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Australian Law Reform Commission

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REVIEW OF FAMILY LAW SYSTEM

ISSUES PAPER 48

I ask that this submission be published.

Question 2 – Principles to guide the early resolution of disputes

Parents who experience a mental health condition that reduces parenting capacity including anxiety, depression and reactive anger should be referred to a skilled clinician who is able to provide tailored family-oriented therapy that is reportable to a Court.

Parents with mental health conditions should have an opportunity to submit a treatment report to a Family Court or Youth Court that describes therapy they participated in and the effectiveness of this therapy in improving their parenting capacity.

The option for a parent to participate in focused family-oriented therapy is especially important when a parent is disallowed from participating in family dispute resolution because of their mental health condition or proneness to outbursts of reactive anger.

Skilled family-oriented therapy can be provided by many accredited mental health clinicians. In 2006 Medicare introduced a Better Access scheme that funds professional therapy for a range of mental health conditions including Adjustment disorders. Many experienced mental health clinicians have now transferred to work in private practice in the community. Many of these clinicians have considerable skills and are able to provide tailored therapy for families with complex and multiple needs. Many experienced clinicians are willing to provide reportable therapy for families who appear before both Family Courts and Youth and Child Protection Courts if adequate arrangements and guidelines for professional conduct are established.

Question 7 – Improve access for people with a disability

Access to family law processes would be enhanced if the distinction made in the 2009 COAG National Framework for Protecting Australia's Children between vulnerable families and at-risk families were incorporated into legislation.

An **at-risk family** presents an immediate and serious risk of significant harm to a child's life or mental health. Immediate removal of a child from an at-risk family is warranted. Once a child is removed from the care of parents for a significant period, authority to make decisions about the welfare of the child is transferred to the state.

Parents of a **vulnerable family** use adverse parenting practices that result in cumulative harm to a child's mental health if the practice is used repeatedly over time. Children exposed repeatedly to adverse parenting practices experience long term mental health conditions such anxiety, depression and traits of personality disorder. Cumulative harm occurs when a child cannot cope with repeated exposure to adverse experiences. The repeated exposure slowly reduces the child's sense of safety and wellbeing. Children who are repeatedly exposed to adverse parenting practices develop dysfunctional coping strategies that lead later to mental health disorders.

A high proportion of families presenting to Family Courts report that both a parent and child are exposed to emotional abuse. Repeated exposure to emotional abuse produces cumulative harm. Vulnerable families can remain intact while reportable therapy is provided that aims both to reduce emotionally abusive parenting practices and to improve a child's resilience in managing normal emotional experiences.

There are established psychological therapies that help parents to manage tensions without resorting to emotional abuse. The effectiveness of psychological therapy in reducing cumulative harm to a child can be monitored in each family. Monitoring is greatly facilitated if there is a Court order that both encourages a parent to participate in therapy and requires monitoring.

Vulnerable families benefit from participating in reportable family-oriented therapy that identifies practices that produce cumulative harm, encourages the parent to use positive parenting practices, and helps children to learn suitable protective skills.

One difference between vulnerable families and at-risk families involves parental decision-making. Parents in vulnerable families can retain parental authority to make decisions about the welfare of their child, as the child does not enter the guardianship of the state and is not removed from the care of the parent. The quality of the parent's decision-making regarding their child can be monitored by the clinician during the period of therapy, and by child protection staff. On the other hand, when children are removed from the care of at-risk families parental authority is transferred to the state.

The concept of vulnerable families is especially relevant for mental health diagnoses of anxiety, depression and traits of personality disorder. Anxious parents often express high concerns about risks and these parents can pass on their anxieties to their children. Parents with depression often express high levels of sadness to children, especially if they are separated from their child, and this can lead to children feeling responsible to improve the wellbeing of their parent or becoming parentified. Parents

with disordered personality traits often express their emotions very strongly especially involving anger, and this results in children becoming overwhelmed, unable to cope, and developing dysfunctional methods of coping that lead to mental health disorders. Parents who use substances often provide very inconsistent parenting. Psychological therapies are available to help each group of parents to greatly improve their parenting practices. These therapies can be delivered in individual weekly sessions by skilled clinicians, and can be tailored to meet the identified needs of each family. These therapies can produce marked changes within 4-6 months. Ongoing therapy is needed to consolidate gains and to manage any relapses.

