Experiences of people with mental ill-health involved in family court or child protection processes

A rapid evidence review

Institute of Child Protection Studies

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Acknowledgements

CONTENTS

1. Scope and rapid review strategy

The National Mental Health Commission requested the Institute of Child Protection Studies (ICPS) at Australian Catholic University to undertake a rapid high-level review of the issues relating to the experiences of people with mental ill-health who are involved in family court and/or child protection processes. The purpose of the review is to identify issues and implications for areas where work can be done to address stigma in three domains: self-stigma, public stigma, and structural stigma/discrimination.

Our approach to the rapid review focused on identifying relevant peer-review literature, existing submissions, evaluations, and others reports.

We searched and conducted a high-level scan of the published peer-review literature (internationally–but focusing on Australian studies where identifiable). Titles or keywords in this literature included themes related to stigma or discrimination experienced by parents with mental ill-health who are involved in family court and/or child protection processes and its impact on children and young people.

- In terms of **family court processes**, this search included:
  - families using mediation services, reaching agreement about residence/contact; families having matters adjudicated, including matters going through specialised processes such as the Family Court of Australia's Magellan case-management model for sexual abuse or serious physical abuse allegations.

- In terms of **child protection processes**, this search included:
  - parents receiving services such as intensive family support through differential response/diversionary strategies from statutory child protection services (including for example, the Cradle to Kinder program in Victoria); families with a child subject to notification, investigation or substantiation; families where a child has been removed into out-of-home care (including issues relating to ongoing contact between parents whose children are placed into foster/kinship or residential care).

Key themes and messages from the international literature were reviewed in the context of the unique features of Australian family law and child protection systems (particularly our focus on shared parental responsibility and consideration for equal shared time in family law decisions). Differences across jurisdictions in the legislative grounds for statutory child protection services to intervene were also taken into account.

We also reviewed key reports in the grey literature, including relevant submissions to recent/current inquiries (e.g., the Disability Royal Commission, and the Victorian Mental Health Royal Commission). The timeframes and scope for the review were limited so it was not possible to exhaustively analyse all relevant material. However, we reviewed selected key findings and implications to illustrate where and how people with mental illness may experience stigma or discrimination, or where there are structural or systemic opportunities for stigma and discrimination to affect practice.

For this review, we have focused on issues relating to mental health stigma/discrimination such as:
- how significant an issue it is

- from whose perspective it is seen as an issue (parents, practitioners, decision makers, children)
- the nature of the issues (direct discrimination, inadvertent discrimination, stigma, etc.)
- how each issue plays out in the family law and child protection systems (e.g., fear of engaging with complex legal processes)
- how difficulty in presenting evidence coherently disadvantages a parent with mental ill-health issues compared to a parent without mental ill-health).

We also explore the impacts of how mental ill-health, if poorly managed by the system, impacts on parents, partners, ex-partners, and their children.

In this review, we identify some key specific programs or strategies that have been deployed to address issues of mental ill-health in family law and child protection service users. We also provide insights into how to best prevent or mitigate the effects of stigma and discrimination.

This review presented an opportunity to draw on ICPS team members' extensive involvement over more than two decades in conducting reviews and evaluations relating to family law, child protection and out-of-home care, family support, and early intervention services, and our knowledge of policy contexts and service delivery. This experience gave us confidence to identify additional themes or issues that affect experiences of people with mental ill-health who are involved in family court and/or child protection processes. We identified from these sources key issues and principles for good practice, and questions or areas for further exploration to address mental health-related stigma and discrimination in the child protection and family law systems in Australia.

2. Background

In his review of fathers and mental illness, Price-Robertson (2015) provided the following summary of four different forms of stigma, based on Pryor and Reeder's (2011) conceptual model:

- **public stigma:** the reactions of people who engage in stigmatising behaviour to those they perceive as having a stigmatising condition
- **self-stigma:** both the fear of possibly being exposed to stigmatising interactions or circumstances and the internalisation of stigmatising narratives
- **stigma by association:** directed towards those associated with a 'discredited' individual with the stigmatising condition, such as family members or health workers)
- **structural stigma**: society's institutions and discourses that endorse or perpetuate a stigmatised status.

In presenting this rapid scan of the literature, we explore both explicit and implicit presentations of stigma and discrimination. In particular, we focus on the intersectionality of mental ill-health with other complexities in the lives of families that family law and child protection systems encounter.

We also focus on the intersection between family law and child protection and its implications for mental health stigma to influence service provision and responses to children and families in need. We note specific issues facing those responsible for ensuring the safety and wellbeing of children in the context of parental separation, and the two separate legal systems: family law and child protection. There is a range of ways in which state-based child protection systems intersect with the federal family law system, with some gaps and some areas of overlap. Recent research–as well as reports from national inquiries–highlights the lack of clarity regarding responsibilities and how families and professionals navigate within and between the systems.

There are some key differences between family law (private dispute between two parties) and child protection (public law) and opportunities for stigma and discrimination to affect processes and outcomes. However, the two clearly intersect when separating parties raise concerns about the safety of children when in the care of the other party. Child abuse allegations in family law proceedings also highlight practical issues involved in the separation of powers between the Commonwealth and states/territories and the allocation of responsibility for child protection to states/territories, and private family law to the Commonwealth. This is the essence of the need for a specialist approach to dealing with cases where these two issues intersect. The different responsibilities are summarised by Higgins and Kaspiew (2008):

> The mandate of child protection authorities is to intervene to protect children only when a parent is neither willing nor able to protect the child from harm. In contrast, the task of the federal law system that deals with parenting disputes is to resolve disputes between parents who are separated over what arrangements are in the best interest of their children. (p. 244)

The state/territory statutory child protection authorities have different concerns from those of the family law system:

> The question for State or Territory child protection authorities is whether the matter is sufficiently serious to justify protective intervention using the powers of the child protection legislation if necessary. The question in family law proceedings is usually about the

competing claims of each parent in relation to residence or their proposals concerning contact arrangements. (Family Law Council, 2002, p. 30)

The formal family law 'system' is not primarily a 'service' system, but a conflict resolution system. The workhorse is the family mediation system, with parents only arriving at the court room door if they have tried and not been able to successfully mediate (e.g., through a Family Relationship Centre) or if they are exempted because of the presence of domestic and family violence making mediation unsafe. Despite reforms to address concerns about the safety of women and children, the family law system continues to be underpinned by a strong philosophy that it is in the best interests of a child to maintain a relationship with both parents after parental separation (Kaspiew et al., 2015b).

But what is common to both child protection and family law systems is the question of how to avoid entry to the legal or statutory arm of those service systems, or to get families out of the system as quickly as possible. Common to both systems too is the need to produce or rely on evidence of risk of harm and factors that may influence what parenting arrangements are in the best interest of a child. In all these scenarios, it is likely that a parent with mental illness will often be involved– whether diagnosed or identified by practitioners in either system.

However, the systems designed to help support safety and wellbeing of children and families can themselves be stigmatising. And this is compounded by the broader social stigma that many families encounter relating to mental ill health. Drawing on the work of Corrigan and Miller (2004), Price-Robertson (2015) argued that:

> Families' shame and concealment is related to social stereotypes and prejudices directed towards families of individuals with a mental illness; specifically, parents are often held to blame for their children's mental illness, siblings and spouses are held to blame for their family member's perceived mismanagement of their symptoms, and children are perceived as damaged or contaminated by their parent's mental health problems. (p. 14)

One of the challenges in looking at the experience of stigma or discrimination relating to mental health in systems such as child protection is that mental illness may not be overt or visible. There is also an overlap with the broader construct of vulnerability. It is worth noting that it is not the statutory role of child protection workers to conduct mental health assessments or diagnose parental mental illnesses, but to assess the risk of harm to a child. Child protection services are targeted at families with multiple, complex issues, many of which will include parental mental ill health. Mental ill health is often the consequence of prior trauma. Typical characteristics of families coming to the attention of statutory child protection authorities include experiences of intergenerational abuse and neglect, domestic and family violence, and being in the care system due to childhood maltreatment. Statutory child protection services also are responding to families where children are exposed to chronic maltreatment (referred to as cumulative harm; see Bromfield, Gillingham, & Higgins, 2007). As noted by Collier and Bryce (2021):

> Adverse childhood experiences that are consistently experienced over a sustained period of time throughout childhood result in an accumulation of childhood adversity, which is often referred to in the literature as cumulative harm. (p. 1)

In our review, we found that parental mental ill-health is seen as a risk factor for child safety. Indeed, statutory child protection intake workers across multiple jurisdictions use a Structured Decision Making tool that features mental illness as an indicator in risk assessment. However, there are potential unintended consequences for viewing mental health as a child protection concern

when parents, despite their mental health struggles, can be child-focused and provide appropriate care, support and safety for their children.

The number of parents in child protection systems who have a current mental health condition is estimated internationally and across Australian jurisdictions to be from 22 to 80%. This is based on a number of different definitions and varied data collection techniques (McConnell, Llewellyn, & Ferronato, 2000, NSW: mental disability of parents in the children's court; O'Donnell et al., 2015, WA: mental health diagnosis of mothers in the child protection system; Riihimäki, 2015, Finland: mental health disorders of parents in child welfare services; Stromwall et al., 2008, United States: parents in child dependency court; Westad & McConnell, 2012, Canada: maternal mental health issues). The most common mental health issues include mood disorders, substance disorders, and stress-related disorders.

Parents with mental health problems are at risk of having children removed from their care due primarily to factors such as lack of parenting skills, neglect, and prenatal exposure to substances, rather than due to physical abuse (Roscoe et al., 2021). Thus, the critical issue is (or should be) the mediating role of parenting capacity and parenting skill deficits that lead to neglectful behaviours. The critical issue should not be parental mental health per se. Roscoe et al. (2021) found that: "unemployment, economic hardship, and social isolation, factors linked to maltreatment risk, are also more common among parents with mental illness". Consequently, they suggested that "in addition to harsh disciplinary practices, factors such as unstable or hazardous living conditions, or unmet essential needs may account for why children of parents with mental health problems are removed."

Stigma relating to mental health may not be the only form of stigma or discrimination that parents face when encountering a systems like child protection or family law. Much has been written in the Australian and international literature about First Nations over-representation (or disproportionate representation in child protection or family law systems. This highlights the experiences of racism in workers, systemic racism and systems bias. For example, talking about pediatricians–one of the primary sources of referral to child protection–Palusci and Botash (2021) noted that:

> Pediatricians have implicit and explicit racial biases that impact the health and well-being of children and their families. Similarly, effects of racism on diagnosis and reporting of suspected child abuse and neglect to child protective services (CPS) can have serious consequences. Although we and others are mandated to report suspected child abuse or neglect in all US states and territories, the threshold for reporting requires only "reasonable suspicion" of abuse or neglect. Pediatricians may also report families that they perceive need additional resources. (p. 1)

The overrepresentation of First Nations children and young people and disproportionate 'systems contact' with First Nations families was a key theme of the Family is Culture report of the Independent Review of Aboriginal Children and Young People in Out-of-Home Care (2019).

