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Parents with a Disability and the NSW Children’s Court

The Family Support & Services Project
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Parents with a disability and The NSW Children’s Court

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary and Recommendations</td>
<td>i</td>
</tr>
<tr>
<td>1 Project Overview and Review of the Literature</td>
<td>1</td>
</tr>
<tr>
<td>2 Prevalence and Family Characteristics</td>
<td>9</td>
</tr>
<tr>
<td>3 DoCS Decision to Initiate Care Proceedings</td>
<td>15</td>
</tr>
<tr>
<td>4 DoCS Care and Protection Concerns</td>
<td>31</td>
</tr>
<tr>
<td>5 The Outcomes of Care Proceedings</td>
<td>41</td>
</tr>
<tr>
<td>6 The Process of Care Proceedings</td>
<td>51</td>
</tr>
<tr>
<td>7 How Care Outcomes are Determined</td>
<td>65</td>
</tr>
<tr>
<td>8 Conclusions and Recommendations</td>
<td>81</td>
</tr>
<tr>
<td>References</td>
<td>89</td>
</tr>
<tr>
<td>Appendices</td>
<td>93</td>
</tr>
</tbody>
</table>

Parents with a disability and the NSW Children’s Court
PROJECT OVERVIEW AND REVIEW OF THE LITERATURE

Contents

Review of the Literature ......................................................... 2
  Introduction ......................................................................................... 2
Parents with intellectual disability ........................................... 3
  Rates of child removal ....................................................................... 3
  Court proceedings ............................................................................... 3
Parents with psychiatric disability .......................................... 4
  Child removal .................................................................................... 4
  Court proceedings .............................................................................. 5
Methods .......................................................................................... 5
  Document review ............................................................................... 6
  Interviews and focus groups ................................................................. 6
  Court observations ............................................................................ 7
Data Analysis ................................................................................... 7
  Analysis of quantitative data ................................................................. 7
  Qualitative data analysis .................................................................. 8
Review of the Literature

Introduction

The number of parents with a disability - either physical, intellectual, psychiatric or sensory - living in the Australian community is not known. It is clear however that numbers are increasing as a result of deinstitutionalisation and increased opportunities for people with disabilities (Cowling, 1996; Haavik & Menninger, 1981; Llewellyn, McConnell & Bye, 1995). A crude estimate based on the prevalence of disabled adults in the population is that approximately 2.6% - 5.4% of families are headed by parents with a psychiatric disability and less than 1% of families are headed by parents with intellectual disability (see Appendix 1). No estimates of the number of parents with a physical or sensory disability are available.

Historically, people with disabilities have been regarded as incapable of being adequate parents. They also have been regarded as likely perpetrators of child abuse and neglect (Hayman, 1990; Tomison, 1996a,b; Westbrook and Chinnery, 1990; McConnell, Llewellyn & Bye, 1997). Such views are an extension of stereotypic beliefs, for example, that people with intellectual disability are ‘eternal children’, dependent and therefore incapable of child rearing (Hayman, 1990; Watkins, 1995). Such views are still pervasive in our society despite international research that demonstrates that ‘disability’ is not a causal factor in child maltreatment or parental inadequacy. Although some parents with a disability do find it difficult to raise their children, many others are competent by community standards (Dowdney & Skuse, 1993; Llewellyn, 1990; Tymchuk & Feldman, 1991; Westbrook & Chinnery, 1990).

INTERNATIONALLY, research suggests that abuse is rare among parents with intellectual disability compared to other poor families. Although child neglect appears to be encountered more frequently this is thought to be related to the parent’s lack of experience, parenting training and appropriate supports (Tymchuk, 1992). Likewise, a body of research suggests that ‘psychopathology’ or ‘mental disturbance’ is not consistently found in child maltreatment perpetrators (National Research Council, 1993, cited in Tomison, 1996b). As Tomison (1996) recently cautioned - “it should be remembered that the majority of children living in a family where parents are suffering from a mental disorder will not be maltreated” (p.10). Parental physical or sensory disability and child maltreatment have received little research attention.

The over-representation of parents with a disability in care and protection proceedings has been used to support assertions that parenting failure is inevitable for these parents (e.g. Shilling, Schinke, Blythe & Barth, 1982). This view however has been challenged. Researchers and legal commentators in the United States and Britain suggest that parents with intellectual and psychiatric disability receive prejudicial treatment in care and protection proceedings (Haavik & Menninger, 1981; Hayman, 1990; Hertz, 1979; Hudson, 1988; Levesque, 1996; Payne, 1978).

Three instances are identified in which parents with a disability receive prejudicial treatment. Firstly, child protection agencies and courts intervene and remove children even though no evidence of maltreatment is present (Hayman, 1990; Levesque, 1996). In some cases, courts uphold termination orders even when evidence of possible neglect is refuted or when the parent is shown to be providing adequate care for her children (Levesque, 1996). In these cases it is a presumption of inevitable maltreatment that prompts action.

Secondly, when a parent is having difficulties, these may be attributed to the disability - when in fact the difficulties derive from poverty, poor housing, harassment, social isolation and lack of appropriate services. This is described by Booth and Booth (1993) as the mistake of false attribution. In other words, poverty, low self-esteem and social isolation are more likely to be viewed as confirmation of a parent’s inadequacy rather than an acknowledgement that social constraints precipitate parenting difficulties.

The third instance is where children are removed with little or no effort to remedy parental deficiencies. Here the presumption is that parents are innately inadequate and their parenting deficiencies irredeemable (Hayman, 1990; Hertz, 1979; Levesque, 1996). International research has shown this presumption to be false. Parents with intellectual disability can acquire and generalize parenting skills and ‘unlearn’ negative behaviours (Budd & Greenspan, 1984; Feldman, 1994; Tymchuk & Andron, 1990). This false presumption may go some way to explaining the findings of Taylor et al. (1991) that child removal is more likely than not for parents with intellectual disability. Hayman (1990) has summarised these apparently prejudicial situations in the following way:
“A discrete sense of difference pervades the (care and protection) process: discrimination begins with the initial decision to intervene, ends in the decision to terminate the relationship, and is manifest in nearly every significant decision along the way” (p. 1127).

Parents with intellectual disability

Rates of child removal

The children of parents with intellectual disability are frequently removed by the state. In the United States, Accardo and Whitman (1989) found 45.5% (103 of 226) of children born to 79 families headed by a parent with intellectual disability had been removed. In a Swedish study, Gillberg and Geijer-Karlsson (1983) found a similar figure of 45% (18 of 40 children born to mothers with intellectual disability). A recent New Zealand study in Otago and Southland identified 46 parents with intellectual disability with 96 children of whom 39 (41%) had been removed (Mirfin-Veitch et al., 1999).

Two Australian studies present a similar picture of unusually high rates of state intervention. Of 77 South Australian parents with intellectual disability, one third of their 116 children had been taken into care (Bowden, 1994). In NSW, parents with ‘cognitive limitations’ attending family support services were reported as being almost twice as likely as other clients to be involved with the NSW Department of Community Services (DoCS) in matters of child protection (Bullen, 1998).

Only one study has reported prevalence and outcomes data in a court sample. Taylor and colleagues (1991) examined 206 cases of child maltreatment before the courts in Boston in 1985/86. In 31 cases (approximately 15% of the total sample) either one or both parents had a diagnosis of intellectual impairment (IQ<79). Despite these parents having less prior court involvement and greater acceptance of court ordered services than any other group, their children were removed nearly as often as the children of substance abusing parents, and more often than the children of emotionally disordered or non-diagnosed parents.