The functioning and progress of a vulnerable family can be monitored by a judge who issues an order for one year for a consenting family to participate in family-oriented therapy. The judge can issue interim access orders that are reviewed on a scheduled basis, such as every 3 months. At a hearing a judge can receive a treatment reports, hear any complaints about contraventions, and review access arrangements to determine whether a parent has made sufficient change to warrant a change in access arrangements.

This approach works well when there is a single decision maker such as a judge. The approach can be undermined if other workers have authority to remove a child from the care of parents due to concerns about minor issues.

Adaire Model of Family-oriented therapy

A scheme similar to that described above was implemented by the writer during the period 1996 to 2006 when the writer was employed as Senior Clinical Psychologist and Team Leader at Adaire Clinic in the Adult Mental Health Service in southern Adelaide. At the time 30% of adult clients with a severe mental illness who were registered with Adaire Clinic were custodial parents of dependent children. If a parent experienced an episode of severe mental illness and needed to be hospitalised then their children might be removed temporarily from the care of the parent and placed into the care of the Department of Child Protection.

Designated mental health professionals from the Adaire Clinic provided family-oriented therapy to identified families.

Therapy was individualized for each family based on assessments of both parents and children. Therapy targeted parenting skills that were reported as being lacking or adverse. As well, clinicians were aware of evidence that parents with certain diagnoses often lack specific parenting skills, and this information was used to identify potential problems for parents with these diagnoses.

The Adaire model had seven main components:

1. One mental health professional was designated as the primary clinician and coordinator of therapy services for a family. The clinician participated in peer review sessions.
2. The clinician assessed a parent's skills and provided individual therapy on a weekly basis to improve parenting capacity by targeting areas of shortcoming and adversity
3. The clinician met children and assessed children's resilience to manage events that occurred in the family. The clinician provided child-focused therapy as required.

4. In many cases the parent was subject to a one year order to ensure the parent was adequately motivated to participate in therapy. The one year order was issued by the Guardianship Board as a Community Treatment Order. Progress in treatment was reported to the Guardianship Board.
5. Parents retained authority to make decisions about the welfare of their child during the period of therapy, and these decisions were reviewed by the therapist.
6. Parents with more complex needs were provided with 2 hours per week of practical in-home support to assist their parenting in the home. The practical support was provided by para-professionals who were accountable to the clinician to ensure that efforts were collaborative. The nature of support was decided on an individual basis.
7. Parenting was monitored by the Department of Child Protection, then called FamiliesSA.

In effect the Adaire model viewed families where a parent had a severe mental health condition as being vulnerable families.

An assurance that parents would retain their parental decision-making authority was a strong motivator for parents in vulnerable families to participate in focused therapy and to improve their parenting practices. This assurance permitted a clinician to address issues without clients feeling threatened that their child would be removed if they disclosed difficulties they were experiencing.

Decisions to remove children from the care of parents were often made jointly by the mental health clinician and a child protection worker. This was sometimes done briefly while a parent was in hospital, or a decision might be made to refer the case to the Youth Court for a long term decision. If a case was referred to the Youth Court then it was common for both child protection staff and the mental health clinician to provide reports to the Youth Court.

The effectiveness of the Adaire programme was evaluated informally. The Adaire programme was effective in restoring the parenting capacity of parents with severe mental health conditions to adequate parenting during a one year treatment programme in about 85% of cases. This improvement was maintained for a two year follow-up period in the large majority of cases. It was found that providing family-oriented therapy stabilized the mental health of parents sufficiently that it was not necessary to continue to remove children from the care of the parent after an initial brief assessment period. Therapy intervention was usually delivered for one year, and maintenance therapy was provided for the following one or two years.

A model of family-oriented therapy such as described here could be oversighted by a Family Law Court or a Youth Court.