3. Literature scan and key messages

Our literature scan identified over 260 publications that address stigma and/or discrimination in relation to mental health of people engaged with either family court or child protection processes. The scan included families using mediation services, families reaching agreement about residence/contact, as well as families having matters adjudicated, including those matters going through specialised processes.

In child protection processes, we included:
- parents receiving services such as intensive family support through differential response/diversionary strategies from statutory child protection services
- families with a child subject to notification, investigation or substantiation
- families where a child has been removed into out-of-home care (including issues relating to ongoing contact between parents whose children are placed into foster/kinship or residential care).

Overview of the literature scan

Key Themes	Experiences	Personal Responses	System Responses	System Issues
Parenting	Migrant	Healing	Child protection	Collaboration
Family	Racial disparity	Voice	Mental health	Complex disadvantage
Clinical approaches	Adolescence	Empowerment	Medical/clinical	Voice
Education	Chronic illness	Attachment	Child removal	Institutional trauma
Awareness	Alcohol & drugs	Identity	Adoption & care	Carer burden
	Gender	Pain	Guardianship	Child friendly
	Family Violence	Trauma	Healing	Barriers & facilitators

The literature search was rapid and does not represent an authoritative review but a snapshot of research findings. Its general nature did provide a framework for examining themes and the opportunity to identify gaps in the research literature in the context of other available knowledge.

We begin with some key background research findings. There is clear Australian research evidence of poor mental health outcomes for children in care (Osborn & Bromfeld, 2007; Vimpani, 2011; Wise, 2016). Research also noted significant numbers of adults with mental health issues would also be parents (Bee et al., 2014; Benders-Hadi, Barber, & Alexander, 2013; Howe et al., 2009). However, the focus is typically on mothers rather than fathers (Benders-Hadi et al., 2013; Price-Robertson, 2015; discussed further in Section 6 below). The publications looking at the implications of these general findings largely examined high-level systems rather than specifically examining the family law and child protection processes or evaluating particular treatments or responses.

Mental health system responses and issues

A recent study from the United States (Powell, 2020) reported pervasive discrimination against parents with psychiatric conditions within the child welfare and family law systems, often resulting in the removal of their children and loss of custody. The study reported that the legal profession lacks understanding of mental health, noting a need for lawyers to assist beyond litigation, including

taking more time to explain the legal process, assisting with administrative tasks, and coordinating with other supports and services. A more recent study from Australia (Hayes et al., 2021) offers some key insights into how mental health and legal services could coordinate to improve process and outcomes.

Another key article on child and youth mental health (Liegghio, 2017) identified structural stigma within and across service systems (including mental health, education, child protection, and criminal justice). This article also noted that fragmentation of the service delivery system is a significant factor exacerbating stigmatising encounters.

Corrigan (2005) offers an analysis of structural discrimination against those experiencing mental ill-health in laws in the United States.

There is evidence of the value of awareness training of the stigma of mental health for practitioners working with children in care (Garcia, 2015) but limited recognition of this value by families (Fong, 2016).

A key study on affiliate stigma (stigma across family members) in the adolescent children of adults with mental health issues (Cai et al., 2019) noted the impact of stigma in family cohesion. Bala et al. (2007) noted the significance of understanding mental health impacts on families in assessing the allegations of child sexual abuse that are made in family law proceedings.

Experiences and roles

The literature offered strong evidence of recognition that mental health issues are often intertwined with other complex issues associated with disadvantage (Duarte & Summers, 2013; Greene et al., 2010; Humphreys et al., 1999; Kokaliari et al., 2019; Scott 2009; Stallman et al., 2010; Wade et al., 2014). These issues include chronic health conditions, housing insecurity, poverty, incarceration, and racism (Hill, 2004); alcohol and drug issues (Baddams, 2011; Doab, 2015) and family violence (Kaspiew, 2010).

These intertwined adversities impact on interactions (including within systems) as patients, parents, children, (Greene et al., 2010; Tran, 2014) and young people (Jackson, 2006; Wade, 2014). Sexual identity and disclosure are increasingly acknowledged as key experiences affecting mental health (Legate et al., 2015) and are identified as relevant experiences for children, parents, and families (Ross, 2008; Bos et al., 2005). Other research has identified significant experiences of historical trauma in refugees and migrants who have fled abuse and persecution arising from sexuality and gender identity (Alessi et al., 2016).

There was acknowledgment of the changing impacts on children and their wellbeing as they move through stages of development from infancy through to adulthood (Allen et al., 2018; Price-Robertson, 2010). As noted earlier, these difficulties tended to be identified at a high systems level and less often in the context of the operation of the family law and child protection systems.

Concerns have been raised about the interconnected nature of mental health, child protection and family violence (Kaspiew et al., 2010) including the limitations of services' ability to appropriately respond to the experiences of the parent. These limitations are usually with respect to the mother, but sometimes the father (Tillitski, 1992) and grandparents (Doley et al., 2015); as well as that of the child to (Khalwa, 1997; Howard et al., 2011; Wade et al., 2014; Quick & Scott, 2019).

A different perspective was offered by an account examining the experiences of children as carers of parents with mental health issues (Jarry, 2009). This account shifts the focus from children as the subject or passive recipients of system responses such as family law and child protection to exploring them as actors, observers, carers, and facilitators in dealing with a range of issues including mental health.

There is a small number of texts that identify the systemic discrimination within service systems and system responses including discrimination against parents or adults with mental health issues (Kaplan et al., 2009; Quick & Scott 2019). Francis (2019) offers an examination of systemic discrimination against parents with intellectual disabilities in the US family law system.

System responses and issues

There was limited literature that connected or commented directly on experiences of parents with mental ill-health who interact with the family law system and child protection systems (either Australian or international).

One study (Draganic-Gajic, 2005) examining complex family law conflict noted that the system can affect communication styles, family rules and norms, and reinforce conflicts. This increases risk of inadequate attention to the care and protection of children and notes the challenge of constructing solutions that appropriately address children's needs.

Early Australian research with children who reach the attention of mental health or counselling services suggest that they are more likely to come from families in which the parental relationship is poor. Studies of the individual parents revealed that the likelihood that the parents will have a mental illness including a personality disorder is significantly increased over the rate in the general population (Waters, 1999).

Several studies detailed the evidence of mental health impacts on children in the family law (Read, 2003) and family law mediation system (McIntosh, 2005). These studies argued the importance of early intervention with separating families that should include screening of children's experience of conflict and their own needs for recovery. There is at least one comparative study of the way in which family courts examine mental health of parents in decision making (McInnes, 2013).

Mental health of parents was identified as a key matter considered in child protection assessments in a variety of contexts with a range of outcomes–usually alongside the complexity previously noted (Mercovich, 2008).

Monds-Watson et al. (2010) argue that child rights obligations under the United Nations Convention on the Rights of the Child call for greater attention amongst social service professionals to listen to children to better understand their wellbeing. They also argue for greater attention to the vulnerability and specific needs of children when parents have mental health difficulties; and for the coordination of mental health and child protection responses to be more preventative to "avoid these children and their families being additionally stressed and stigmatised by the 'double whammy' of child protection and mental illness".

Another relevant text included a detailed examination of the Mental Health Liaison Project in South Australia–an initiative developed to facilitate collaboration between the mental health and child protection services (Arney et al., 2010). Parental mental health problems were identified in a significant proportion of families in contact with child protection services. The Project sought to

enhance the skills of practitioners to work across parents' mental health and child protection issues. In examining the factors that help and hinder such an intersectoral approach, it noted benefits in addressing the intersection of child-focused and adult-focused services. The Project was evaluated and was considered successful (Zufferey & Arney, 2006). This was also explored in a clinical context (Lange & Williams, 2011) and for the role of nurses (Strawbridge, 2014).

Studies found clear benefit for training for professionals in supporting children of parents with mental health and/or substance use issues (Vigano et al., 2017) and across a range of social service settings (Featherstone & Broadhurst, 2003; Kemp et al., 2009; Gray et al., 2009, McConnell et al., 2011, Kalebic et al., 2020).

Issues for school-aged children were identified in the review, with schools being a key support site for identifying mental health issues (Snyder, 2015). Young carers of parents experiencing mental ill-health noted that their responsibilities affected their educational outcomes (Moore et al., 2009). In contrast, childcare is an under-utilised site for support and interventions (Davis et al., 2010).

Collaboration was also a key theme in relevant Australian texts that identified the complexity of challenges for adults. The texts noted that there are opportunities in building the capacity of such services to become "child and parent sensitive". This approach could improve responses to adults as parents and improve the safety and wellbeing of particularly vulnerable children (Lewin & Gatley, 2015; Scott, 2009). Jee et al. (2014) endorsed an integrated care model for mental health in care settings.

Although not tested directly, several articles raised the value of population health and/or public health approaches to the challenges of complex experiences and limited system responses (Sharfstein, 2019; Prinz, 2009; Kemp et al., 2009).

Trauma-informed workforces

Kezelman et al. (2015) estimated that childhood trauma affects around five million Australian adults, with mental health concerns a commonly cited outcome of adverse childhood experienced including abuse and neglect. The most ambitious epidemiological research in Australia currently underway is the Australian Child Maltreatment Study (Mathews et al., 2021). This study aims to quantify the extent of child maltreatment and the trauma-related health and mental health outcomes in the Australian population. See: https://www.australianchildmaltreatmentstudy.org/

Disorders commonly associated with mental illness are related to trauma and stress, including diagnoses such as post-traumatic stress disorder (PTSD). Complex trauma is also associated with mental illness. A recent systematic review (Suomi et al., in press) shows that rates of current PTSD in parents in the child protection system based on 11 studies (n = 4,871) was 27.2% for mothers, and 10.6% for fathers.

While trauma-focused treatments are often beyond the scope for child protection services, growing evidence highlights a clear need for trauma-informed service provision for parents and children in the child protection as well as the family law systems. There is a clear call for trauma-informed approaches across sectors including mental health services, Wall et al. (2016) noted that exposure to adverse, potentially traumatic events in childhood is not uncommon. They cite the example of the large-scale US study of Adverse Childhood Experiences (ACE), which had 17,337 respondents. The study found that 64% had experienced at least one adverse experience and approximately 12% had experienced four or more in the first 18 years of life (Anda et al., 2006). As noted by Wall et al. (2016):

> Trauma-informed care is a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage… As trauma affects a large proportion of the population, survivors are clients in a broad range of human services, and organisations across all settings should consider how a trauma-informed approach could benefit stakeholders, regardless of whether or not the organisation also provides evidence-based trauma-specific interventions. (p. 1)

Some of the challenges to trauma-informed care implementation identified by Wall et al. (2016) included:

- lack of clearly articulated definitions (e.g., of trauma-specific interventions vs the concept and principles of trauma-informed care)
- translating trauma-informed care to specific practice and service settings
- consistency across service settings and systems
- care-coordination
- lack of guidance for facilitating care coordination that requires complex system change.