Court proceedings

Cases cited in the literature illustrate a range of discriminatory circumstances in relation to court proceedings. In some cases, children have been removed despite there being little or no evidence of actual or potential harm to a child1. There are several examples cited in which infants were removed shortly after birth and placed out-of-home by court order2. In other cases, decisions to remove a child appear to have been based primarily on a parent’s score on a standardised intelligence test, that is, on their ‘IQ’3. Children have been removed even when the evidence of neglect has been refuted and the parent’s adequacy as a parent acknowledged by the court4. These cases support Levesque’s (1996) claim that parents with intellectual disability are held to a different and potentially higher standard of parenting performance and their children removed “when states present evidence which, if used against non-disabled parents, would not be enough to sever the parental relationship” (p. 15).

1 E.g. In re Geiger, 1975 (cited in Hayman, 1990). In this case, the parent-child relationship was severed even though the court found that “the children are not undernourished, they receive ample food and have minimal clothing and are generally in good health. The children have not been physically abused and they have not suffered any serious accidents”. Similarly in In re G.C.P., 1984 (cited in Marafino, 1990). A termination order was upheld by an appellate court despite the fact it acknowledged that there was no indication of intentional abuse, and the alleged neglect was supported only by reference to substandard housekeeping.

2 E.g. In re Orlando, 1976 (cited in Hertz, 1979). In this case, a three day old boy was removed despite evidence of his mother’s adequacy. The mother reportedly loved and wanted the infant; was physically and financially able to care for the infant; and had already raised one child who was ‘properly cared for’. A more recent case took place in England in 1987. A newborn child was removed at birth and made a ‘ward of court’ despite the protests of the intellectually disabled parents who believed they were capable of parenting (cited in Hudson, 1988).


Another discriminatory circumstance is where evidence of neglect has been substantiated yet the child removed with few or no support services provided prior to court proceedings\(^5\). This is in contradiction of the requirement in many states in the USA where the provision of services is a statutory prerequisite. Such cases illustrate that courts do make exceptions and apply the law differentially in cases involving parents with intellectual disability. There have been instances for example where appellate courts have overturned termination orders on the grounds that family preservation through support services was either not attempted or that only token efforts were made\(^6\). Notwithstanding this, other cases are also cited in which higher courts have upheld the order to remove a child\(^7\).

Gilhool and Gran (1985) identified three factors that may account for the failure of courts to insist upon the provision of support services. In the first instance it may be that appropriate support services for parents with intellectual disability are not available. A second factor is the courts’ lack of understanding about the learning capacity of people with intellectual disability given appropriate instructional methods. Thirdly, these authors argue that many courts have assumed that, as greater time and effort is required to teach skills to these parents, this requirement “relieves the state of the duty to provide any training at all” (p.32).

Parents with psychiatric disability

Child removal

Losing custody of their children is a realistic fear for many parents who have a psychiatric disability. A number of studies have highlighted the high prevalence of parental psychiatric disability in families where the children have been removed and placed in the care of others – such as kinship or foster care. For example, Quinton and Rutter (1984) found that nearly 78% of mothers who had children in care had a handicapping psychiatric problem; Miller and Finnerty (1996) found that 48.5% of mothers with a mental illness had a child in foster care, and 54.8% had their child being raised informally by another - while for non-mentally ill mothers the figures were 2.3% and 9.1% respectively. Some studies use this prevalence data to support the association between parental psychiatric disability and child maltreatment. This association has been challenged however by the presence of other factors more likely to contribute to child removal, such as domestic violence, substance abuse, poverty (Zuravin & DePanfilis, 1997) and discrimination against those with mental illness (Carriera, 1980; Mosoff, 1995).

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\(^5\) E.g. In re Jeannie Q, 1973 (cited in Payne, 1978). The court ordered immediate removal of five children from a mother with intellectual disability. Although State legislation required that supportive services be provided prior to findings of neglect, the court disregarded this legislation. In re Love, 1977 (cited in Hertz, 1979), an agency representative testified that support services were not offered because the services would be of no benefit. A state psychologist testified that no program existed in the USA which could assist a parent with intellectual disability acquire the skills necessary to perform the roles of parenthood. See also Elmer v. Lucas County Children Servs, 1987; Dept of Social Serv. v Humphreys, 1988 (cited in Hayman, 1990).

\(^6\) E.g. In re Petition of Catholic Guardian Society, 1986 (cited in Marafino, 1990). The court reversed a termination order for failure of the evidence to establish the mother’s inability to care for her children in the foreseeable future. No evidence of child neglect was present and the mother had not been provided with any support services. In re R.S., 1985 (cited in Marafino, 1990), the appellate court overturned a termination order ruling that less severe alternatives to child removal had not been explored for a mother with intellectual disability.

\(^7\) E.g. In re P.J.K, 1984 (cited in Marafino, 1990). The appellate court overturned a termination decision on the basis that specialised support services had not been available for the parents. Notably, the Supreme Court of Minnesota reversed the appellate courts ruling upholding the termination order.
Court proceedings

Much of the legal commentary in relation to parents with a psychiatric disability and care and protection court proceedings is concerned with the issue of ‘terminating parental rights’. This predominantly comes from continuing debates in the United States.

Historically, Payne (1977-78) claims that the courts have generally tolerated parents with a psychiatric disability. In addition, various states in the USA (e.g., Alabama) do advocate that the parent’s psychiatric disability should only be considered in relation to the parent’s ability to adequately care for their children. However, in a number of cases parental psychiatric disability has been raised as the determining factor in making the decision to terminate a parent’s rights (Shelton & Smith, 1990). In many of these cases the parent’s legal representatives argue that this is unconstitutional because the parent is not given the same due process as other non-disabled parents. However, these arguments rarely result in a change in the final decision of termination.

In 1980 Carrieri highlighted the inherent discrimination against parents with a psychiatric disability under the New York Social Services Law that allowed children of ‘mentally ill’ or ‘mentally retarded’ parents to be automatically adopted without any hearing, or without even notifying the parents. In contrast, ‘abusive or neglectful’ parents are entitled to an adoption hearing under the same statute. The New York Social Services Law was later revised and required that parental rights could only be terminated on the ground of parental mental illness if the parent was shown to be ‘presently and for the foreseeable future unable, by reason of [her/his] mental illness…to provide proper and adequate care for [her/his] child’ (Bogle, 1982, p. 126). Parental psychiatric disability remains as a key variable in determining whether a parent’s rights should be terminated.

More recently, Taylor and colleagues (1991) examined the care and protection court records of the Boston Juvenile Court over a one-year period (1985-6) for family and case characteristics. Although they found that judicial outcome was not associated with the type of parental psychiatric diagnosis, the diagnosis did predict which parents had their children permanently removed. In contrast, far fewer parents with ‘emotional’ (neurotic and affective) disorders experienced permanent child removal. They concluded that a key determining factor in cases where the children were removed was the parent’s perceived noncompliance.

Mosoff (1995) argued that ‘the simultaneous operation of child protection law, mental health law, and the power of the psychiatric paradigms almost inevitably severs the relationship between mothers with mental health histories and their children’ (p. 108). In other words, the chief concern becomes the parent’s psychiatric diagnosis with the court deferring to psychiatric and psychological evidence in order to make a final decision. The result is that child protection cases tend to be decided overwhelmingly against the mother where she has a psychiatric disability (Mosoff, 1995; Shelton & Smith, 1990).

