time and other conditions.

## 10 - Impacts on children

Current policies pay little attention to the impact on children of family disputes being taken to legal systems as a first intervention.

A paper by Loxton, Townsend, Doija-Gore, Fordser & Coles 2018 (Adverse childhood experiences and healthcare costs in adult life) surveyed people over 20 years. The study found that 41% of participants reported some form of adverse childhood experience. 17% had experienced psychological abuse, 9% had witnessed domestic violence, and 8% experienced physical abuse. Women with adverse childhood experiences had higher health costs over time. 16% of the sample reported that one family member had a mental illness.

## 11 - Role of private psychologists

Private psychologists can play a greater role in providing reportable therapy for families before family courts.

Four incentives are required to motivate private psychologists to work in this complex area:

- Training such as the training being considered by the Australian Chapter of the Association for Family and Conciliation Courts AFCC, a new professional association that brings together family law judges and psychologists
- Additional therapy sessions, as the current 10 sessions allocated by Medicare is not sufficient to deal with the range of issues that arise in a vulnerable family
- Payment of suitable therapists at the clinical range to respect the high level of skills required in this form of therapy.
- A capacity for a private mental health professional to be able to direct work of support workers to spend time in a parent's home to help an individual parent to improve parenting skills on nominated topics. This will coordinate clinical services and support services, as occurred in the Adaire model.

## References

More detail about references can be obtained from the website of the Australian Institute of Family Studies.

## Appendix 1 – Adaire model

A model to provide individualised family-oriented therapy for parents who had a severe mental illness that disrupted their parenting of a dependent child was provided by the Adaire Clinic in Noarlunga South Australia in the 9 year period from 1998 to 2006.

Thirty percent of adult clients registered with the community mental health team were parents of dependent children, with half being single parents. Participants in the programme were at high risk of needing to be hospitalised due to their mental health condition, and many clients were referred on discharge from hospital.

The Adaire model had four main components:

- One mental health professional was designated as the parent’s primary clinician and coordinator of services
- In many cases the parent was subject to a one year order from a Guardianship Board that required the parent to participate in therapy.
- Parents with more complex needs were provided with up to 2 hours per week of practical in-home support from a practical worker to assist their parenting in the home. The practical worker was accountable to the clinician to ensure that efforts were collaborative. The nature of practical support was decided on an individual basis.
- Cases were registered with FamiliesSA, and in many cases children had been placed in the care of FamiliesSA while a parent was hospitalised.

It was found that providing family-oriented therapy stabilised the mental health of the parent and reduced need to remove children from the parent’s care. Therapy intervention was usually delivered for one year, with monitoring follow-up occurring in a second year. A total of 86 parents were referred in the study period. In 85% of cases (73 parents) parents were assessed as providing competent parenting in the treatment and follow-up periods. In the remaining 15% of cases children were removed permanently from the care of their parent.

## Appendix 2 – A child’s capacity to form multiple attachments

Early research on attachment reported by Dr John Bowlby et al. (1956) emphasised the attachment bond between a mother and child. Bowlby proposed that an infant always attaches first to its mother, that the mother-child bond is primary, and that infants are not able to form secure attachments with multiple people.

Later research reviewed by Lamb<sup>i</sup> (2012) showed that not all of these early presumptions have been supported by further evidence. It is now clear that infants aged over 10 months are able to form secure attachments with a few people who care for them, including with fathers and grandparents. An infant forming a secure attachment with one carer facilitates the infant forming further attachments to other carers (Schaffer & Emerson, 1964). Infants raised in non-Western cultures often form strong attachments to several family members who provide consistent care for them. It is the case that infants become distressed if they receive only brief episodes of care from a large number of brief carers, as occurs when a child in out-of-home care lives in accommodation with rostered staff, or when many people transport a child to see their parent.

There is ample case evidence that children of separated parents are able to form multiple attachments with both parents, and with grand-parents when children transfer between the care of different adults. While problems can occur, professionals have a range of interventions to manage these problems.

### **Children in out-of-home care**

Scott et al (2005) reported that while children in out-of-home care can form attachments with several carers, about 82% of children in out-of-home care experience conflicts of loyalty or separation anxiety when they move between carers, compared to only 19% of children in a control group of children who move between their parents. Scott et al. found that 73% of children aged 5-9 years were able to form a new attachment relationship with a foster carer within a year.

Research shows that children can develop different types of attachment bond with different carers who provide different types of care to a child. This research is relevant for children whose parents re-marry and a child forms a step-parent relationship.

Dr Sara McLean (2016) from the Australian Centre for Child Protection drew attention to the significance of a child’s capacity to form multiple attachments when a child is in out-of-home care. A child protection worker who applies Bowlby’s early presumption that a child cannot form multiple attachments is likely to consider that the relationship between alternative carers is competitive, and to reduce time a child spends with a birth parent to improve the child’s opportunity to bond with a foster carer.

McLean noted that children placed in foster care benefit from maintaining contact with their birth parent, especially when a birth parent is a single parent who has a secure attachment bond with the child. McLean recommended that decisions about contact with a birth parent whose child is in out-of-home care be based only on issues about the child’s safety, the child’s wishes, and the impact of contact on the child. Separation anxiety alone is not a reason to restrict a child’s contact with their birth parent and to disrupt a secure attachment bond with the birth parent. McLean recommended that child protection workers help children in foster care to maintain their attachment with their

birth parent while also developing an attachment with a foster carer, saying, 'It is important to acknowledge that it is possible for children to maintain contact with birth parents without compromising the development of an attachment bond with a child's foster carer.'

Other writers comment on the importance of helping a child in a step-parent relationship or in out-of-home care to make sense of being part of two families, or of viewing themselves as being a member of an extended family.