Traumatic experiences are closely associated with other adverse childhood experiences, such as abuse, neglect, and interpersonal violence (Wall et al., 2016). This trauma is likely to underlie the high levels of mental health difficulties of parents engaging with either (or both) of the child protection and family law systems. Wall et al. note the value of whole-of-organisation approaches to trauma-informed service delivery. These approaches need to be directed at every level to ensure a focus on what helps clients feel safe. According to Wall et al. (2016), workforce training should include:

- understanding trauma presentations (impacts of trauma and typical modes of reacting)
- skills in de-escalation for clients who are experiencing an acute trauma/re-traumatisation
- skills in debriefing and protocols for staff responding to clients presenting with complex circumstances and trauma histories
- knowledge of typical events or circumstances in the lives of families that they work with that may be traumatising/re-traumatising.

Another key theme identified by Wall et al. (2016) is the need for self-care for staff in dealing with one of the typical causal factors in mental illness–past trauma. Judicial and other staff in family and children's courts need organisational supports to prevent or address 'vicarious trauma' for staff. (Vicarious trauma is the psychological term for changes that can occur to people when they are repeatedly exposed to the traumatic experiences of others particularly in workplace settings.) This support should also be available to departmental and other support organisations working in the context of child protection and family law. Other support should include: clinician self-care skills and reflective practice, caseload management, supervision, debriefing, staff and peer support, workplace safety, comfort, and a supportive work culture that acknowledges the reality of vicarious trauma. Training for staff should include information about preventing and/or responding to secondary or vicarious trauma. For example, see: www.aifs.gov.au/publications/feeling-heavy.

Gaps in research literature

Considering the rates of engagement with the child protection system, the academic research with Aboriginal and Torres Strait Islander families is limited (AIHW, 2012). Research has noted complex and chronic family needs including domestic and family violence, parental mental health problems,

family homelessness and precarious housing, and parental drug and alcohol problems (Matthews & Burton, 2013; Tilbury, 2012).

There is a small but growing area of research literature which examines the responses of Indigenous communities particularly to trauma and disadvantage which often reframe service responses. They offer a more direct and community-based approach to addressing experiences of complex disadvantage (Hunter et al., 2020).

Intersectional approaches that address awareness and response to domestic and family violence could offer a possible area of comparative and parallel learning. They share the challenge of hearing the perspectives of different but interconnected roles and identities (children and adults; victims/actor/perpetrator, etc.).

There was a notable lack of academic research that examined the experiences of refugee or migrant families and children and families with experiences of disability in either the family law or child protection systems.

The Multicultural Youth Advocacy Network (2014) has noted that young people from refugee and migrant backgrounds often face additional barriers that prevent their engagement in mental health services. This may include stigmas and expectations that are heightened in culturally diverse communities.

4. Child protection in Australia today

In general terms the child protection system in Australia is based on separate but similar legislative models of child protection operating in every Australian state and territory. Each system is principally focused upon tertiary level child protection activity. This is reflected in each set of enabling legislation in each state and territory. The legislation is not uniform but sets out substantially the same process with the same general priorities.

Tertiary child protection is based on concerns about child welfare. Where a risk of harm is identified, there is an intervention by child protection authorities in family life. This includes the removal of children from their families and their placement into out-of-home care. Each system acknowledges the opportunity for primary (universal) and secondary (more targeted) measures to address child maltreatment before tertiary child protection involvement. However, child protection systems in Australia remain oriented towards tertiary responses.

The collection of information for investigation of concerns is generally built around mandatory reporting obligations (enforced by statute law and reinforced by penalties including criminal offences for failure to report). The reporting is notionally oriented towards assessing risk to the child and then the assessment, to identifying and managing the risks of harm. This orientation is reactive.

There is limited referral to services that could be provided to support parents in their parenting and care of children and to facilitate a safe family environment. This orientation is reflected in the weight of funding allocation within statutory child protection systems to tertiary child protection compared with primary/universal and secondary/targeted prevention and early intervention programs and services.

Within state and territory statutory child protection systems in Australia, we are not aware of any systemically funded evidence-based child maltreatment prevention and early intervention programs and services that are widely accessible to all or most families. We are not aware of parenting and family support programs or services available from or integrated into other services systems (for example, the early childhood, education or health systems) that are accessible to families and designed to prevent or reduce the risk of child maltreatment.

In their review of statutory child protection systems, the Australian Research Alliance for Children & Youth concluded that Australia's approach is heavily weighted towards the tertiary end of the public health continuum (primary, secondary and tertiary) (ARACY, 2008). Their report argues that we need to 'invert the pyramid' and prioritise primary prevention. Family support programs that are available are usually narrowly targeted (i.e., to high-risk children/families) and entry is usually via referral from the statutory service. This means that services are not 'preventative' or offering 'early' intervention. While services can be helpful to the families involved, they only reach a limited number, and even then reach families quite late in the trajectory of problems they are facing. One example of a pilot of a primary prevention program in Australia includes the Victorian Government's Cradle to Kinder program (see Appendix B).

Alternative models of child protection

The focus of Australian child protection systems is fairly similar to other Anglophone countries–with its focus on investigations, risk-assessments. This contrasts with some European models of child protection in which there is a greater focus on family support: implementing child maltreatment prevention and positive parenting intervention strategies through population-wide measures, including through services not associated with tertiary child protection (Higgins et al., 2019).A range

of factors could explain the orientation of statutory child protection systems away from a primary focus on delivery of family support (including addressing the parenting support needs of those with mental ill-health). These include:

- the legislative mandate of our systems, coupled with strong mandatory reporting laws, and structured risk assessment tools
- the intense focus of the media on failures of the system to detect and respond to risk of imminent harm (such as is exposed through reports from child death review committees).

The aim of these family support and parenting intervention strategies is to reduce the likelihood of children requiring intervention for welfare concerns. The European models are more consistent with public health population approaches to address child maltreatment. Population approaches seek to address the primary drivers of public health problems across the whole population. They have been used with other complex health related issues such as tobacco-related cancers and HIV (Sanders et al., 2018).

Targeted tertiary child protection services only reach a small proportion of the population and are typically introduced quite late in the trajectory of family dysfunction (Herrenkohl et al., 2015). The public health approach to child protection supports a child's right to safety and wellbeing at a whole-of-population level and can enhance prevention of child maltreatment. It also allows for approaches that target groups of children at greatest risk.

There is evidence that prevention and early intervention strategies reduce the prevalence of child maltreatment and associated indicators (Sanders et al., 2018). For example, there is evidence that individual programs and services that are aimed at preventing child maltreatment can be effective in achieving specific outcomes such as increasing positive parenting skills; reducing child behaviour problems; reducing parental problems like substance misuse, and so on (Doyle et al., 2021). However, there is no single country or jurisdiction globally that has adopted a comprehensive public health approach to prevention of child maltreatment. As such, there is no specific research to point to the effectiveness of such a comprehensive approach.

Currently, the best evidence from a single program approach comes from the population-wide implementation of Triple P as part of a randomised control trial. Triple P has also been implemented in the United States, where follow-up data showed reductions in notifications to child protection services (Sanders et al., 2018).

Complexity and disadvantage in the Australian child protection system

As identified in the literature search, there is clear evidence of complex and interconnected experiences of vulnerability and disadvantage among families within the child protection system. However, research that examines these experiences and their relationship with the child protection system itself is limited. It shows, for example, that the experiences of families with disability in contact with child protection systems are underexplored in Australia. There is particular lack of research on the experiences of First Nations parents with disability (Collings et al., 2017).

All parents need and can benefit from support in their parenting at various points in their parenting careers. However, some will need much more support than others. Given their orientation towards tertiary responses, Australian state and territory child protection systems often miss opportunities to work with parents to address their needs through better supports to create a safer environment for children and prevent unnecessary child removals.

However, the focus of statutory systems is not primarily one about identifying and meeting the support needs of parents, but about assessing risk to the safety and wellbeing of children. The mechanisms of risk assessment used in child protection systems tend to examine points in time, individual incidents or experiences, and not necessarily in a cumulative or contextual manner (Bromfield et al., 2005). Yet it is recognised that experiences of child maltreatment are rarely isolated incidents; different forms of abuse often co-occur, and trauma often develops over prolonged periods (Price-Robertson, 2013).

When opportunities to appropriately support parents and address risks within family environments are missed, the problems tend to escalate. It becomes harder to remediate and more likely to contribute to maltreatment. Intervening early could involve low-intensity techniques such as enhancing parenting knowledge and skills that are known to reduce risk factors for child maltreatment, and are designed to address the needs of mothers and fathers with mental ill health. Research shows that enhancing parenting knowledge and skills can effectively reduce the severity of risk factors for child maltreatment (Sanders et al., 2018). Properly designed prevention and early intervention supports that are provided by staff competent in working with parents, including mothers and fathers with mental ill health, may particularly benefit parents with additional support or learning needs.

The support needs in families coming into contact with child protection services are complex and intersectional, and linked to conditions connected to the social determinants of health, such as poverty, unemployment, housing inadequacy, and family violence, Because of this, families often require longer-term multi-disciplinary approaches to address their needs. The most common supports that families need are related to the 'big three': parental mental ill-health, substance misuse, and domestic and family violence (Higgins et al., 2019).

Aboriginal and Torres Strait Islander children are vastly overrepresented in statutory child protection systems (SNAICC Family Matters, 2019). The impact of historical and intergenerational trauma such as that experienced by First Nations people in Australia can also be associated with poor mental health and substance misuse behaviours that are drivers of child protection intervention (Nogrady, 2019). Studies have found that racism is also in itself an environmental risk factor that manifests in high levels of stress within families (Paradies et al., 2015). Although the research in relation to child protection and families from culturally and linguistically diverse backgrounds is very limited, this is likely to be a factor in their experiences as well.

The support needs of families also include structural and systemic disadvantages such as poverty, unemployment and overcrowded or unstable housing. While not diminishing accountability for individual behaviour, these structural and systemic contributors also require structural and systemic solutions. Tertiary child protection responses are not directed at addressing these structural and systemic disadvantages.

Australian child protection agencies should focus on building the capability of parents to care for and provide safe environments for their children, with removal being a last resort. This would be relevant for parents with mental health issues, substance issues, experiences of domestic and family violence, homelessness, disability or poverty or interconnected experiences of any of these.

Addressing trauma is also critical, particularly in an intergenerational context and noting the experiences of First Nations families and the legacy of the Stolen Generation (Atkinson, 2013). There are clearly impacts upon First Nations children as well as their parents. One study with First Nations children in out-of-home care examined their perceptions of what would make for better out-of-home care environments for them. They responded that their parents should be provided with the help that they need (to address problems like substance misuse and family violence) and that they

should be able to be reunited with their community and family (Sanders et al., 2018). Such services and supports should be culturally appropriate, trauma informed, and child-centred.

Mental ill-health (and the resulting experience of stigma and discrimination) as observed in parents encountering child protection systems overlaps strongly with other aspects of family vulnerability, particularly with parental issues such as suspected or actual drug and alcohol misuse (Coates, 2017; Stromwall et al., 2008; valentine et al., 1999). Many of these other challenges in the life of parents can also attract stigma of being a 'bad parent' which may be difficult to separate from stigma relating to mental ill-health (Hamilton et al., 2020).