Question 10 – Reduce cost of private reports

Parents are eligible to receive reportable therapy that is provided by an accredited mental health clinician and funded by the Medicare Better Access scheme if their GP issues a Mental Health Treatment Plan. Parents are eligible to receive therapy to treat an eligible mental health condition including an Adjustment disorder with symptoms of anxiety and depression. Reportable therapy can aim to improve

parenting capacity on topics that have been criticised either by the other parent or in a family consultant's report.

A parent who requests a treatment report is asked to pay the reasonable cost of preparing the report as Medicare funds only sessions where a therapist makes direct contact with a client. Information that is included in a treatment report has been gathered during funded therapy sessions.

A mental health treatment report typically provides the following information: issues of concern that were referred to the clinician, the capacity of the clinician to address all issues of concern, nature of treatment provided, participants in therapy and adequacy of participation, updated risk assessment, and summary of outcomes achieved together with a description of assessment methods used.

Question 23 – Diversion

Cases where a parent has a diagnosed mental health condition that impacts on parenting capacity can be considered for diversion to receive treatment from an accredited mental health clinician, rather than automatic removal of their child from their care. This diversion provides parents with an opportunity to address concerns that have been raised about their parenting capacity.

When a parent is diverted to reportable therapy, assessment reports that document shortcomings in their parenting capacity can be made available to the therapist rather than declared as confidential. Providing assessment reports to therapists both minimizes the need for clients to retell their stories and become re-traumatized, and ensures that therapists are well informed.

Question 25 – System abuse

Introducing a system of reportable therapy both helps vulnerable families and introduces some risks of system abuse.

Some abusive parents ask their lawyer to subpoena confidential therapy notes so they can obtain access to confidential material they use to continue to intimidate their ex-partner. Courts can be asked to resist issuing subpoenas to obtain the confidential clinical notes of an accredited mental health therapist unless significant reasons are advanced. Instead parties can be asked to request a treatment report from the therapist, and to offer to pay the reasonable cost of preparing the treatment report. A system that supports reportable therapy will emphasise provision of treatment reports, will encourage parties to participate in therapy, will protect parties from unnecessary subpoenas, and will ensure that Courts are informed about therapies provided to participants.

The Family Law Council has reported that they have received some submissions that discourage the use of reportable therapy. Two arguments were raised with the Family Law Council. The first argument is that evidence a person has participated in mental health therapy can be used to stigmatize a participant. The second argument is that providing a treatment report undermines the therapeutic relationship between therapist and client.

In response to these two arguments. The writer is confident that judges in Australian Courts do not themselves stigmatize people who have participated in mental health therapy, and that they discourage stigmatization. A reply to the second argument is: a treatment report can be provided to the parent or lawyer rather than directly to a Court, leaving the parent to decide whether to submit the treatment report to a Court as evidence.

It is important that treatment reports describe therapy that has been provided, as this distinguishes a treatment report from a character report. A treatment report describes therapies that have been applied to address issues that have been acknowledged as being adverse parenting practices in an individual case. Character reports simply affirm that a person is of good character. Family Courts have long rejected the idea of receiving second opinion character reports as being adversarial reports.

It is the case that a proportion of reports submitted to both Family Law and Child Protection Courts contain information that is stigmatizing for parents. Writers use a stigmatizing approach when they apply a psychiatric label to a parent, evoke a stereotype and then presume that the parent exhibits characteristics of the stereotype without providing an individualised assessment. This misuse of psychiatric labels is especially serious when the writer does not provide evidence that a parent meets all criteria for a diagnosis to be given.

The admission of treatment reports that address a parent's progress on each specific criticism of their parenting practices will reduce stigmatization that is based on the misuse of psychiatric labels.

In conclusion, an emphasis on reportable therapy will reduce some abuses that occur under the current system. Acknowledging reportable therapy and accepting treatment reports should not introduce new abuses.

Question 28 – On-line information

I inform the Law Reform Commission of the existence of an online website called **complexfamilies.com.au**. This website summarizes rulings made by Family Courts in Australia in the period 2006 to 2014. The purpose of the website is to educate the general public including mental health professionals about topics raised in Family Courts, about the nature of evidence presented by treating professionals, and about rulings made.