A project in Tasmania reported that over half of children who had been removed from the care of their mother at a young age renewed contact with their birth mother after they were discharged from care, showing that attachment bonds are long lasting.

### **Children of separated parents**

Golsis, Ozcan and Sigle (2016) found that children who maintain more contact with their non-resident parent have better mental health outcomes.

### **References**

- J Bowlby, M Ainsworth, M Boston & D Rosenbluth. 1956. The effects of mother-child separation: a follow-up study. *Psychology and Psychotherapy*, 29, 211-247.
- A Golsis, B Ozcan & W Sigle. 2016. *Child outcomes after parental separation: Variations by contact and court involvement*. London: Ministry of Justice.
- ME Lamb. 2012. A wasted opportunity to engage with the literature on the implications of attachment research for family court professionals. *Family Court Review*, 50, 481-485.
- S. McLean. 2016a. *Children's attachment needs in the context of out-of-home care*. Australian Institute of Family Studies.
- S McLean. 2016b. *The effect of trauma on the brain development of children: Evidence-based principles supporting the recovery of children in care*. Australian Institute of Family Studies.
- Schaffer HR., & Emerson, PE. 1964. The development of social attachment in infancy. *Monograph of the Society for Research in Child Development*, 1-77.
- Scott, D et al 2005. *Contact between children in out-of-home care and their birth families: Literature review*. NSW Department of Community Services.

## Appendix 3 – Impacts on a child’s mental health or prolonged separation from an attachment figure

A child being briefly separated from a parent they have an attachment to is described in professional literature as showing separation anxiety.

It is well established that prolonged separation of a child from their parent produces distress in most children.

The question of how long a child’s distress continues following separation has been addressed by writers including Bowlby et al. (1956), M Rutter (1971), Lamb (2012) and McLean (2016, 2018). These writers conclude that a child experiencing a prolonged separation from a parent with whom the child has a secure attachment bond is a traumatic experience for the child. McLean (2018) noted evidence that a child’s brain functioning changes when a child experiences severe trauma, interfering with the child’s ability to process their emotional experiences and to think clearly. McLean reviewed evidence that severe disruption of an established parent-child attachment bond can have an ongoing impact on the development of a child’s brain, and this can produce long term mental health difficulties. This information has been well established since 2006.

Writers recommend that if it is necessary to remove a child from parental care because a child is at risk of immediate and serious harm, then it is important to provide the child with trauma-focused therapy to help the child to manage their separation anxiety and trauma, and not only to facilitate attachment to a new carer. Parents can be taught how to manage the impact of separation on their child so that the parent adopts practices that minimise harm and facilitate their child’s recovery.

Writers report that breaking the continuity of a child’s attachment relationship during a critical stage in a child’s development without appropriate therapy commonly results in ongoing impairment to the child’s ability to manage their emotions and to form cooperative relationships, and that this impairment extends into the child’s later life. One critical period when damage to a child’s attachment skills can occur is during the age 3-6 years. Children who develop a pattern of disorganized attachment at this time are unable to find any method to obtain comfort and security from a parent figure. Children with disorganized attachment often develop an ‘affectionless character’ and later show an increase in aggressive tendencies and difficulty in managing their emotions.

A study by Guy, Furber, Leach and Segal (2016) found that family disruption during the early years of a child’s life, including because of their parents separating, is a risk factor for children developing a mental illness as an adult. They noted that family disruption also provides an opportunity for therapeutic intervention.

Howard et al. (2011) report that a child being separated from a parent with whom they have a secure attachment has been explicitly linked to a disorganized attachment disorder and to subsequent mental health problems including to borderline personality disorder. Howard et al. report that untreated mental health conditions commonly continue into adulthood.

McLean also notes that trauma has an especially strong impact on a child who has a disorganized attachment with a parent. This child is often unable to find any consistent way to elicit comfort and support from a new foster carer.

## References

- Bowlby, J., Ainsworth, M., Boston, M., & Rosenbluth, D. 1956. The effects of mother-child separation: a follow-up study. *Psychology and Psychotherapy*, 29, 211-247.
- FACSAR 2016. Birth family contact for children and young people in out-of-home-care. NSW Family and Community Services.
- Golsis, A., Ozcan, B., & Sigle, W. 2016. Child outcomes after parental separation: variations by contact and court involvement. London: Ministry of Justice.
- S Guy, G Furber, M Leach & L Segal. 2016. How many children in Australia are at risk of adult mental illness? *Australia and New Zealand Journal of Psychiatry*, 50, 1146-1160.
- Howard, K., Martin, A., Berlin, L., & Brooks-Gunn, J.. 2011. Early mother-child separation, parenting and child well-being in Early Head Start families. *Attachment and Human Development*, 13,5-26.
- Humphreys C., & Kiraly, M.. 2010. Developmentally sensitive parent contact for infants when families are separated. *Family Matters*, 85, 49-59.
- Lamb, M.E. 2012. A wasted opportunity to engage with the literature on the implications of attachment research for family court professionals. *Family Court Review*, 50, 481-485.
- McLean, S. 2016. The effect of trauma on the brain development of children: Evidence-based principles supporting the recovery of children in care. Australian Institute of Family Studies.
- McLean, S. 2016. Children's attachment needs in the context of out-of-home care. Australian Institute of Family Studies.
- McLean, S. 2018. Developmental differences in children who have experienced adversity. Australian Institute of Family Studies.
- Moloney, L. 2014. Sharing the care of children after separation. Australian Institute of Family Studies.
- Rutter, M. 1971. Parent-child separation: psychological effects on the children. *The Journal of Child Psychology and Psychiatry*, 12, 233-260.
- Wallace, M. 2018. The effect of separating children from their parents. *Psychology Today*,