Stigma and mistrust

Many parents who come to the attention of child protection authorities feel stigmatised as 'bad parents' or 'failures' as a result. The sense of stigmatisation can be heightened through the investigation and intervention. There is often mistrust and fear associated with the threat of child removal. This often creates barriers to building trust and confidence and therefore in effective working relationships between child protection workers and parents.

Mistrust is likely to undermine the capacity of statutory child protection workers to provide practical input and support, to facilitate referrals and access to services to improve their parenting capacity and skills and address other risks within the family environment. The mandatory and punitive nature of child protection services contribute to the mistrust from parents. For example, the requirement to participate in parenting programs and services at the stage of tertiary child protection response can also be seen by parents as punitive, which operates as a disincentive to their engagement and cooperation with them. Unfortunately, aggregate data on child protection systems do not provide detail on the number of families referred to such parenting or support programs, and whether the rate of completion (or the outcomes, such as improvements in parenting) for parents with mental illness differ from other parents (Australian Institute of Health and Welfare (AIHW), 2021). The only data they report is that in the most recent year (2019-20), "about 40,200 children aged 0–17 commenced intensive family support services" (p. 79). Most of these children were living with their parents at the time. AIHW noted that the extent of overlap between these children and those counted in the child protection data cannot currently be identified.

Research with First Nations families in Australia (e.g., Bailey et al., 2017) illustrates that the stigmatisation, fear, and mistrust associated with statutory child protection authorities can itself be intergenerational and as a particular legacy of the Stolen Generations. Ongoing removal of First Nations children perpetuates this trauma cycle. A strategic step to address these significant barriers is underway in some jurisdictions, driven by First Nations community organisations' increasing involvement in care and protection decision making, consistent with the principle of self-determination. For example:

- In Queensland, Aboriginal and Torres Strait Islander community-controlled organisations able to exercise delegated authority for a range of child protection activities. See: https://www.qatsicpp.com.au/wp-content/uploads/2020/05/QATSICPP_Submission_1_legislative_reform_discussion_paper.pdf
- In Victoria, the *Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan* is targeted to address overrepresentation of Aboriginal children in child protection and out-of-home care systems. See: https://www.dhhs.vic.gov.au/publications/wungurilwil-gapgapduir-aboriginal-children-and-families-agreement

It is not unreasonable to expect that these intersecting experiences of stigma and mistrust are likely to be further compounded by mental ill-health stigma for families with those experiences. Stigma in relation to mental ill-health is likely to further erode the development of trust between families and child protection caseworkers (e.g., through non-disclosure of the illness itself, its impacts on family life, and practical issues related to its management such as attending appointments). In this way, stigma relating to mental ill-health may compound an already fraught set of circumstances in child protection.

Stigma is not always subtle. It can be overt and explicitly discriminatory. McDonnell and Llewellyn (2000) reviewed 407 consecutive cases in the NSW Children's Court. Of the 285 cases where the NSW statutory child protection department initiated a care application, they found 30 parents (10.5%) had psychiatric disability on its own, and 25 (8.7%) where it was accompanied by suspected drug and alcohol abuse. While their analysis focused primarily on parents with intellectual disability, they describe a range of discriminatory actions (leading to more intrusive outcomes) that people with disability who happen to be parents face. These actions include removal of their children, "despite lack of evidence of abuse or neglect, or when evidence was refuted or, indeed, even when the parent was shown to be providing adequate care" (p. 883). McDonnell and Llewellyn identified barriers to justice that parents with disability face in having their voices heard against the statutory child protection worker represented by lawyers, in an adversarial process (as opposed to an inquisitorial process that is often used in northern European systems). Even the context of having to wait around in the court environment with crowds of angry or anxious people can disadvantage parents with mental ill-health. They also highlighted the inequitable access to resources for expert reports, which are highly influential in determining outcomes. Further, they found that 90% cases where there was a parent with disability of any kind (intellectual, psychiatric, physical, or sensory), expert opinion(s) on balance favoured child removal–the Court order was made to this effect.

The stigma of mental ill-health can continue beyond the point of child removal. For example, Morris (2018) explored the experiences of mothers in the UK separated from their children by the statutory child protection authority: They are silenced "… through the stigma and shame of being judged to be a deeply flawed mother, the justifiable fear of future children being removed, and court-ordered reporting restrictions" (p. 816).

Hamilton, Cleland, and Braithwaite's (2020) analysis looks at how the stigma that child protection workers attach to 'bad' parents is passed on to other workers in the community who provide support relating to issues such as mental health. In the Hamilton et al. qualitative analysis of a small sample of 15 workers in the ACT, they found that these community workers were "stereotyped negatively, undermined professionally and socially excluded" (p. 452). They conclude that "stigma by association is a plausible explanation for the persistent tensions that exist between government child protection officials and community workers" (p. 455).

Child protection workforce: awareness, skills, and training

As outlined by Lonne et al. (2019), much of the professional training, skill and knowledge of statutory child protection workers is directed towards forensic investigation and responses to risks to children, rather than considering, arranging and providing preventive strategies, or even targeted supports to families with identified needs, such as the experience of mental ill-health. This orients their practice towards reactive approaches to risk, rather than population-wide approaches to support.

Statutory child protection workers work in pressured and often under-resourced decision-making environments with high levels of stress and burnout. With the introduction of mandatory reporting, the task of assessment of increasing numbers of notifications has grown exponentially so that the demands on the child protection system are overwhelming. This is also reflected in the caseload of child protection workers.

This also is likely to contribute towards a systemic bias towards tertiary intervention in the form of child removal without exhausting other means of enabling parents to better care for their children and providing them with support for their needs. This also is likely to contribute towards a systemic bias towards tertiary intervention in the form of child removal without exhausting other means of enabling parents to better care for their children and providing them with support for their needs.

This experience is also particularly relevant to First Nations families experiencing the entrenched structural and systemic disadvantages that are associated with child protection involvement. This is also likely of particular relevance to families of parents with disability who, as a result of their disability, need additional or tailored support in their parenting.

Most child protection workers have backgrounds in disciplines such as social work, youth work or psychology. They do not have significant training or professional knowledge or understanding of disability, mental ill-health or health settings. Most disability workers complete a vocational qualification in disability or community services. There is limited overlap in the pre-service training of child protection workers and disability support workers, and each sector has different certificate/diploma/degree pathways. If there is overlap in the content within such courses, it is more likely to be for the care needs of children with disability (than working with adult parents with disability, including mental ill-health).

Child protection workers who do not have professional disability awareness and skills, are unable to assess the impact of a parent's disability upon their capacity to care for and protect their children. In addition to these skills, workers also need time to access relevant information in a timely manner.

There is increasing focus to include support for trauma-informed approaches in service settings including child protection and disability services. In the context of child protection, the focus is largely preventative (avoiding further harm) rather than therapeutic (addressing underlying experiences). There are fewer mechanisms for ensuring awareness, and knowledge of trauma-informed approaches is integrated into work practices in child protection, particularly in the pressured environments referred to above. The value of trauma-informed training is also predicated on the knowledge and skills to identify or acknowledge the trauma and the time to reflect and address the issues with changes or concessions in practice or decisions. The limited time and resources in child protection decision making mitigate against these opportunities.

Two mechanisms that could enhance the opportunities to build better trauma-informed practice into child protection decision making would be multidisciplinary case assessment procedures and ongoing multidisciplinary and cross sectoral case conferences. Each needs to be collaborative and respectful of different information and knowledge. In these settings, knowledge of trauma and mental health experiences (amongst other relevant information) can be shared and inform decision making.

Otherwise in these circumstances, child protection workers face an uncomfortable and difficult burden when required to make decisions, develop case plans, and implement protective strategies to keep children safe, regarding families without the necessary information or the ability to weigh the relevance and context of the information. This general gap in knowledge within child protection

systems is also likely to impact upon child protection workers' ability to work effectively with parents and children with experiences of mental ill health. This would include in respect of making reasonable adjustments to their practices to ensure that parents can understand the information provided to them and its implications, as well as fully participate in decision making. (See discussion on the legal system on page 19.)

Legal systems and child rights

The Australian legal system offers limited opportunities for the enforcement of rights particularly in a preventative manner. Particular legal systems offer corrective review (administrative law and civil law). In child protection law, the assessment (or review of a decision) that a child is in need of protection is rarely used in a consistently or comprehensive manner to drive preventative action or supports. Disability discrimination law has been used to drive policy around the provision of supports (for example in schools to ensure equitable access to education). But in the current legal culture, limited access to legal remedies and limited mechanisms of enforcement do not offer obvious opportunities for children, parents, or families to drive support for preventative interventions.

Application of human rights principles (in some jurisdictions and some circumstances) may be shifting the focus. Increasingly, advocacy in Australia makes references to international human rights principles and findings to build the case for policy and systems change. In its most recent consideration of Australia's child rights situation, the United Nations Committee on the Rights of the Child (2019) has recommended improved support and interventions in mental health (paragraphs 37-39) and particularly for children in care (Paragraphs 33 and 34).

Implications

There is likely to be significant value in supporting the shift to a population-level public health approach for child protection in order to address stigma and discrimination in mental health experiences. It can assist in identifying and addressing a range of interconnected experiences of vulnerability and disadvantage including mental health. It can also support the sharing of interdisciplinary knowledge and build collaboration.

In terms of national policy, there is opportunity for building awareness and understanding of mental health issue and experiences in child protection and family law through the following steps:

- the successor to the National Framework for Protecting Australia's Children
- the National Plan to Reduce Violence Against Women and the Children
- the implementation of the recommendations of the Royal Commission into Institutional Response to Child Sexual Abuse.

Further attention should be given to working with strategies to address and support First Nations peoples and culturally and linguistically diverse communities to build community and culturally aware responses. Building engagement with families and children and young people in the context of their experiences in child protection and family law will also support more effective strategies to address stigma and discrimination.

It is also worth noting that the National Action Plan for the Health of Children and Young People 2020-2030 already makes specific reference to children and young people in the child protection system.

Priority Area 5: Strengthening the workforce, includes:

Support professional development to improve the workforce's ability to implement trauma-informed practice (including intergenerational trauma), particularly relating to Aboriginal and Torres Strait Islander peoples, **children and young people in the child protection system, and those who have experienced violence**, including asylum seekers, refugees and migrants who have fled violence …"

These are all key opportunities for interconnected strategy and coordination that would be consistent with a public health approach that can address stigma and discrimination in mental health experiences in the child protection system and beyond.

5. Grey literature on family law

In this section of the review, we summarise policy documents that relate to stigma/discrimination in child protection and family law matters relating to parents with mental health issues. This includes court processes and outcomes, mediation, as well as services related to family law, such as Family Relationship Centres.

AIFS Family Law Reform evaluation

One of the most comprehensive and robust sources of evidence from which to examine the potential for mental health issues to be encountered in the family law system and the experiences of parents with mental ill health is the multi-study evaluation of the reforms to the Family Law system reforms in 2006 and the subsequent family violence amendments in 2012 conducted by the Australian Institute of Family Studies (see: https://aifs.gov.au/our-work/research-expertise/laws-and-families). We provide selective discussion of the issues raised, focusing particularly on the study of the experiences of separated parents by Kaspiew et al. (2015a) and the outcome study of matters proceeding to court (Kaspiew et al., 2015b).