There is scope for Family Courts to summarize findings and rulings on mental health topics in a format similar to that used in the complexfamilies website to facilitate the ongoing education of the public and mental health professionals who submit treatment reports.

There is considerable scope for Youth Courts to report on cases in a manner similar to that used in Austlii. Austlii commonly summarises de-identified reports, providing information about issues raised in Court, rulings made by a judge, and significant evidence presented to the Court by expert witnesses. Judges often make comments about the adequacy of evidence submitted by experts.

There appears to be a practice in Australia for Youth Courts to keep all information confidential. This high emphasis on confidentiality might have an effect of protecting professionals rather than protecting

clients. There is scope for Youth Courts to issue de-identified reports using a format similar to the Austlii format, for the education of mental health professionals who practice in this field.

Question 29 – Reduce risk to children in families with complex needs

An important legal step that can be taken to reduce risk to children is to introduce into legislation the distinction between vulnerable families and at-risk families that was recognised in the 2009 National Framework for Protecting Australia's Children.

While this distinction is not recognized in legislation, child protection departments continue to use one strategy to manage both groups of families. The favoured strategy in many states of Australia is to remove children from the care of parents as a first priority if there is any risk of maltreatment of children, to remove decision-making authority from parents, and not to refer parents to skilled family-oriented therapy. Some Child Protection Departments then raise the threshold and decline to implement a reunification strategy and instead argue that the top priority has become to provide stability for a child by retaining the child in the care of the Minister.

The strategy of commencing by removing children from the care of their parents for a prolonged period does not recognize the substantial literature about the importance of maintaining an attachment bond between a child and at least one parent, and does not recognise the damage that is done to the long term mental health of young children when this attachment bond is disrupted.

Overall risks to the mental health of children can be reduced substantially if laws are amended to recognize the distinction between families who are vulnerable to cumulative harm, and families who are at-risk of producing immediate substantial harm to their child. Once this distinction is made, different management strategies can be introduced for the two groups of families.

Many families with complex needs are vulnerable families who are responsive to targeted therapy that is provided by a skilled mental health clinician. Many of these families can improve their parenting capacity considerably if they are provided with one year of targeted therapy that is provided by a skilled therapist.

It is important to recognize that when parenting capacity has been questioned on the grounds that a parent has a mental health condition, it is usually not viable for a judge to resolve parenting issues in a single hearing. Sustainable solutions can be achieved if a judge adopts a structured approach by scheduling further hearings at set periods of about every 3 months for a year. The judge can receive progress reports and can determine whether sufficient change has been made in a parent's behaviour to warrant changes in orders about access or other matters.

When a family has complex needs it is best to refer the family to a single skilled clinician who is able to manage the various needs of the family in a coordinated manner, rather than either to refer the family to multiple agencies, or to refer the family to a non-government agency that does not employ clinicians who have advanced skills.

INTEGRATION AND COLLABORATION

Question 31 – Integrated approach for families with complex needs

This question asks how to provide comprehensive treatment for members of a family with complex needs, including a parent who has a treatable mental health condition that impacts on parenting.

The best way to achieve integrated therapy for a family with complex needs is to refer the family to an accredited mental health clinician who has skills to address each of the issues that arise in the family. Referring a family to one therapist reduces the need to refer a family to multiple agencies whose efforts then need to be coordinated.

Following the introduction of the Medicare Better Access scheme in 2006, there are now many skilled mental health clinicians who work in private practice in community settings who have the skills to address the main risk issues that present to Family Courts. The main risk issues for maltreatment of children involve parental mental illness, substance use, reactive anger, behavioural disorder of a child, and a parent's own experience of being parented. Many skilled clinicians are motivated to work with Family Courts and Youth Courts, if adequate financial arrangements and guidelines for professionals are provided.

Family-oriented therapy for families where one member has a mental health condition requires weekly sessions for about one year to be effective. The Better Access programme provides only 10 subsidised sessions for psychologists and this is not sufficient to provide comprehensive family-oriented therapy. As well Medicare funds only direct contact with clients and does not fund reports. An additional source of funding will be required if skilled private therapists are to become more involved in providing family-oriented therapy for cases that appear before a Family Court or Youth Court.