Methods

For the purpose of this study, parents with a disability were defined as those with an identified impairment documented in the court file, including:

- Parents with intellectual disability diagnosed by a psychologist or psychiatrist, including those identified as having a ‘borderline’ intellectual disability.
- Parents with psychiatric disability, that is, ‘mental disorders’ diagnosed by a psychiatrist, for example - psychotic, mood, anxiety and personality disorders.
- Parents with physical disability, including those with an acquired brain injury or other physical disability that is permanent or likely to be permanent.
- Parents with a sensory disability, including those with a significant vision or hearing impairment that is permanent, or likely to be permanent and that is unlikely to be corrected or compensated for by technological aids.

Note: Parents with ‘substance abuse disorders’ were excluded from the definition of parents with a disability in this study.

The research project employed multiple methods to develop a comprehensive picture of parents with a disability in care and protection proceedings in the NSW Children’s Court.
The methods included:

- A review of court files
- Interviews and/or focus groups with magistrates, legal representatives and DoCS’ officers
- Courtroom observations of care proceedings.

The views of parents with a disability and their children were not covered in this project. We do however acknowledge the critical importance of their perspectives. The decision not to interview parents and children was made on the following grounds:

1. The focus of the study was on how decisions are made and outcomes determined by the professionals involved.
2. Given this focus, exploring the views of those who are responsible for decision making was paramount.
3. Parents’ and children’s experiences of care proceedings is a different research question warranting a thorough and rigorous investigation in and of itself.
4. The stress and anxiety evident among parents and children involved in care proceedings raises both ethical and methodological dilemmas with regard to recruitment and the conduct of parent and child interviews.

Due to the time and resource constraints of the project, certain items of information were only recorded in cases involving parents with a disability. These included the grounds of establishment, and the details of affidavit evidence and reports filed.

**Interviews and focus groups**

Interviews and focus groups were conducted to canvass the views and experiences of magistrates, legal representatives and DoCS officers with regard to care proceedings involving parents with a disability. Interviews and focus groups with magistrates and legal representatives were conducted on-site at the Children’s Courts, or in their offices. Focus groups with DoCS officers were conducted at each of the participating Community Service Centres (CSC). The interviews and focus groups were semi-structured and interactive with several questions consistent across each occasion. Concurrent data collection and analysis permitted sharing of preliminary findings as part of the focus group/interview process.

**Magistrates**

All 8 Specialist Children’s Magistrates (at the time of the study) participated in an individual interview and two round-table discussions with their colleagues. The focus of these interviews and the group discussions was:

- The court process and difficulties faced by parents with a disability
- Explicit and implicit factors that influence court outcomes
- The principles and ‘rules of thumb’ guiding magistrates’ decision-making

Any previous child in the family had been removed and the present concerns documented by DoCS in the initiating affidavit.
Legal representatives
A total of 34 legal representatives participated in either an interview (n=26) or a focus group (n=8). Four legal representatives were interviewed a second time when the first interview was unavoidably cut short. Interview and focus group participants included DoCS’ legal officers, Legal Aid solicitors and private solicitors acting for parents and legal representatives acting for children. Several of the solicitors performed more than one role. All participants provided legal representation at Campsie, Cobham or Camden Children’s Courts. The focus here was on the court process and difficulties facing parents with a disability and the explicit and implicit factors that influence court outcomes.

DoCS’ child protection workers
Seventeen focus groups were conducted involving a total of 155 DoCS personnel from 20 CSCs in the Sydney metropolitan region. An invitation to participate forwarded to DoCS Area Managers was sent on to those CSCs where care proceedings involving a parent with a disability had been initiated in the nine month period of the court file review. The topics for the focus group discussions were:

- The decision to initiate care proceedings
- Formulating recommendations to the Children’s Court in care matters
- The court process and difficulties faced by parents with a disability
- Explicit and implicit factors influencing court outcomes.

DoCS workers were asked to complete a brief information sheet on their position, experience and whether their caseload included any parents with a disability at the time.

Box 1
Statistical comparisons were made between the following groups of cases:

Group 1. Parents without a disability and no mention of drug and/or alcohol use.
Group 2. Parents without a disability with suspected drug and/or alcohol use.
Group 3. Parents with psychiatric disability with no mention of drug and/or alcohol use.
Group 4. Parents with psychiatric disability with suspected drug and/or alcohol use.
Group 5. Parents with intellectual disability.

Note: Parents with physical or sensory disabilities and parents with multiple disabilities (e.g. psychiatric & intellectual) were excluded from group comparisons due to low prevalence and the need to keep the comparison groups as homogenous as possible.

Court observations
The third dimension of data collection was observation of Children’s Court proceedings from the rear of the courtroom. In total, 35 days were spent observing court proceedings at Campsie, Cobham and Camden Children’s Courts. Observations were made on Court list days as well as at contested hearings involving parents with and without a disability.

Data analysis
Analysis of quantitative data
The Microsoft Access database was exported into SPSS (Statistics Package for the Social Sciences) for analysis. The statistical procedures used are reported with the findings. Statistical comparisons were made between the 5 groups listed in Box 1.
Qualitative data analysis

All interviews and focus groups were audio taped with the permission of participants. There were three instances in which participants requested that the interview or focus group not be taped. In these instances detailed field notes were taken. All interviews were transcribed for analysis. All transcripts and field notes were imported into NUDIST (Non-numerical Unstructured Data Indexing Searching and Theorizing), a computer software package designed to assist with qualitative data management and analysis. The qualitative data was analysed using the constant-comparative method (Glaser & Strauss, 1967). Put simply, this involved coding each unit of meaning with due regard to the context in which these were embedded, and subsequently comparing and contrasting these to identify categories of meaning.
# Prevalence and Family Characteristics

## Contents

### Background ......................................................... 10

- Study time frame and cases ........................................... 10

### Prevalence .......................................................... 10

- Prevalence and over-representation of parents with psychiatric disability ....................................................... 10
- Prevalence and over-representation of parents with intellectual disability ........................................................ 10
- Prevalence of physical & sensory disability .................................................. 10
- Co-morbidity ........................................................................ 10
- Mothers & Fathers .................................................................. 10
- Care Applications made by parents on Ground
  - C-irretrievable breakdown ................................................... 12
- Variation & Rescission Applications ........................................ 12

### Family Characteristics .................................................. 12

- Groups for statistical comparison ........................................ 12
- Aboriginal and Torres Strait Islander families (ATSI) ................................. 12
- Culturally & linguistically diverse backgrounds (CLDB) .......................... 12
- Number of children ................................................................ 12
- Age of children ..................................................................... 12
- Child disability ...................................................................... 13
- Relative socio-economic disadvantage ..................................... 14
- Household type ..................................................................... 14
- Drug &/or alcohol use among parents with psychiatric disability .......... 14
Prevalence and Family Characteristics

Background

Care proceedings pertaining to one or more children (defined as a person under the age of 18 years) are initiated by a Care Application or an application for variation or rescission of a current court order made under s.72 of the Children (Care and Protection) Act, 1987 (hereon referred to as ‘the Act’).

Care Applications are made by the statutory child protection authority, the Department of Community Services, on behalf of the Director General (hereon referred to as ‘DoCS’). A person with parental responsibility (custody) for a child under s.57 (1) of the Act can also make a Care Application but only on the ground that there is a “substantial and presently irretrievable breakdown” in their relationship with the child.

An application for rescission or variation of a court order is made by DoCS, the child subject to the order, a person with parental responsibility for the child, or any person who deems himself or herself to have a sufficient interest in the welfare of the child.