Parents who use family law services typically are those affected by complex problems. According to Kaspiew et al. (2015a), these include "family violence, safety concerns and other issues, including mental ill-health, substance misuse and gambling" (p. 194).

Based on two cohorts (one group of parents who separated in 2012, and another who separated after the reforms in 2014), Kaspiew et al. (2015a) found that a significant proportion of parents experience mental health issues. Over ⅓ in both samples self-reported mental health issues (35% and 39%). They were more frequently reported by mothers (43%) than fathers (35%). This was often the result of (or exacerbated by) the presence of domestic violence.

For those who reported experiencing family violence, more than half said that one of its effects was on their mental health, including increased depression, anxiety, and stress. In the 2012 cohort, 51.8% reported that the other parent's violent/abusive conduct before/during separation affected their mental health. Two years later, in the cohort from 2014, this had significantly increased to 65.7%.

A major implication of the family law system is to sensitively account for and mitigate the impact of domestic and family violence on the mental wellbeing of clients. Another is to ensure that mental health effects are understood to be a likely consequence of their exposure to domestic and family violence prior to or during separation. It's not enough to just frame the observed mental health behaviours as indicative of their pre-existing or ongoing parenting capacity, once the violent relationship ends, and they are supported in separating safety and keeping children safe.

In terms of the effects of exposure to family violence on separating parents, Kaspiew et al. (2015a) found a "statistically significant increase between the two cohorts in parents' reported experiences of mental health issues before/during separation, with 66% of parents reporting these issues in the SRSP 2014, compared to 52% of parents in the SRSP 2012" (p. 59). They note that this may be explained by a higher rate of use of psychologists and psychiatrists reported by parents in 2014 compared to 2012.

Kaspiew et al. (2015a) also found that the presence of mental health issues was more likely in cases that proceeded to court (55% of parents) compared to those parents who used lawyers (41%) or family mediation services (41%) to resolve their parenting dispute. Parents also commonly

reported that witnessing family violence commonly impacted on their children's mental health and adjustment. Typically, they observed distress, fear and anxiety in their children. Kaspiew et al. (2015a) concluded that:

> Overall, children who were exposed to family violence before/during and since separation were reported to be having significantly more behaviour problems than children who were not exposed to family violence. Significantly higher proportions of parents reported that their children who had been exposed to fear-inducing behaviour by the focus parent since separation were faring somewhat or much worse than their peers in all three domains–learning and schoolwork, socialising, and in most areas of life–when compared with children not reported to have been exposed to such behaviour. (p. 191)

A common experience parents have is their own anxiety about children's safety (particularly when spending time with the other parent) contributing to their own poor mental health. Kaspiew et al. (2015a) found that concerns about ex-partners' mental health were strong drivers of separating parents' safety concerns. For example, Kaspiew et al. (2015a) noted that for separating parents, mental health issues and violent or dangerous behaviour were other commonly nominated behaviours giving rise to parents' safety concerns. They were high in their 2012 data (55% and 51%) and even higher in the 2014 post-reform data (62% and 53%), but with significantly more mothers than fathers reporting these concerns (see p. 45).

Gender is a critical factor to bear in mind when considering the results of the surveys of parents. The AIFS reports (Kaspiew et al., 2015a) and Court Outcomes Study (Kaspiew et al., 2015b) highlight the gendered nature of violence victimisation–women more likely to be subjected to family violence. However, for those who were victims, men and women were just as likely to report that this violence led to mental health consequences (see AIFS Table 3.6, chapter 3). But because women disproportionately bore the burden of family violence victimisation, they also disproportionately bear the consequence of this in terms of their own mental health and wellbeing.

A key conclusion from two of the AIFS family law evaluation reports—the Experiences of Separated Parents Study (Kaspiew et al., 2015a) and Court Outcomes Study (Kaspiew et al., 2015b)—was that family violence, child abuse and a range of other complex issues including substance abuse and mental ill-health are not uncommon for families who use family law services.

It is particularly important to understand whether the presentation of these issues affects court processes and outcomes, in terms of decisions made, and the impact of these decisions on parties. For example, Kaspiew et al. (2015b) examined the extent to which factual issues such as family violence, child abuse, parental substance misuse and ill health are raised in the context of protective concerns, and the potential effects of the 2012 reforms to the family law act. Tables 3.14 and 3.15 are highly relevant, as they set out comparisons (before and after the family law reforms were implemented (see pp. 48-49). Across all cases, the reforms led to an overall statistically significant increase post-reform in parental concerns leading factual issues alleging parental family violence, parental substance misuse, protection from abuse, and parental mental health. In the sample of cases that proceeded to judicial determination, they found statistically significant increases post-reform in the proportion of cases involving allegations of (a) parental family violence and (b) parental mental health issues.

After highlighting the importance of three issues–family violence, substance misuse, and parental mental illness–Kaspiew et al. (2015b) concluded that "not only are these issues being raised more frequently in proceedings following the reforms, but the cases in which they are raised have become less likely to be amenable to resolution by agreement at some stage on the litigation pathway in

comparison to the pre-reform context" (p. 49). This may be explained in part by the more frequent identification of parental mental health issues being raised in cases post-reform.

Analysis of court file data by Kaspiew et al. (2015a) suggest 'subtle shifts' towards prioritising safety in court outcomes for matters where family violence and/or child abuse were raised. These limited effects, however, were still seen as being consistent with the rationale for implementing the 2012 family violence amendments–namely, to improve the appropriateness of parenting orders by giving greater weight to protection from harm:

> Post-reform, children in the judicial determination sample were less likely to be subject to orders for shared parental responsibility in cases involving allegations of family violence and/or child abuse, and less likely to be subject to orders for shared care time (35-65% of nights shared between parents) where these cases involved allegations of both family violence and child abuse, when compared to the pre-reform period. (p. viii)

However, it is not clear from their report whether the slight trends towards greater emphasis on 'protection from harm' post-reform has affected how mental health concerns are considered. Kaspiew et al. (2015a) concluded that:

> …courts remain concerned to ensure that wherever possible, children's relationships with both parents are maintained after separation except in cases where the evidence is unambiguously in favour of an outcome inconsistent with this approach. Evidence in relation to the nature of the child's relationship with the alleged perpetrator of family violence is especially important in this respect. In circumstances where this is not the case, the conceptualisation of harm as arising from the cessation of a child's relationship with one parent continues to underpin views of best interests outcomes as requiring the maintenance of the parent-child relationship in all but the most clear-cut cases (p. 100)

Sexual abuse allegations in family law matters

The Magellan case-management model was implemented in the Family Court of Australia nationally in 2003 to address the complexity of court processes for parenting disputes involving allegations of sexual or serious physical abuse of children. The Magellan model highlights the cross-over between processes and responsibilities of child protection and family law system–a complex interrelationship. The key issue is how to respond to the most serious of concerns alleged by parties in parenting matters that come before family law courts.

The Magellan model is an integrated case-management system that works to reduce trauma for children and that keenly focuses the evidence-gathering and trial processes on ensuring the best outcomes for children who may have been abused or may be at risk of abuse. It functions as an interagency collaborative model of judge-led case management, drawing on the contributions of police and state/territory child protection agencies. Interagency collaboration is essential given the differences between the intersecting legal systems and the paradigms within which they operate.

Higgins (2007) completed a comprehensive case-file analysis of child protection matters in the family law system as part of his evaluation of the Magellan case-management model. He noted that:

> Magellan sits among a complex set of expectations, at the intersection of a range of agencies and systems involved in responding to issues of child abuse allegations in family law matters. It is important to understand the role of family courts–to resolve private law issues, such as parenting matters, in children's best interests–and how this differs from the

role of police, child protection departments, forensic investigators, Directors of Public Prosecutions, and criminal courts in protecting children, enforcing laws and bringing criminals to justice.

Each of the agencies and systems has overlapping interests, yet distinct responsibilities. It was this "black spot" intersection that necessitated a case-management system to coordinate and bring together information from each of these areas to ensure that private family law disputes are resolved in a timely way that provides for the safety and ongoing best interests of children. Central to ensuring the best interests of children is the need to balance their right to know and have a relationship with both parents, with the paramount need to be protected from harm. Despite research in the social sciences that shows the frequency with which sexual abuse and serious physical abuse of children occurs, significant difficulty exists in proving the occurrence of child abuse, as the private nature of the crimes result in a lack of evidence that meets the requirements of criminal courts. (pp. 17-18)

Higgins (2007) found that:

Research in the social sciences shows the frequency with which sexual abuse and physical abuse of children occurs, as well as the private nature of the alleged behaviours, which often means that it is difficult to produce clear evidence, regardless of the jurisdiction in which the matters are raised–particularly in relation to child sexual abuse. (p. 48)

Unfortunately, Higgins (2007) did not address the potential intersection with mental health services and the role of mental health reports in assisting judicial officers to assess not only parenting capacity and the best interests of children, but also motivations and context of the concerns that parents bring to such parenting disputes. The possibility of stigma or discrimination was not one of the areas of focus for the case-file analysis, and the methodology did not include follow-up with families to ascertain their perspectives of Magellan, which may have revealed whether the approach to case-management reduced (or exacerbated) perceived stigma of mental health issues. While the interviews with key stakeholders involved in parenting disputes in the Family Court (judges, registrars and family consultants, parties' lawyers, as well as professionals from legal aid commissions, police, state/territory child protection departments, etc.) provided the opportunity for the issues to be raised, there was no identification in the report of themes relating to either stigma or discrimination for parents with mental health issues raising (or responding to) allegations of serious child abuse in parenting matters.

The intersection between the family law and child protection systems, and the differing legal basis and obligations is highlighted by one of the key features of Magellan–an agreement between the court and state/territory governments requiring their child protection services to promptly provide a Magellan report to the Family Court. The Magellan report is a critical way of summarising as quickly as possible the statutory child protection department's activities and concerns. The availability, timing, and quality of these reports was critical to the success of the Magellan listing. Higgins found that cases resolved more quickly in registries where Magellan reports are available.

The key finding was that compared to Magellan-like cases that proceeded in a comparable registry (where Magellan had not yet been implemented), cases that proceed through the Magellan case-management model resolved more quickly, and came before fewer different judicial officers. Regardless of the outcome (sole parental responsibility and share of time spent), parents, including those with mental health issues, have consistently raised concerns about delays in having matters resolved. Magellan assists with timely resolution, which is clearly positive for all parties. But a

significant limitation of the study was that it didn't look at outcomes, their durability, and whether they increased safety for children or not.

Higgins (2007) also noted 'inconsistency in practice' as a key issue. While not specifically addressed in the report, it is likely that parents with mental health issues encountering these divergent practices may form the view, rightly or wrongly, that their own treatment by the court is due to their mental health. There is no data to show whether this is the case. One solution proposed by Higgins is to improve dissemination of practice developments, and to clarify practice directions that the Family Court provides to its judicial officers, registrars, and court staff (see: http://www.familycourt.gov.au/wps/wcm/connect/fcoaweb/rules-and-legislation/practice-directions/). If implemented, parties and their legal representatives, as well as all judicial officers involved, would have the same expectations, and more rigorously documented processes against which any potential discriminatory or stigmatising practices can be identified and 'called out'.