A further issue is that many skilled therapists are not well trained to work collaboratively with legal practitioners. There are many pitfalls for novices who work in the area of Family Courts. Guidelines outlining good professional practice are required to encourage skilled clinicians to work with families who appear before Family Law Courts.

Question 32 – Reduce need for families to engage in more than one court to address safety concerns

Families with complex need are likely to be referred to both Commonwealth Family Courts and State Child Protection Courts.

One report by the Family Law Council examined provision of legal aid, and found that about 30% of families with complex needs who appeared before a Commonwealth Court also sought funds to appear before another court.

Improvements can be made to reduce appearances before multiple courts by encouraging States to amend their Child Protection legislation and to adopt the paramount consideration that is expressed in the amended Commonwealth Family Law Act, that requires the best interest of the child to be the paramount consideration. The paramount consideration can be defined as it is in a child's best interest to

maintain a meaningful relationship with at least one birth parent, so long as the child is safe from physical harm and long term psychological harm.

It is essential to have a common definition of long term psychological harm. At present some definitions confuse a child being briefly emotionally upset with severe psychological harm. Legislation does not sufficiently recognise that some forms of emotional abuse become harmful for children when a child is exposed repeatedly to emotional abuse that produces cumulative harm to a child's mental health by eroding a child's confidence in their capacity to cope.

Adverse parenting practices that produce cumulative harm can be identified and distinguished from practices that produce immediate and substantial psychological harm. Adverse parenting practices can be remedied if a parent participates in skilled therapy, where their ongoing access to their child depends on their demonstrating significant improvement in implementing positive parenting practices including in difficult situations. Judges can make ultimate decisions about whether parenting practices are adequate, based on information provided by expert witnesses.

Family-oriented therapy is effective in changing parenting practices that produce cumulative harm. The effectiveness of family-oriented therapy can be monitored in individual families if Courts issue orders that require monitoring and reporting.

It is proposed that therapy and monitoring be provided by professionals who are not employed by the same agency.

Question 33 – Promote collaboration between Commonwealth Family Courts and State Child Protection Courts

Greater collaboration can be achieved between Commonwealth Family Courts and State Youth Courts if both courts adopt the same paramount consideration. The amended Family Law Act indicates that the paramount consideration is to promote the best interests of the child, based on a presumption that it is in the best interests of a child to maintain a meaningful relationship with at least one birth parent, provided the child is safe from risk of physical harm and serious psychological harm.

Greater collaboration can also be achieved if a distinction is made in legislation between families who are vulnerable and at-risk. Agreed definitions will be needed to distinguish the two types of family.

Children in an at-risk family are at risk of immediate physical harm or severe psychological harm. The immediate removal of a child from the care of their parent is warranted when a child is in at at-risk family. The immediate cessation of the parent's authority to make decisions about the welfare of the child is warranted when a child is in the care of an at-risk family.

On the other hand, children in a vulnerable family are exposed to adverse parenting practices that have a cumulative and slow negative impact on the child's mental health. Vulnerable families can be treated using family-oriented therapy that targets specific adverse parenting practices, while the family remains intact and the parents retain their authority to make decisions about the welfare of their child. A judge makes the ultimate decision whether a child's mental health is adequately protected, based on reports received.

It is beneficial if vulnerable families are subject to a monitoring order for one year, as this permits parenting practices to be monitored by a child protection worker. One common practice is for child protection staff to ask parents to tell them about lessons the parent is learning from the therapist. A child protection worker who monitors does not need the authority to remove a child from the care of parents on learning about mild concerns. Decisions to remove a child from the care of a vulnerable family can be made by a judge.

Therapists can provide periodic treatment reports to a relevant Court that describes progress made on identified parenting practices.

Consistently between Courts can be achieved if all Courts publishing their rulings and reasons for reasons, drawing attention to thresholds that have been upheld in specific circumstances.

CHILD'S EXPERIENCE

Question 34 – Participation by the child

There is scope to change family law proceedings to improve participation by children.