Study time frame and cases

- 407 care matters were finalised, involving 622 children from May 1\textsuperscript{st} 1998 – February 1\textsuperscript{st} 1999.
- 262 cases (64.4%) at Campsie Children’s Court
- 145 cases (35.6%) at Cobham Children’s Court.

Figure 1 shows the breakdown of care matters by applicant and application type.

Prevalence

Objective 1

To determine the prevalence of parents with an intellectual, psychiatric, physical, and/or sensory disability appearing before the NSW Children’s Court.

- Almost one-quarter of all cases (n=99, 24.3%) involved parents with a disability.
- Of DoCS Care Applications (70% of all cases), parents with a disability featured in nearly one third (n=84, 29.5%).

Prevalence and over-representation of parents with psychiatric disability - Table 1

- Parents with psychiatric disability featured in 18.4% of all cases (n=75) and 21.8% of cases initiated by a DoCS Care Application (n=62).
- These figures represent a substantial over-representation of parents with diagnosed psychiatric disability based on a general population estimate of parents with psychiatric disability of between 2.6% and 5.4% (see Appendix 1).

Prevalence and over-representation of parents with intellectual disability – Table 1

- Parents with intellectual disability featured in 7.1% of all cases (n=29) and 8.8% of cases initiated by a DoCS Care Application (n=25).
- These figures represent a substantial over-representation of parents with intellectual disability based on a general population estimate of between 0.25% and 0.99% (see Appendix 1).

Prevalence of parents with physical or sensory disability – Table 1

Physical disability and sensory disability were least prevalent with only 4 cases (1%) involving parents with a physical disability and 3 cases (.7%) involving parents with a sensory disability.

Co-morbidity – Table 2

12 cases featured parents with more than one disability. Of these, 9 were parents with psychiatric and intellectual disability. Of the remaining three, one was a mother with intellectual and sensory disabilities, the second a mother with intellectual and physical disabilities, and the last a mother with psychiatric and physical disabilities.

Mothers & Fathers

- Substantial over-representation of mothers - 83.8% (n=83) of all 99 cases featuring parental disability.
- In 12.1% (n=12) of the 99 cases, both parents (biological or non-biological) had a disability.
- In 4% (n=4) of the 99 cases, only the father had a disability.

\textsuperscript{8} A breakdown of DoCS Care Applications by Community Service Centre (CSC) is given in Appendix 2.
Prevalence and Family Characteristics

Figure 1: Care proceedings by type and applicant

![Diagram of care proceedings by type and applicant]

Table 1: Prevalence by disability

<table>
<thead>
<tr>
<th>Parental Disability (not mutually exclusive)</th>
<th>No. of cases (%)</th>
<th>No. of cases (%)</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Total, n=407</td>
<td>DoCS Care Application cases, n=285</td>
</tr>
<tr>
<td></td>
<td>No. of cases (%)</td>
<td>No. of cases (%)</td>
</tr>
<tr>
<td>➢ Psychiatric disability (inc.)</td>
<td>75 (18.4%)</td>
<td>62 (21.8%)</td>
</tr>
<tr>
<td>- Emotional (mood &amp; anxiety disorders,</td>
<td>15 (3.7%)</td>
<td>14 (4.9%)</td>
</tr>
<tr>
<td>post-natal depression)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Psychotic (schizophrenia, substance induced disorders)</td>
<td>20 (4.9%)</td>
<td>14 (5%)</td>
</tr>
<tr>
<td>- Personality</td>
<td>13 (3.2%)</td>
<td>12 (4.3%)</td>
</tr>
<tr>
<td>- Other (undifferentiated/multiple)</td>
<td>27 (6.6%)</td>
<td>22 (7.7%)</td>
</tr>
<tr>
<td>➢ Intellectual disability</td>
<td>29 (7.1%)</td>
<td>25 (8.8%)</td>
</tr>
<tr>
<td>- Mild/moderate</td>
<td>11 (2.7%)</td>
<td>11 (3.9%)</td>
</tr>
<tr>
<td>- Borderline</td>
<td>18 (4.4%)</td>
<td>14 (4.9%)</td>
</tr>
<tr>
<td>➢ Physical disability</td>
<td>4 (1%)</td>
<td>3 (1.1%)</td>
</tr>
<tr>
<td>➢ Sensory disability</td>
<td>3 (0.7%)</td>
<td>3 (1.1%)</td>
</tr>
</tbody>
</table>
**Care Applications made by parents on Ground C – irretrievable breakdown**

- Care Applications (n=41) made by parents on Ground C comprised 10% of all cases.
- No parents with a disability were identified (however file information is limited in these cases).

**Variation & Rescission Applications**

- Variation and Rescission Applications (n=81) comprised 20% of all cases.
- Of the DoCS applications for variation, 9 (19%) featured a parent with a disability
- No parents with a disability applied for variation of a court order
- Parents with a disability made five applications for rescission (19% of all applications for rescission); all were parents with psychiatric disability.

**Family characteristics**

**Objective 2**

To examine characteristics of families headed by parents with a disability and those without a disability in matters initiated by a DoCS Care Application.

Family characteristics are reported only for cases initiated by a DoCS Care Application due to low numbers of parents with a disability among cases initiated by other means. Cases featuring parents with physical and sensory disabilities and cases of comorbidity are excluded due to very small numbers. Cases included in the analysis are listed in bold in Table 2. Five groups were identified for statistical comparison (see below). Demographics for each group with means, standard errors and medians are presented in Table 3.

**Groups for statistical comparison:**

- **Group 1.** Parents without a disability and no mention of drug and/or alcohol use
- **Group 2.** Parents without a disability and suspected drug and/or alcohol use
- **Group 3.** Parents with psychiatric disability and no mention of drug and/or alcohol use
- **Group 4.** Parents with psychiatric disability and suspected drug and/or alcohol use
- **Group 5.** Parents with intellectual disability.

**Aboriginal and Torres Strait Islander families (ATSI) - Table 3**

- 11% of care matters featured ATSI families (n=31). There were only 3 cases featuring parents with a disability of ATSI background. ATSI families were concentrated in two groups – (1) cases involving parents without a disability (n=12, 39% of all ATSI families) and (2) cases involving parents without a disability and suspected drug &/or alcohol use (n=16, 52% of all ATSI families).

**Culturally & linguistically diverse backgrounds (CLDB) - Table 3**

- 14.4% of care matters featured CLDB families (n=41). Of these, 7 matters involved parents with a disability. Notably, almost one third of families headed by parents without a disability (Group 1) were from CLDBs.

**Number of children - Table 3**

- 469 children were subject to court proceedings initiated by a DoCS Care Application.
- Average number of children per case was 1.64 (SE = .07).
- Cases featuring parents with intellectual disability had, on average, the highest number of children subject to care proceedings (mean = 2.12), and cases featuring parents without a disability had, on average, the lowest (mean = 1.52). However, between group differences were not statistically significant.

**Age of children - Table 3**

- The average age of children was 5 years and 5 months (SE = 3.51 months). Median age was 4 years 1 month indicating that 50% of cases involved children 4 years of age or younger.
- The children of parents with a disability (groups 3-5) were significantly younger than children of parents without a disability and no mention of drug &/or alcohol use (Group 1) (F=9.475, p<.001).9

---

9 Drug and/or alcohol use was suspected in five cases. These five cases were not separated out in order to maintain a sufficient sample size for statistical comparisons.
10 Differences between groups were examined using One-Way Anova and the Bonferroni procedure for between group contrasts with an alpha level of .05.
Parents with a disability and the NSW Children’s Court

Child disability - Table 3

- 24% of all children had an identified disability or medical condition.
- The most prevalent disability types were, in descending order:
  - Developmental delay (n=36, 32%)
  - Multiple disabilities (n=10, 9%)
- ADD/ADHD (n=6, 5%)
- Psychiatric disability (n=6, 5%)
- A significant association was found between group (parental disability status) and child disability ($\chi^2 = 11.804, p<.05$). A significantly higher proportion of cases featuring parents with intellectual disability (Group 5) involved children with a disability.