Analysis of Family Court judgments

Mental health concerns are common for parties initiating or responding to family law matters that proceed to judicial determination. Webb et al. (2021) provide the most recent and comprehensive examination judgements from the Family Court of Australia between 2012 and 2019 in which parties raised clearly defined allegations of child sexual abuse. From an initial set of 841 judgments involving an allegation that a child was at risk of sexual harm in the care of one parent or the other, a further 320 were excluded for a range of reasons, including because they involved "chaotic parenting for most of a child's life … such as a history of involvement by child protection authorities, mental health issues, violence, abuse of alcohol or other drugs, on the part of both parents, sometimes in conjunction with allegations by both parents of sexual abuse in the care of the other parent" (p. 6). The large number of exclusions from their data analysis for reasons including mental health issues (over one-third of cases) suggests that parental mental health issues are inextricably linked to the family law system–particularly at its most complex end (where matters are contested by parties who are unable to agree on parenting matters and judges are required to make determinations about where children reside and spend time with parents post-separation).

For parents with mental health concerns who have raised allegations about safety of their child, a large portion live with the outcome of children spending significant time with, or being the sole responsibility of, the other parent. Unfortunately, given Webb et al.'s exclusion of many cases with serious mental health issues or 'chaotic parenting' for most of the child's life, it is not known whether these cases with more serious or chronic mental health issues result in judgments with a similar pattern. A key issue for further research is to understand the degree to which mental health issues are perceived to affect the believability of a parent's safety concerns, and ultimately in a judicial officer's belief or otherwise in the allegations.

6. Grey literature on child protection systems

Child protection systems work with families with complex needs that often involve multiple intersecting issues. One of these issues is poorly treated parental mental illness. For example, using the NSW Child Development Study (NSW-CDS) a population longitudinal cohort study of child mental health and wellbeing, Green et al. (2019) identified that maternal mental health disorder is one of six risk factors for entering out-of-home care in NSW.

One of the challenges in understanding the extent and impact of mental health discrimination/stigma experienced by parents in contact with child protection systems is the fact that the systems themselves are already stigmatising. The very fact of being in the system is perceived by families as an 'accusation of failure' (Jenkins, 2021). Therefore, it is a challenge to separate out the degree to which this is compounded by parents' mental health conditions, either actual or imputed. While there is guidance available for caseworkers in the ways they can help manage the stigma of child protection involvement in their interactions with clients (e.g., Quick & Scott, 2019), there is an absence of guidance that more specifically addresses the intersection or compounded stigma of parents with mental health issues.

Children's Court (Victoria)

In line with all states and territories, the Children's Court of Victoria is a separate branch of the Magistrates' Court. The role of its judges and magistrates is to hear evidence and decide whether a child is in a need of protection and whether the decision reached has to be based on the burden of proof principles known as the balance of probabilities (Martyn & Levine, 1998). Magistrates make an assessment based on evidence supplied by protective workers, witnesses, families and other professionals involved in the child's welfare. The Children's Court of Victoria in Melbourne is a specialist court with two divisions to deal with matters relating to children. Child protection matters are dealt with in the Family Division of the Children's Court and juvenile matters are dealt with in the Criminal Division. The child protection legislation (*Children, Youth and Families Act*, 2005) directs the court to remove the child from his/her family `if there is an unacceptable risk of harm to the child' (s. 87[1] [j]), because of sexual or physical abuse, emotional harm or threat of harm to a child's emotional development. The definition for what constitutes an unacceptable risk of harm' is not set up in the legislation and the interpretation is left for magistrates to judge (Martyn & Levine, 1998).

Given that magistrates do not necessarily have training or knowledge about child development, attachment, parent mental health and parenting practices, the task of making informed decisions of where the child should be placed or what support services should be provided for the child and family may be complicated (Suomi, 2012). Magistrates make an assessment based on evidence supplied by protective workers, witnesses, families and other professionals involved in the child's welfare. In Martyn and Levine's study (1998), the magistrates stressed some of the difficulties that arise from magistrates' lack of formal training in family welfare and psychology, although, the decisions they make are often based as much on psychological considerations as well as on legal criteria. For instance, all magistrates had significant concerns about removing the child from the parents' care. This was based on their personal belief of preserving the family unit as well as on poor outcomes of alternative care that fail to provide continuity. It is likely that in the absence of understanding of parent's mental health, court child protection decisions the judicial officers may rely on their own implicit biases on what constitutes 'good enough care' for the child (Suomi, 2012).

A commonly accepted model of child abuse describes an interaction between emotionally conflicted parents, vulnerable children, and social stress–with episodes of abuse occurring during periods of heightened tension in these relationships (Reder & Duncan, 1995). Therefore, it is reasonable to

expect that judicial officers of children's courts can benefit from affiliation with, and input from, both child and adult mental health services. For example, cases of emotional abuse are often challenging for legal decision-makers, because such cases require them to make judgments about parental wellbeing, behaviour and the quality of parent-child relationships rather than a determination about an observed act of harm to a child (Glaser, 2002).

Children's Court Clinic

The *Children, Youth and Families Act* (2005) was specifically aimed at developing more therapeutic and child-centred models of care and to facilitate better care and understanding of vulnerable children and their families. In most ambiguous or problematic child protection matters, magistrates refer cases for a clinical assessment and opinion in order to assist them make an informed decision the Children's Court Clinic of Victoria (Suomi, 2012). The clinic fulfils a unique function in child protection in Victoria. The psychologists and psychiatrists of the clinic provide the court with psychosocial assessments of children and families who are before the court. Clinicians of the children's court clinic make expert interpretations of the problems and issues affecting the child's life and well-being (including parental mental health) and make recommendations to the court about arrangements that may best serve the child's circumstances and needs. These assessments become an important source of information for guiding the decision processes of the Court. They represent a small proportion (less than 10%) of all protection matters before the court (Suomi, 2012). Specialised Children's Court Clinics are unique to Victoria (circa 1960) and to the State of NSW which modelled the Victorian Clinic in the early 2000s.

Given that parents' personal and mental health problems do not automatically lead to abuse and neglect of their child, a major task of a specialised court clinic is to assess the situational factors related to the problems of parents at both the individual level and the level of the wider community (Suomi, 2012). In protection matters, courts are interested in how these problems interact with other exacerbating factors and individual characteristics, and whether they warrant a court ordered intervention. It is important to note that court clinics are intended to be independent from the court which is evident in Suomi and Lawrence's study (2013) showing that court decisions about child placement were in agreement with 74% of the clinicians' recommendations.

Further, Suomi (2012) reported that magistrates were less likely to place children with their biological families than with the clinic in the court hearings following the clinic assessment, particularly when their mothers had been assessed to suffer from mental health problems. Suomi categorised her comparisons between clinic and court protection orders into three groups. In the largest group (57% of cases) the court and clinic agreed on the orders. But worryingly, the second largest group (28% of cases) the first substantive court order was more intrusive than the orders recommended by the Children's Court Clinic practitioners. Finally, in the smallest group (15% of cases), the first substantive court order was less intrusive. One explanation of this is that the salience of parents' problems, including parental mental ill-health, was substantially higher in the second group, where the Court made a more intrusive order. These findings are likely to reflect the implicit biases related to maternal mental health in the child protection context, and the different dispositions between legal and mental health professionals–and how they relate to the best interests of the child.

Intensive family support

A recent focus of statutory child protection services is to put in place intensive family support services for eligible families to prevent child removal or return the children back to their families safely. This could be court-mandated, or via a voluntary agreement with case-worker to prevent

escalation of the matter to court for a care and protection order. One of the issues that such support services encounter is parental mental illness, however, the intensive family support programs are not specifically set up (or funded) to address mental health problems, despite being a common feature of families in contact with child protection services. For example, a recent study of parents in the ACT receiving intensive family support services (Suomi & Trew, 2020) shows that parents exhibited high rates of current anxiety, depression, personality disorder and PTSD symptoms, consistent with other samples of parents in the child protection system (e.g., McConnell, Llewellyn, & Ferronato, 2000; O'Donnell et al., 2015; Riihimäki, 2015; Stromwall et al., 2008; Westad & McConnell, 2012).

The study of ACT parents also found that parents with mental health problems were less likely to benefit from the intensive family supports, compared to parents with no mental health background. While not specifically related to mental health problems, the parents in the study highlighted that their negative service experiences were often attributable to individual worker characteristics and behaviours, and to difficulties navigating the complex service system, including the wider statutory child protection system. These negative experiences were exacerbated by the fear of losing their children, feeling checked up on and being set up to fail by services and workers and parents not knowing what was required of them. The fear of child removal prevented the parents voicing their concerns with the workers or child protection authorities, including concerns about their own mental health needs. This highlights the challenges people with mental illness have with child protection systems over and above the challenges that other parents who encounter child protection may have. This is likely exacerbated for First Nations parents with mental health needs who fear removal as a consequence of the legacy of the Stolen Generations (Atkinson, 2013).

Based on this evidence, services that engage with parents who have concerns about child protection, should be set up for more holistic approaches to manage parents' complex psychological needs. They could include trauma and other mental health screening at intake, as well as comprehensive referral pathways to appropriate mental health treatments. The high rates of trauma have major implications for parents who have had their child removed by the protective system. Parents with trauma histories are likely to be further traumatized by the experience of child removal (Pannor et al., 2010; Wells, 1993; Wilson-Buterbaugh, 2010), thus it is concerning that child protection literature consistently reports a lack of supports for parents by protection authorities after a child is removed (Memarnia et al., 2015).

The results of the ACT study referred to above (Suomi & Trew, 2020; see Appendix A) are similar to those reported in less-intense preventative family support services in Australia, including Family Foundations in the ACT (Trew et al., 2018), in which the parents reported that workers were the key enablers of positive change. Particularly, parents reported that a positive worker-client relationship was a key factor in improving parent-child interaction, as well parents' enhanced self-reflection, being in control, and emotional insight (Trew et al., 2018). In another intensive family preservation program in Victoria, Cradle to Kinder (Scott et al., 2017; see Appendix B), mothers and fathers involved in the program highlighted the value of their relationship with the caseworker and how they supported them in building parenting capacity and provided practical day-to-day support (Scott et al., 2017). Similar results have been found internationally: Lehtme and Toros (2020) found that trusting relationship between the worker and the parent was the key factor enabling important change processes in the parent. This trusting relationship, together with supportive service environment was the most important factor in keeping parents engaged with the child protection services.

Essential to intensive family supports is communication and collaboration with other services. For example, the fundamental premise of the Victorian Cradle to Kinder program was to identify those

families who are at risk and to provide them with the necessary supports to circumvent the need for children to enter the statutory child protection system. Access to mental health services and supports is a critical part of this picture and evidence shows that mental health is not necessarily well addressed through intensive support programs. In addition, delivery of such intensive supports can pose challenges in establishing and maintaining consistent communication and collaborative working arrangements with some services. It is also easy to underestimate the complexity of the issues facing the families involved.