Rulings by judges of Family Courts show that judges can distinguish three levels of capacity of children to make decisions:

- Children under about 6 years are unable to make decisions about adult topics as these children have difficulty understanding adult matters, so they are represented by their parent, and they are not kept regularly informed about adult matters
- Children aged about 7-12 years can understand matters that impact on them, they want to be informed, and they have been granted a right to be heard
- Children aged above about 13 years often have the maturity to make their own informed decisions and some claim this right to decide some family matters. Some of these children have the maturity to manage the emotional reactions that result from certain decisions being made.

Professional assessors who are skilled at assessing capacity to decide are able to provide reports about the capacity of each child to make mature decisions.

Psychological research often uses a model of decision making to frame assessments of a child's capacity to make mature decisions. Both psychological and legal approaches adopt a similar framework when addressing ability to make an informed consent about a proposal. A person can give informed consent if the person understands the nature of the issue to be decided, can identify at least two options, can make reasonably accurate predictions about the likely outcomes of both options covering both benefits and disadvantages in the short term and long term, and can select one option that is preferable to them. A person who meets all of these criteria for a proposition is said to display capacity to make an informed decision.

An assessment of a child's capacity to make an informed decision can include the child's ability to recognise artificial inducements and threats that are not directly relevant to the basic proposition.

When children are making decisions about topics that have strong emotional impacts, the child's capacity to manage the emotional impact of their decision is important as well as their capacity to predict outcomes. A further assessment is required of a child's maturity or capacity to manage the emotional impacts of their decisions.

There is scope to add a second test of a child's competence to make mature decisions using the model of capacity to make decisions that are informed and within a child's emotional capacity, in addition to the Gillick test of competence.

Question 36 – Mechanisms to ensure child's voice is heard

Progress would be made in the family law system if the concept of a child's capacity to make informed decisions about emotional topics was added.

Children who are assessed as being capable of making an informed decision on a proposal, and capable of managing the emotional impact of that decision, could be permitted to make submissions to a family court under their own name.

Question 38 – Risks of involving children in decision making

There are risks if children are asked to make decisions that are beyond their capacity to cope.

Risks can be managed by ensuring that assessments of a child's capacity to decide are conducted by an objective professional who is skilled in this area of assessment. This professional should be informed about basic elements of the family situation, including whether either parent uses coercive and controlling methods, about family violence, and about whether either parent often displays high levels of emotion when they are displeased.

PROFESSIONAL SKILLS

Question 41 – Measures to ensure professionals have and maintain suitable competencies

It is important that mental health professionals who participate in family court matters maintain a high level of objectivity and professionalism.

It would be useful to introduce a system of accreditation for participating mental health professionals to introduce a greater sense of collegiality and to reduce urges to offer adversarial reports.

It would be useful to ask a professional group that represents members of several disciplines to submit proposals about suitable standards for professionals to follow. The Australian Chapter of the Association of Family and Conciliation Courts appears a suitable professional body to be consulted.

Question 43 – Management of professionals who exacerbate conflict

Some mental health professional adopt a role of being an advocate for a specific client rather than being an objective assessor who draws conclusions and makes recommendations only when objective information supports the conclusion. These professionals can exacerbate conflict between parties by submitting adversarial reports.

There is scope for a judge who considers that a professional report provides advocacy rather than objective information to inform the professional in writing that their report was not helpful to the Court, and that the report has been set aside as being an adversarial report.

A judge who decides to set aside a professional report should include reasons for this determination. There is scope to publish these determinations through an appropriate professional body for the education of other professionals and to clarify standards.

Question 44 – Promote welfare of participating professionals

It is important to take steps to protect the welfare of mental health professionals who participate in assisting family courts. There are examples of litigants making complaints about registered professionals to the registration bodies because the litigant dislikes a finding or conclusion drawn by an objective assessor.

Three ways to protect competent professionals are proposed:

- Refer complains about professionals about family law matters to a judge of the Family Court rather than to a professional body that has little expertise in this area
- Ask registration bodies to defer consideration of a complaint until the relevant matter has been heard in the Family Court, communicate with the judge of the Family Court about whether the judge found the report to be helpful and whether the judge has any complaints, and then proceed.
- Ask registration boards to include a representative of a Family Court when they hear complaints about functioning in that area.

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