Table 2: Distribution of care matters by type, applicant and parental disability status

<table>
<thead>
<tr>
<th>PARENTAL DISABILITY</th>
<th>Care applications</th>
<th>Variation applications</th>
<th>Rescission applications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DoCS</td>
<td>Other</td>
<td>DoCS</td>
</tr>
<tr>
<td></td>
<td>No. (clm %)</td>
<td>No. (clm %)</td>
<td>No. (clm %)</td>
</tr>
<tr>
<td>No disability, n=174</td>
<td>96 (34%)</td>
<td>37 (90%)</td>
<td>26 (51%)</td>
</tr>
<tr>
<td>No disability + suspected D&amp;A use, n=134</td>
<td>105 (37%)</td>
<td>4 (10%)</td>
<td>16 (31%)</td>
</tr>
<tr>
<td>Psychiatric disability, n=34</td>
<td>30 (11%)</td>
<td>0</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Psychiatric disability + suspected D&amp;A use, n=31</td>
<td>25 (8.8%)</td>
<td>0</td>
<td>3 (6%)</td>
</tr>
<tr>
<td>Intellectual disability, n=18</td>
<td>17 (6%)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric + Intellectual disabilities, n=8</td>
<td>5 (1.8%)</td>
<td>0</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Intellectual + physical disabilities, n=1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intellectual + sensory disabilities, n=1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sensory disability, n=2</td>
<td>2 (.7%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physical disability, n=2</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mother with psychiatric &amp; intellectual disabilities + Father with intellectual disability, n=1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mother with psychiatric &amp; physical disabilities + Father with physical disability, n=1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>285 (100%)</td>
<td>41 (100%)</td>
<td>51 (100%)</td>
</tr>
</tbody>
</table>

11 Cross-tabulation with Chi-square statistic was computed to determine whether the proportion of cases involving children with a disability varied across groups.
Prevalence and Family Characteristics

<table>
<thead>
<tr>
<th>Table 3: Family characteristics – DoCS initiated care applications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
</tr>
<tr>
<td>No disability</td>
</tr>
<tr>
<td>(n=96)</td>
</tr>
<tr>
<td><strong>ATSI status</strong></td>
</tr>
<tr>
<td><strong>CLDB status</strong></td>
</tr>
<tr>
<td><strong>No. of children subject to care proceedings</strong></td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Age of children</strong></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td><strong>Child disability</strong></td>
</tr>
<tr>
<td><strong>Relative Socio-Economic Disadvantage (IRSED)</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Household type</strong></td>
</tr>
<tr>
<td>- single mother</td>
</tr>
<tr>
<td>- single father</td>
</tr>
<tr>
<td>- both parents</td>
</tr>
<tr>
<td>- parent + defacto</td>
</tr>
<tr>
<td>- other</td>
</tr>
</tbody>
</table>

* NB: The median score for NSW is 1015. Low mean and median IRSED scores are indicative of greater socio-economic disadvantage.

Relative socio-economic disadvantage - Table 3
Socio-economic disadvantage was examined using the Index of Relative Socio-Economic Disadvantage (IRSED) published by the Australian Bureau of Statistics (1998). This index provides a blunt measure of relative socio-economic disadvantage for each suburb in Australia, derived from variables such as low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations. High scores occur when an area has few families on low income and few people with little training and in unskilled occupations. In NSW, the median score is 1015. This means that 50% of collection districts have a score on the IRSED below 1015.

- 70% of the families involved in care proceedings lived in suburbs with index scores falling below the median score for NSW. This finding suggests that a disproportionately large number of families involved in care proceedings live in relative socio-economic disadvantage. Differences between groups in terms of relative socio-economic disadvantage were not statistically significant.

Drug &/or alcohol use among parents with psychiatric disability
Suspected drug and/or alcohol use was noted in:
- 69.2% of cases featuring parents with emotional disorders
- 42.9% of cases featuring parents with ‘other’ psychiatric disability
- 41.7% of cases featuring parents with personality disorders
- 21.4% of cases featuring parents with psychotic disorders.

Household type - Table 3
Five household types were distinguished: single mother, single father, both parents, parent + defacto and other. There was considerable variation between groups in terms of household type.

- Most of the parents with psychiatric disability in Group 3 and most of the parents with intellectual disability in Group 5 were single mothers.

12 Chi-square could not be computed as greater than 20% of cells in the cross-tabulation had expected counts less than 5.
DoCS Decision to Initiate Care Proceedings

Contents

Background ................................................................. 16

Is the child in immediate danger? ................................. 18

Is the situation good enough for the child? .................... 19

Assessment of the child's present situation ..................... 19

Hope of effecting change and improving the child's situation ................................. 19

The relative seriousness of cases .................................. 19

The strength of the evidence ......................................... 21

Can the child's situation be improved and made good enough? ........................................ 22

DoCS presumptions about the parenting capacity of parents with a disability ........................................ 22

Parental history and/or history of DoCS involvement .................. 22

The complexity and cumulative effects of care concerns and life stressors ........................................ 23

Parental compliance ................................................... 23

Adequacy of supports and services ................................ 25

DoCS resource constraints .......................................... 28

Summary ......................................................................... 29
Objective 3

To identify the key influences on the decision by DoCS to initiate care proceedings featuring parents with a disability.

Background

In this section we present the key influences on the decision by DoCS to initiate care proceedings in cases featuring parents with a disability. The findings are based on a qualitative analysis of data from 17 focus groups with 155 DoCS personnel from 20 Community Service Centres across the Sydney Metropolitan Area. Extracts from the focus groups are used to illustrate the key points.

A range of considerations and contingencies were found to influence the decision by DoCS to initiate care proceedings. DoCS participants emphasised that the child’s safety and wellbeing is their primary consideration. This focus is reflected in the three questions which drive child protection practice. These questions are:

- Is the child in immediate danger?
- Is the situation good enough for the child?
- Can the child’s situation be improved and made good enough?

These three questions lead to two basic scenarios that result in the initiation of care proceedings (see Figure 2). In the first, there is a crisis that requires immediate child removal; the child is judged to be in immediate danger. For example, there may be reliable allegations of sexual abuse, serious physical injury or evidence of malnutrition. Once DoCS remove a child under s.60 or s.62A of the Act, a Care Application must be made within three days, s.62A (3).

The second and more commonly occurring scenario is when a child is not in immediate danger but the situation is judged to be bad enough to warrant court proceedings. In such cases there is usually a period of intervention aimed at improving the situation for the child and helping the parents to ‘get up to scratch’. This usually means getting the parents to understand what is - and what is not - acceptable care and linking families into relevant services. The decision to initiate care proceedings follows, if, despite efforts to remedy the situation, it remains not good enough for the child and is bad enough to warrant court proceedings. Often there will be an accumulation of minor concerns and a critical incident that alone seems quite trivial but is sufficient to “push you over the edge”.