Suicidal thoughts: mental health issue for children in out-of-home care

Evidence shows that there is a relationship between the complex backgrounds and mental health of young people in out-of-home care (OOHC) and with risk factors for suicidality (Russell et al., in press; Trew et al., 2020). There is a large body of literature showing the poor mental health outcomes for children in OOHC (e.g., AIFS et al., 2015). In a recent review, we also looked at one of the more extreme presentations of mental ill-health: suicide-related behaviours (Russell et al., in press). Children and young people in OOHC are 4.9 times more likely to display suicidal behaviour than peers with no involvement with child protection/OOHC. Around 50% of children in OOHC reported with clinical depression and anxiety and that some of the strongest risk factors for suicidal behaviour among children and young people are physical, sexual, and psychological maltreatment and depression and anxiety. While some researchers have found that having experienced childhood maltreatment is a direct predictor (or contributing risk factor) for suicide ideation, others have found that that it *indirectly* predicts suicidal ideation, because it increases the likelihood of anxiety and depression (Russell et al. in press).

Russell et al. (in press) found that there is a shortage of interventions designed for children and young people in OOHC that target suicidal behaviours. There is also limited evidence showing what works to support children and young people in OOHC at risk of suicidal behaviours. However, given the strong overlap between the experiences of children in OOHC and risk factors for suicidal behaviours, current interventions in use for children and young people in the general population should be implemented and adapted for children and young people in OOHC and evaluated for their effectiveness in preventing and reducing suicidal behaviours in this group. There is also a clear need for the development of trauma-focused care models with clearly articulated definitions of trauma interventions for children and young people who have experienced complex trauma, who have associated poor health outcomes, and who are at risk of suicidal behaviours.

Parenting supports to address fathers with mental illness

Men are at increased risk of experiencing psychological distress during the transition to fatherhood and the early years of childrearing (Price-Robertson, 2015). In his overview of the role of fathers and mental illness, Price-Robertson (2015) noted, however, that few researchers looked specifically at the role of stigma associated with mental illness in fathers' lives. This is likely a consequence of few mental health services asking fathers about their families/parenting issue. Medical or psychiatric services often ignore the complex interrelationships between mental illness in fathers and the quality of their family life and wellbeing of their children (Fletcher et al., 2012; Price-Robertson, 2015). It is not surprising therefore that he did not identify any research relating specifically to fathers with mental health issues in relation to either family law or statutory child protection systems.

Price-Robertson (2015) identified some key messages from his review of research relating to fathers and mental illness (though it is likely true of mothers as well):
• The observable signs of behaviour problems in children that may come to the attention of professions in either the family law or child protection system, such as internalising (i.e.,

emotional) and externalising (i.e., behavioural) problems, or diagnosis of a mental illness in childhood may relate to poorly diagnosed or treated parental mental illness.

- Parenting behaviour is one of the mechanisms by which parental mental illness may translate into problem outcomes in children.
- Despite the lack of research exploring fathers' experiences of mental illness, the available evidence suggests that fathers' experience of mental illness and their paternal identity are inextricably linked.
- Fathers with a mental illness can be subject to unique forms of stigma.
- Psychiatric and welfare service providers in Australia and internationally have often struggled to effectively engage fathers, either failing to see men as members of a family unit, or failing to offer services tailored to their specific needs.

In terms of stigma in service provision (including welfare services offered by, or in the context of child protection authorities), Price-Robertson (2015) noted that fathers with mental illness are also likely to be the subjects of stigma and discrimination. Even if they do seek professional help, the services are likely to perceive them as an individual, rather than as a father with family and care responsibilities.

In terms of service provision, some of the other key points raised by Price-Robertson (2015) are:
- differences in help-seeking behaviour between men and women, and ongoing stigma associated with mental ill-health and help seeking (Reavley & Jorm, 2011)
- fathers with mental illness do not engage with health and welfare services in proportion to need
- this is likely to result from a combination of different forms of stigma–public, structural, self-stigma, and stigma by association.

Price-Robertson (2015) provided an insightful summary of the key issues fathers with mental illness encounter specifically with child welfare services. From his review of the research, he found that services were poorly equipped to effectively engage men and were likely to hold negative or ambivalent attitudes towards men. Fathers risked encountering bias or stigma due to the dominant discourses in child protection services about male clients presumed to be violent and coercive, seen either as little value in the task of care of children, or as a threat. Price-Robertson (2015) explained that this apparent prejudice against fathers is likely related to "the female-dominated child and family welfare workforce, the traditional societal assumption that childrearing is predominantly women's responsibility, and worker's fears of violent male clients" (p. 16). He acknowledges though that this is understandable given the very real and frequent concerns about male-perpetrated family violence, coercion, and control in child protection cases.

According to Price-Robertson (2015), collaboration across services and sectors is critical. It should start with an understanding of the interconnectedness of the issues:

> In contrast to medical and psychiatric services, child and family services (e.g., statutory child protection, family relationship services) are better positioned to acknowledge the interconnections between parental psychopathology and family life as they often assist with problems that obviously involve multiple family members (e.g., family violence, relationship difficulties). (p. 15)

7. Conclusions and implications

We conclude this rapid review with a brief summary of the key issues and implications for areas where work can be done to address self-stigma, public stigma, and structural stigma/discrimination as they are encountered in child protection and family law systems. We also distil key promising principles from this review that can be used to underpin strategies for preventing and ameliorating stigma encountered in the family law and child protection system.

Addressing stigma and better engagement of fathers and mothers with mental illness in child welfare and family relationships services requires multi-level foci on policy, attitudinal, and service-level changes. Based on this high-level review, here are some key issues, implications, and potential principles we have distilled that can underpin efforts to reduce stigma.

1. **Improve the focus on parenting (for both men and women) engaging with mental health services.**

Currently, few adult mental health services are child-focused and/or parent-inclusive. For example, services for fathers rarely address their families/parenting issues. Gender-neutral, child-focused, family-inclusive practice in mental health services requires service providers engaging with clients who might be at risk of, or are encountering, child protection services to be inclusive. This can be done by enquiring about both male and female (or non-binary) clients' family lives using simple questions such as: "Do you have children?" and "What is your involvement in your children's lives?" (based on Fletcher et al., 2012 p. 35, cited in Price-Robertson, 2015).

2. **Improve the focus on mental health and building parenting capacity for parents encountering family support and child protection services.**

Mental health screening is essential during program intake processes, as is a focus on the development of positive worker-client relationships. This helps a worker to understand whether a mother's and/or father's mental illness may be affecting parenting capacity, and safety and wellbeing of their children. It can also lead to an understanding of how mental illness is affecting their parenting. Given that parenting behaviour is a mechanism by which parental mental illness may translate into problem outcomes in children, when professionals in the family law or child protection systems (including the prevention and early intervention supports they intersect with) observe behaviour problems, they should consider the following:

- the role of parental mental illness as a contributing factor (particularly where they observe low levels of parental engagement, warmth and appropriate monitoring
- the potential benefits of evidence-based parenting supports that could prevent or alleviate child behaviour problems by improving parenting capacity to understand and deploy positive parenting strategies.

Early on in the engagement with both child protection and family law systems, parents would benefit from an outreach model that sought to ask about how people's mental health issues are being managed, and refer them to evidence-based supports to address parenting capacity in the context of their mental health support needs. This means recognising parenting behaviour as a key 'mediator' of the relationship between parental mental illness and child wellbeing. This approach helps to focus interventions on improving parenting capacity in the context of both fathers' and mothers' mental illness, or care responsibilities for partners with mental illness. However, the success of such an approach would also require a degree of trust by the parent that disclosing a mental health problem would not disadvantage them in any way.

There are several evidence-based parenting programs that either have explicit focus on parental mental illness, or address skills of relevance to parents with complex issues, for example:

- Parents Under Pressure: https://www.pupprogram.net.au/
- SafeCare: https://www.parentingrc.org.au/programs/safecare/
- Tuning in to Kids: https://tuningintokids.org.au/
- Triple P: https://www.triplep-parenting.net.au/

3. Address intersecting, compounding stigma.

The intersection between stigma and bias associated with mental illness and other forms of bias (e.g., against fathers, or same-sex parents, teenage/young parents, Indigenous parents, asylum-seekers, or recent migrants with children in their care) needs to be acknowledged and addressed in any strategies.

4. Promote trauma-informed service models – for parents, children and young people.

Trauma should be seen as a priority mental health issue and develop an overarching policy to support a transition to trauma-informed interconnecting service systems that include mental health, child welfare, family support, statutory child protection and family law services. Regarding children and young people in out-of-home care, given the lack of evidence-based suicide prevention or other mental health interventions, we reiterate and endorse the following recommendations provided by Trew et al. (2020):

- Adapt, implement, and evaluate existing clinical interventions that target suicidal behaviours in the general population for young people in out-of-home care.
- Implement trauma-focused interventions and trauma-informed care models in out-of-home care.
- Develop trauma-focused interventions to support the cultural needs of First Nations young people, who are overrepresented in the Australian child protection and care systems.
- Adapt high-quality evaluations of any current intervention to reduce suicidal behaviour in young people interacting with child protection and out-of-home care.

5. Be more prevention focused, based on a public health approach.

Better access to supports would improve the sensitivity and responsiveness of family law and child protection systems, and possibly even prevent families from encountering legal or statutory systems. This requires strategies to address the support needs of parents with mental illness, and the parenting support needs of families caring for children with emerging mental health needs. There are opportunities for interconnected strategy and coordination consistent with a public health approach that can address stigma and discrimination in mental health experiences in the child protection system and beyond. One example is the National Action Plan for the Health of Children and Young People 2020-2030 which already makes specific reference to children and young people in the child protection system.

6. Foster cross-sectoral collaboration.

More effective communication and collaboration between mental health and the child protection sector is needed, including preventive, early intervention and other family relationship and welfare services. In the absence of collaboration, parents with mental health concerns can easily fall into the cracks between child welfare and mental health systems: "Their mental illness is viewed as an individual problem that is the responsibility of the local mental health service, whereas the safety

and welfare of their children is the responsibility of the child welfare system" (Ackerson, 2003, p. 187). Collaboration across discipline sectors and service systems is one of the keys to addressing the stigma and discrimination faced by parents in child welfare services, and addresses the often multiple intersecting needs (mental health, other forms of disability, substance misuse, etc.).

7. Build mental health literacy and disability awareness in the child protection and family law workforces.

The lack of disability awareness and mental health training in professionals who make protective decisions should be addressed as an urgent priority across the social and health sectors. This includes adopting a whole-of-organisation approach, including high-quality workforce training that helps workers dealing with trauma (one of the typical causal factors in mental illness) and in self-care (see Wall et al., 2016). Given that the quality of the worker-parent relationship is critical to engagement and success in intensive family support work, there should be a focus on integrating mental health literacy training with engagement and worker-client relationship-building strategies.