Example 1: “While ever you feel you’re making progress by working informally with a family and bringing in supports and seeing improvements or working towards reaching attainable goals, you probably wouldn’t bring a matter into court unless there was a critical incident which arose which was so serious that you couldn’t go on just sitting on that on an informal basis. For example, I can think of a case where we were working with a mother with an intellectual disability, she had three small children,… one of the critical factors which arose was the district officer started to become aware that the mother was in the habit of putting the children in the bath upstairs and then coming downstairs and doing work. And they had tried to explain to her… That was the one I think that brought to light to them the seriousness of the incapacity. Which before, while they were trying to work towards getting in appropriate supports and helping her to cope and suddenly it became clear that on a day-to-day basis, these children were actually in a much greater risk in the house than had been previously realised. And she was not, didn’t seem to be capable of understanding that that was entirely inappropriate and she was not to do it anymore. And so therefore it was that sort of risk which said to the district officer, I can’t take the responsibility of having the knowledge that this is what she is in the practice of doing and running the risk of a drowning. So we had to bring it into the court system…”

Example 2: “I mean even with the … family who were notified prior to birth who had severe intellectual disability, I mean, we didn’t remove on day one. We actually had an intensive support plan. At one level, before they went to Tresillian we had somebody coming in on a daily basis to assist them and check on the child. - *So it’s not that they didn’t get a chance to prove themselves.*

*What took it over the edge?* 

*there was another notification I think. And the notification was, that’s right, how it eventually came about was, Mum rang CP (child protection) on a Friday night saying that they had no money for formula. And this was after we’d had all these supports in place, budgeting, disabilities was involved. They went out searching for formula or something, I don’t know in the end, I can’t remember. But it just pushed us over the edge basically...”
Figure 2: Overview of DoCS Decision Making Process

**Question**
Is the child in immediate danger?

**Assessment**
Yes, the child is in immediate danger

**Action**
Remove child &/or file a Care Application

**Assessment**
No, the child is not in immediate danger

**Question**
Is the situation good enough for the child?

**Assessment**
No, the situation is not good enough for the child

**Question**
Can the child’s situation be improved?

**Assessment**
No, the child’s situation is not bad enough

**Yes – the child’s situation is bad enough**

**Ongoing evaluation**
Is the child’s situation improving?

**Improving, continue intervention/evaluation**

**No - Is the child’s situation bad enough to warrant court action?**

**Yes, intervene in an effort to improve the child’s situation**

**Yes – the child’s situation is bad enough**

**Good enough, no further action**

**Improving, continue intervention/evaluation**

**No, it is not bad enough**

**Yes, it is bad enough**

**No**– Is the child’s situation bad enough to warrant court action?
Is the child in immediate danger?

When, in response to a notification, DoCS conducts an investigation and finds that there is a clear and present danger, child removal is often immediate. In other cases, the clear and present danger may not be realised early on, or may emerge only when the child’s situation deteriorates. DoCS participants defined ‘immediate danger’ by way of examples. Often children were found to be in immediate danger after notifications made by police officers or medical practitioners. The circumstances might include serious physical injuries such as spiral fractures of the vertebrae associated with ‘shaken baby syndrome’, cigarette burn marks on the child, severe domestic violence, failure to thrive, malnutrition or child abandonment. The circumstances are many and varied, but most involve incidents of child abuse and/or neglect of an extreme and usually unambiguous nature. In some cases, the immediate danger may be addressed, for example, by the perpetrator leaving or being removed from the home, or the admission of parent and child into supported accommodation. In many cases, child removal is perceived to be the only option.

Although immediate child removal is usually a response to immediate danger, DoCS workers observed another trend. Increasingly they are taking matters to court early, even when the danger does not seem immediate - “just to err on the side of caution”. In part, this trend was attributed to increasing scrutiny and criticism of child protection practice in the media. Understandably, DoCS workers do not want to be held accountable for any unforeseen tragedies. This trend could be interpreted as lowering the threshold for what is to be considered ‘immediate danger’.

In the case of mothers with a disability, for some, merely giving birth may be deemed a serious crisis warranting child removal. Several examples were given of cases where the child was removed from the mother on the maternity ward after notification by hospital staff. Several DoCS workers noted that these parents “stand out” and are therefore more likely to attract the scrutiny of maternity ward staff.

Comment
This finding raises two serious concerns:
- Maternity ward staff and DoCS workers may hold the empirically invalid and prejudicial presumption that mothers with a disability ipso facto are not capable of caring for their children. The notification and subsequent child removal are based on presumed incapacity rather than evidence that the child is at risk.
- Pre and post-natal support for parents with a disability is lacking. Appropriate pre-natal support involves planning for the future as well as preparation for pregnancy and labour. If there are legitimate care concerns, post-natal support may need to include supported accommodation for a period of time.

Example 3: “Well the hospitals generally contact us if there is a person. I mean not if the person looks like they’re doing well with the child or previous children and things are fine. But yeah if there’s a parent with a disability or a mental illness they’ll contact us. They’re certainly more obvious. Do you know what I mean?… like people are more aware of it. Does that make sense? So where the disability may not necessarily impact on the care of the kids…”

Example 4: “I mean there’s one case, a woman who was quite severely intellectually disabled, she also had mental health problems and her mum had severe mental health problems. Her mum was medicating her and mucked her medication and stuff. And she was pregnant and we can’t notify babies, unborn babies. So we had started working with the family anyway. And as far as I could see we didn’t have a legal mandate to do it, so, it was sort of like … She was a mother of wards. She had two other children taken from her almost at birth. Yeah, so we worked it as a “C” (parent) file. So she had the other baby and we knew about it and we made a plan with the hospital that when it was born we’d be down there. So we went down to pick it up, take it to court, and like in that instance there’s nothing we could do. We already knew the risks twice before. So we had to take the Care Application and remove the child as soon as it was born. But on the way out of the hospital she started to cry over the baby in the capsule. She started to cry and I asked her what was wrong and she said she’d never got to take any of her children out of the hospital. So I let her carry the capsule out to the car, she was bawling her eyes out.”
Is the situation good enough for the child?

Most investigations find that the child is not in immediate danger. However, the situation may be deemed to be not good enough for the child. A distinction has to be made between 'not good enough' and 'bad enough'. Not good enough means that the child’s situation is not ideal, maybe far from ideal, based on judgements made by individual DoCS workers. Bad enough means that the child’s situation is such that the threshold warranting child removal and/or court proceedings is crossed. The point is that DoCS workers may believe that a child’s situation is far from ideal, but this does not necessarily mean that they will initiate court proceedings. Court proceedings are likely to be initiated only when DoCS workers (1) lose hope of effecting change and improving the child’s situation, (2) when the child’s situation is assessed as relatively serious – relative to other cases being managed by the DoCS CSC at the time, and (3) when there is convincing evidence that the child is in need of care. There are four potential scenarios. These are shown in Box 2.

Assessment of the child’s present situation

The focus of assessment is on risk; the likelihood that a child may be harmed if left in their present situation. The notion of risk shapes how many DoCS workers ‘think’ about their cases. Families are often classified in terms of low, moderate and high risk. The presence of risk factors is weighed up against the presence of protective factors. For example, extended family support and adequate supervision / monitoring are viewed as mitigating circumstances which reduce the level of risk.

Hope of effecting change and improving the child’s situation

To a great extent, the judgement of whether a child’s situation is bad enough to warrant court proceedings is related to DoCS hope of effecting change and improving the situation for the child. As long as DoCS workers feel that they are making progress the situation is unlikely to be deemed bad enough to warrant court proceedings. When DoCS workers lose hope and the child’s situation is judged irredeemable, court proceedings usually, but do not always follow. This is because DoCS also considers the relative seriousness of the case and the strength of the evidence as outlined below. Much of the focus group discussion was about the factors that influence their hope of effecting change in cases featuring parents with a disability. These are discussed in detail below under the heading – Can the child’s situation be improved and made good enough?