8. Develop rights-based practice frameworks.

There is an opportunity to develop and promote a practice framework in child protection and related family support and family relationships services. Such a framework would be informed both by a rights-based orientation (to eliminate stigma and discrimination) and would build on best-practice from the broader field of parent perspectives on what works to prevent contact with child protection, improve parenting capacity and increase safety for children.

Next steps: further research

We suggest further targeted research that explores key systems and outcomes questions and issues, such as:

- Does parental mental illness affect believability of allegations raised by parents in family law/child protection proceedings?
- Are there implicit biases impacting professionals' decision making in the context of child welfare (legal, social work, mental health professionals), and what factors contribute to such biases?
- Would improvements in supports for parents with mental health issues prior to and during involvement with family courts or child protection proceedings increase the quality of evidence and outcomes for the safety and wellbeing of children? For example, can addressing mental health supports (and workforce training for professionals) increase the believability of allegations of harm or other evidence, and ultimately affect decisions to improve the safety and wellbeing of children in families affected by mental illness?
- What interventions targeted at professionals in the child protection and family law systems are successful in reducing stigma and discrimination experienced by clients and the families with which they interact? What are their characteristics?
- What programs are effective in reducing the mental health issues experienced by children and young people removed from the care of parents and placed in out-of-home care? Given that globally, only two studies evaluated the efficacy of interventions to reduce suicidal behaviours in young people in out-of-home care (Trew et al., 2020), high-quality evaluations are needed to test whether any interventions developed and/or used to address trauma, mental health issues and reduce suicidal behaviour in young people interacting with child protection and out-of-home care systems are effective.

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9. Appendices

Appendix A: Background information on parent perspectives on intensive family support services in the ACT

The overarching aim of a study, conducted by ICPS, was to examine the experiences of parents receiving intensive family support services in the ACT. The focus of the study was on the parents' personal accounts about their service experience and wellbeing during the service engagement. Parents faced adversities and trauma before and after becoming parents, including complex and long-standing difficulties with mental health, substance use and victimisation of violence. Despite these difficulties, the parents demonstrated remarkable resilience and positive outlook to parenthood through their personal stories and achievements in overcoming these challenges.

The study interviews highlighted three broad areas where parents identified further needs for support:

1. complex mental health needs of the parents
2. communication between the client and worker as well as between intensive family support services in the ACT and Child Youth Protection Services, including transparency in goal setting and case planning
3. clients' post-service needs.

Mental health of parents in intensive family support services in the ACT

High rates of trauma symptoms in the current study appeared to be closely interlinked with childhood exposure to traumatic events, complex histories of substance abuse, mental health problems, criminality, and domestic violence that continued to impact the lives of the parents at the time of the interviews. Despite these disadvantaged backgrounds, most parents had been able to overcome major challenges with sustained and persistent efforts to work towards positive change within themselves and their environments to return or to keep their children at home. Parent qualities included psychological inner-strength, courage to speak out if they felt poorly or wrongly treated by services, determination, patience, insight about own past actions. The parents we interviewed were able to engage with the programs with sustained focus, and the ability to adapt to and work in unknown (and somewhat unpredictable) service environments, while navigating the complex child protection systems.

The findings of this study show evidence of post-traumatic growth in the parents we interviewed, where individuals who endure psychological struggle following adversity can experience growth and development as a result (Collier, 2016). Greater investment in trauma-informed care could further enhance the success of parents in the challenging task to overcome their own difficulties as well as some of the hurdles in the child protection system.

Given the complex mental health profiles of some of the parents in the current study, intensive family support services may benefit from a 'blended care' model, that combines universal and targeted elements in an integrated strategy (Prinz, 2015). One such example is a parenting program, Family Foundations that has been developed and evaluated in the ACT context (Trew et al., 2018). They combine both group-based supports as well as highly targeted wrap-around and needs-based supports for the parent, including drug and alcohol counselling and rehabilitation

services; domestic violence specialist services; and psychological and mental health specialist services. In this model families are interconnected through a shared agency multi-service agreement, designed to target specific areas intensively and responsively in families lives, being flexible to families fluctuating needs and requirements.

Parent wellbeing while receiving intensive family support services in the ACT. Notwithstanding most parents had positive experiences of engaging with intensive family support services in the ACT, only four of them reported improved wellbeing in relation to themselves or children during their engagement with intensive family support services in the ACT. Those who described improved wellbeing, said they felt "*relieved*", "*less stressed*", "*emotionally healed*", and "*feeling more positive*". Improved wellbeing was largely attributed to the practical supports they received from intensive family support services in the ACT in managing daily living and the approach of individual workers that was "*making us feel like humans*". Those who felt their wellbeing declined during engagement with intensive family support services in the ACT was mostly associated with unresolved mental health difficulties, mental health impacts of violence victimisation, or ongoing substance use problems. A handful of parents reported their wellbeing declined directly because of the involvement with intensive family support services in the ACT, and often the reasons were related to negative experiences of dual service involvement with child youth protection services.

Workers as key enablers of positive change – reducing and preventing stigma and discrimination through worker-client relationships

The types of supports parents reported they had received from intensive family support services in the ACT were related to practical needs, building their capacity as parents, and interpersonal support from the worker. Most parents reported positive experiences in their engagement with intensive family support services in the ACT. Positive experiences were almost always attributed to individual workers' characteristics and practice model: their genuine approach and non-judgmental attitude and the trust they helped the parents build. This was important in terms of service engagement, as many of the parents had their trust broken in the past, by their own family, spouses, or support services.

A significant factor contributing to the parents' success at intensive family support services in the ACT were the individual worker characteristics, their practice model and attributes and the ability for both parents and workers to develop meaningful, safe and healing relationships where the parents felt genuinely heard and supported. Parents stayed engaged with the service when their workers were non-judgmental, "*genuine*" in their manner and approach, provided "*flexible*" service, and who were "*upfront*" and "*honest*", "*followed through*" with their support and celebrated parents' achievements, "*wins*", with them.

Discrimination and stigma – nature of the issues and how it plays out within the child welfare system

Parents' negative service experiences of engaging with intensive family support services in the ACT were also largely related to individual workers, and to difficulties navigating the service system, including the wider statutory child protection system. These negative experiences were exacerbated by the "*fear of losing my child*", "*feeling checked up on*" "*being set up to fail*" or "*not knowing what is required of me*". Some issues parents found particularly challenging were a lack of communication and transparency from the workers, missed meetings and 'no shows', and difficulties getting in touch with their allocated workers. Many parents also reported difficulties around mixed messages from different workers (child protection services, and intensive family support services in the ACT)

and a lack of clarity of what was required of them to 'succeed' in each program. The fear of child removal prevented the parents voicing their concerns with the workers or child protection authorities, that are similar experiences of parents reported in other studies. Although the interviews did not ask directly about what motivated parents to sustain their engagement with intensive family support services in the ACT, many parents reported the fear of having their child removed as the main motivator.

The current results are consistent with findings from other qualitative studies of parents involved in the broader child welfare system (Collings, 2018; Harries, 2008). These studies outline common experiences of parents involving rapidly changing caseworkers and young inexperienced staff, bureaucratic confusion, lack of courtesy such as returning phone calls, misinformation or lack of information, disrespect and dishonesty, despair, isolation and ongoing trauma of parents and families. Harries (2008), reports some specific experiences related to reunification services in particular: hurdles the parents must go through to achieve reunification with ever increasing list of 'things to do'; surveillance rather than support; 'always watched and never helped'; powerlessness; and lack of communication between support services.

Appendix B: Background information on Cradle to Kinder

Cradle to Kinder is a Victorian intensive 'early' intervention to prevent child protection involvement for vulnerable/high-risk cohorts

As outlined by Scott et al. (2017), the Cradle to Kinder program is an early intervention program designed to address the needs of vulnerable children and families in Victoria. It targets young pregnant women under 25 years of age. It also prioritises Aboriginal parents and their families, parents who are or have been in out-of-home care, and parents with a learning difficulty. It provides support for families from pregnancy through to when their child reaches four years of age, with the objective to:

- improve child health and optimise child development and wellbeing
- promote child safety and stability
- strengthen parenting capacity
- promote positive parent-child relationships and attachment.
- strengthen parent/carers' mental health, communication and problem-solving skills
- increase the family's connection to their culture and community.

To achieve these aims, a flexible service model is used, focusing on the whole family. A key worker provides parenting support to promote play and learning opportunities; models infant and parent-child communication and interaction, engages parents in antenatal and postnatal services including specialist services, such as mental health.

The program is strengths-based, aims to be culturally aware, developmentally and trauma informed, and dynamic and responsive in relation to changes in the family's situation. It is also emphasises professional judgement, using analysis and accurate assessments and planning effective interventions with families. For more information on the program refer to the Victorian Cradle to Kinder and Aboriginal Cradle to Kinder Practice Guide < https://providers.dhhs.vic.gov.au/family-and-parenting-support>

The Victorian Government's statutory child protection service (Department of Health and Human Services) contracted the Australian Institute of Family Studies (AIFS), in partnership with the Centre for Community Child Health at the Murdoch Childrens Research Institute (MCRI), to undertake an evaluation of the Cradle to Kinder program from 2013-2015 (Scott et al., 2017). Rich quantitative data were collected that gave a robust understanding of the experiences of people involved, which aspects are a strength of the program and which could be improved.

According to Scott et al. (2017), service providers, stakeholders and parents who received the program were generally positive. Parents particularly liked the strengths-based approach, while caseworkers and service providers felt the service model worked well and had a positive impact on families. The success of the program was influenced by factors such as: the long-term nature of the program, the connection with other community services, and the availability of brokerage funds. The evidence from this evaluation indicates strongly that the Cradle to Kinder was a highly valued and much-needed program by all those involved. Early intervention programs like this can assist and respond to the needs of young parents whose children may be at risk of entering the statutory child protection system.

The evaluation of the early implementation of Cradle to Kinder demonstrated that there were elements within the program that worked well in supporting families to make progress towards their goals. The program offered enhanced responses that were embedded within local service systems and child protection services to assist vulnerable families with complex needs. However, service capacity was a significant issue.

In terms of outcomes for parents participating in the program, Scott et al. (2017) concluded:

> The findings from the evaluation research suggest that the Cradle to Kinder program had a positive impact on parenting skills and wellbeing. Although the evaluation time frame does not allow a complete assessment of program outcomes for clients, it still provides some useful insights into elements of the program that worked well.
>
> The close working relationship between case workers and clients meant that a whole range of issues could be addressed in a timely way. These ranged from providing necessary referral to family violence services in the case of a disclosure, addressing health problems, ensuring stable housing and accessing employment and education to safeguard the longer term stability and future of the family unit. Making linkages to early intervention services like Maternal and Child Health and pre-school education services was also a positive outcome noted by both clients and caseworkers. (p. 12)

Evidence from the evaluation also highlighted the positive impact of the Cradle to Kinder Program for children. The children of families participating in the program were less likely to be in long-term out-of-home care or to have permanent care and protection orders:

> Having regular contact with Maternal Child Health Services meant that any health issues with children could be identified and addressed. Parents were more likely to understand the importance of immunisation, and were provided with information about whether children were meeting developmental milestones as well as how to protect children from injury through safety measures at home. (p. 13)