The relative seriousness of cases

From DoCS perspective, cases have to be ‘managed’ within the constraints of finite resources. Consequently, cases are prioritised. Those perceived to be relatively serious, where the risk of harm is more immediate and the situation less amenable to change are more likely to result in court proceedings. In other

<table>
<thead>
<tr>
<th>The child’s present situation</th>
<th>Hope of effecting change</th>
<th>Relative seriousness</th>
<th>Strength of the evidence</th>
<th>Likelihood of Court Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Not good enough</td>
<td>Hopeful</td>
<td>Not serious</td>
<td>Weak</td>
<td>Very unlikely</td>
</tr>
<tr>
<td>2 Not good enough</td>
<td>Little or no hope</td>
<td>Serious</td>
<td>Strong</td>
<td>Uncertain</td>
</tr>
<tr>
<td>3 Not good enough</td>
<td>Little or no hope</td>
<td>Serious</td>
<td>Strong</td>
<td>Certain</td>
</tr>
<tr>
<td>4 Not good enough</td>
<td>Little or no hope</td>
<td>Serious</td>
<td>Strong</td>
<td>Certain</td>
</tr>
</tbody>
</table>
words, competing resource demands influence whether a child’s situation is deemed bad enough to warrant court proceedings.

Example 5: “… about the issue about going to court… I think it’s difficult to generalise across. It’s difficult to generalise across areas never mind just within an area between CSCs because the distinction often will be, are the more serious cases that exist, have they already been taken before the court? And do the staff and the Assistant Managers see that out of the number of cases that they’re able to manage at that time, is this one of the serious ones?

Resource constraints can have the effect of either decreasing or increasing the threshold - that is, how bad a child’s situation has to be before court proceedings are initiated. On the one hand, when human resources (time and skills) and the availability of support services and the money to fund family preservation initiatives are scarce, cases are more likely to be judged irredeemable and bad enough to warrant court proceedings. On the other, when suitable out-of-home placement options are scarce and the number of court days is limited, the threshold for court proceedings is driven up and relatively worse situations are tolerated.

DoCS workers observed that the limited number of foster care placements was a major disincentive to child removal as well as the known fate of removed children who had drifted from placement to placement.

See examples 6-7

The threshold for court action varies over time and between geographical areas depending on available resources and levels of demand. Therefore, families living in areas where resources are relatively scarce are particularly disadvantaged. Support services, which could reduce the need for protective intervention, are less readily available at the same time as protective intervention services are overwhelmed by their caseload. Morale among DoCS workers from the socially disadvantaged areas of Sydney was visibly low. This may be due in part to their feeling unable to substantially improve the situation of children through either casework or out-of-home placement.

Example 6: “We have nowhere to put children. We had a situation where we had to remove six children under the age of seven to one mother of 23 years of age. Removed. We had nowhere to put those children. Nowhere for babies. You can’t get a placement.

* We had the opening of this building and one of my wards went up to the Director-General and said to her ‘I don’t have anywhere to live’, her reply to that was, ‘we don’t do long term placements … we only do emergency placements’. He said ‘well I’ve been in emergency placements for two and a half years and when am I going to get a roof over my head?’ Now that boy is thirteen and I’m literally moving him day by day by day. …So why would we make them wards in the first place frankly? Because we have nothing better to offer on the other side... wards, my adolescent wards, have told me that ‘we congregate at Parramatta Park because at least we’ve got the same tree to sleep under’. So why would you make a child a ward when you have absolutely nothing to offer. I can’t even give that boy a home!

“There’s no placements. If a child’s small, maybe we can get a foster carer, you know a short, temporary, one night here one night there, it’s shocking. If a child is somewhere between the age of 10 and 15 there is no agency out there providing. The agencies, the refuge system is providing for 15 to 18 year olds, there is nowhere for 10 to 15 year olds. Nowhere. The refuges won’t take them because they are not covered by insurance for a child under 12...

“So that’s a big reason for not taking matters to court. That’s why it always has to be an incredible crisis for us to remove because we know that if we do remove, what are we gonna do with them from the day after? And I mean, we were just saying we’re not going to do much, we can’t do much. And so if there’s any possibility of working the family that’s always got to be done, and then when it gets to the crisis point where you have to take the children to remove, that’s why we still go, when we go to court, we’re still looking at restoration. You know, the second after removal, you know you do the removal and the next day you’re trying to work out how many services you’ll need in place and what sort of supports you can offer so we can get them back. Because the less time you spend in court with it the better for everyone.”
Parents with a disability and the NSW Children's Court

DoCS Decision to Initiate Care Proceedings

In some cases the input of psychiatrists and psychologists in cases featuring parents with a disability was highly influential on the course of action taken by DoCS. Assessment reports often gave them the ‘confidence’ to initiate court proceedings when the ‘evidence’ was otherwise unconvincing. For example, one DoCS worker stated “the diagnosis, this sounds terrible, the diagnosis makes it easier for us to take action in many ways”. Alternatively, professionals or others advocating on behalf of families could influence DoCS to persevere and commit resources toward family preservation initiatives. (See example 9). Reliance by DoCS workers on psychiatric and psychological assessments raises a number of serious concerns that we address in Section 8.

The strength of the evidence

The fourth influence on whether a child’s situation is deemed bad enough to warrant court proceedings is the strength of the evidence. This was a controversial point of discussion in several focus groups. Some DoCS workers spoke of being reluctant to initiate care proceedings unless they were confident that the evidence was “watertight” and the case would “get up”. These workers emphasised the need to be realistic about getting a result. They would consider, before proceeding, the time required to prepare a case, their rapport with the parents and the scrutiny they were subject to in the adversarial context of court proceedings. Many experienced care proceedings as intimidating and to be avoided if at all possible. Other participants argued that the ‘welfare’ or ‘best interests’ of the child was their only consideration and would readily risk having an application dismissed.

Example 7: “It’s like if you could take kids into care and guarantee that they’re going to have a better life then it would be less traumatic, there’s no way in the world you’re going to be able to guarantee that. And in fact we’ve got lots and lots of evidence of our own kids that we already have got, placement after placement or no placements and so that...

“It is but ultimately the children and their protection is our priority. And if we see that the child is at risk, then action needs to be taken.

“Yeah, but ... it’s at risk of what? If you’re at risk of an incident right now, that doesn’t prevent you from being at risk in foster care or at risk of having a shit life or at risk of having everything break down... Taking it to court is a part of the process. It doesn’t guarantee you anything. We all think oh we’ll go to court that’ll be the end of the problem, we’ve fixed it. All it does is mean that this crisis is passed ... we can’t guarantee what’s going to happen for the rest of their life. How do we know that if we still get over the crisis and leave them in their home, is it any worse?”

Example 8: “I’m always very comprehensive in court reports. I give them every little last bit of information they need. Like sometimes you’ll think, can we go to court? Will this get up in court ... you’re definitely thinking about will the court go for this? (DoCS AM)

“But the decision shouldn’t be based on whether the matter will get up. It should be based on the fact that we believe it is in the best interests of the child, we’ve exhausted every other option, - (DoCS officer)

“I think you still have to be realistic though. I mean we don’t... Yeah. I understand what you’re saying. But I think that we still balance you know being realistic about what amount of evidence will make a case.” (DoCS AM)

Example 9: “a really good example is a particular family that ... has known for years that is a disability family, dad is mild, mum is moderate, ... every child has a disability in the family, everyone, every single one of them, there is four kids, oldest is twelve and youngest is about five or six. The oldest one was made a ward but he was the only one that was made a ward. He was made a ward now about eighteen months ago, it was a six month wardship order, but now it has been extended. Um, and we have paid for the last three years for family support to go into that family and it started out as twelve hours a week, at the moment it is only four hours a week. But we have paid for that for the last three years to stop every one of the other kids from coming into care. Because if we don’t, we will have every one of them. Now what the hell will we do with four kids with disabilities. They will not be able to stay together, there is no way.

the only reason we ever did it (supported the family) in the beginning was because of a local doctor here,… who rang up, and said ‘I need a favour. You are involved with this family, and I know you are at the point of wanting to take the kids away because of... I know what has been happening. Please don’t do it. Please look at what else you can do because these are parents who love their kids and with support will somehow survive’. And he groveled really well. And we did it for six months and then it went for twelve months and now we have been doing it for about three years, and whilst it is certainly not cheap, even though we have decreased it, it certainly has been cheaper than having those three kids, as well as the other one as state wards and, and the disability will never go away.”
Can the child’s situation be improved and made good enough?

The judgement that the child’s situation is irredeemable can be made early in the process. In most cases however, the judgement follows after a period of intervention that fails to remedy parenting deficiencies and improve the situation for the child. Six inter-related factors influence DoCS workers’ hope of effecting change and improving the situation for the child. These are:

- DoCS presumptions about the parenting capacity of parents with a disability
- Parental history and/or history of DoCS involvement
- The complexity and cumulative effects of care concerns and life stressors
- Parental compliance
- Adequacy of supports and services
- DoCS resource limitations

We discuss each of these influences in turn accompanied by illustrative examples.

DoCS presumptions about the parenting capacity of parents with a disability

Pessimistic views about the parenting capacity of people with a disability militate against any hope of change. In particular, parents with intellectual disability were often thought unable to manage parenting. Some examples include: parents with intellectual disability need to be parented themselves; as parents they require 24 hour supervision; they are unable to put their child’s needs first; they may cope when their child is a ‘passive’ infant but not as their child grows older or, in reverse, they may cope when their child is more independent but not when they are a dependent baby.

Example 10: “In some cases we do need to be tested. But in most cases if you’re, particularly clients with disabilities, like I’ve taken several clients, the guy came from ... and his partner had had the child. They both had, I think we put evidence up there, IQ tests, they were below 80 or something you know, really, not going anywhere and they’re really hopeless. So we all knew what was gonna happen”

Example 11: “But the concern is at the stages like, so the baby’s just coming up to 13 months old. The parents have been coping really, really well with her and those basic needs and stuff at that age. But the biggest concern is as the baby starts meeting her milestones, starts walking and starts challenging her parents on that level. Like it’s a lot easier, I feel, to look after someone who’s fairly, what’s the word? Not getting around, not getting into the things ... these parents, so far are doing really really well. But if there was no community support agency... Like if Barnardos wasn’t in there and this other service that’s taking over, I mean, who knows maybe it would’ve been taken to court....they’ve got a fantastic, relationship with the Department, they ring you up if the baby coughs and stuff like that. ... this particular case doesn’t warrant court action yet, but I mean, it possibly might. And once that child starts, like gets older, but the child’s been tested as being like above average and the parents have got an intellectual disability. I mean I think that’s what’s warranting basically us having ongoing contact with the family as well on that level. Like you could look at it probably now and say that the child’s being cared for, fed, bathed, everything that should be done. But I mean as far as being the district officer who is in charge of the case, what I was recommending to my assistant manager, that’s the biggest concern of more future harm in the sense as she does grow older and does start challenging them.”

Parental history and/or history of DoCS involvement

A family’s history or the history of DoCS involvement with the family can elicit pessimism on the part of DoCS workers about the possibility of change. In such cases, newly born children may be removed and care proceedings initiated without new or additional parent support initiatives being put in place. One example of this included a family where previous children had been removed despite efforts to remedy parenting deficiencies. A second example was a parent with a substance abuse disorder who had repeatedly failed to engage with drug rehabilitation services or ‘stay off the drugs’. A third example was a parent with psychiatric disability who had a long history of mental health problems and non-compliance with medication.
Parents with a disability and the NSW Children’s Court

DoCS Decision to Initiate Care Proceedings

Example 12: “If I had someone who has got a 10 or 15 year history of fairly severe mental health problems with lots and lots of either inability to maintain medication or follow through with services, and like if I took a child in, I say, okay obviously something wrong, contact the mental health team or a psychiatrist, and they say, oh yeah, I’ve been treating her for ten years and she only comes and sees me every now and then. Then you’re gonna have to, it’s different then if you’ve got someone who’s having some episode now, you know like a post natal depression or some episode of depression, you know a mum who may have experienced a relationship breakdown or be in financial problems. So right now the things that are happening for her are isolated or looks like it’s, then you’re decision to and what you’re going to do would be greatly different.

On the first one you’re probably thinking oh well, we’re gonna call it quits, let’s get this kid into care as soon as we can. The other you’re gonna try and not to go near court for as long as you can. You’re gonna see what you can do.”

The complexity and cumulative effects of care concerns and life stressors

Several DoCS participants suggested that when parental disability is the sole concern, a case is more ‘manageable’. When there are concerns about substance abuse or domestic violence – in addition to the parent’s disability - cases become ‘unmanageable’ or ‘unacceptably high risk’. The hope of effecting change can therefore be undermined when there are other life stressors such as poverty and social isolation.

Example 13: “Because I also think, even with intellectual disability, okay the parents may have an intellectual disability but what else is happening in the home? Like is there domestic violence? Is there you know economic problems? Does that all come with intellectual disability? How does that impact on the parent’s ability to parent the kids? Because they may have an intellectual disability but that may be it. So then it’s more likely that we don’t require that much work with them because it’s sort of like only that side you have to deal with. Whereas if there’s domestic violence, you know other issues involved, then that’s obviously going to impact on how we sort of work with them as well in a different way.”

Parental compliance

From the DoCS point of view, parent insight, willingness to cooperate and to demonstrate change is the bottom line. Unless parents comply with DoCS requests, workers perceived little hope of improving the child’s situation. This led to a breakdown in the DoCS – parent relationship, which was identified as a primary reason for initiating care proceedings.

Example 14: “It’s highly likely that if the parents are willing to work with us, we’ll take it as far as we possibly can before we consider it to be not good enough parenting. You know. In terms of you know, we give em a go, we give them another go, as many goes as we can - …

*Which again brings us back to that whole thing, that circle back of compliance really doesn’t it? Because if we do all that, we say it’s not good enough and this is what we’re doing to help you do it. Then if they don’t go along with that and they’re back to their not good enough, the circle again -

*Going to court is not often always to remove it can be just to make a wake up call. So we’ve tried to put in the supports and it might just need the magistrate to say well you will accept these reports you will work with these people. And some people go okay, some don’t.”

Example 15: “You can also engage at that level. You’ve triggered the crisis within the family and then you engage and you can co-opt and you can work with the family …

*Sometimes it’s adjourned a couple of times and they will realise that we’re serious, it’s not just another lot of social work, or social welfare I should say, wankery, you know, please be good, they’ve heard that all their lives. So they often take that.”

Focus group participants identified several strategies used by parents, both overt and subtle, to resist DoCS intervention. These included:

♦ open hostility
♦ the threat of violence and/or ‘barricading the door’
♦ non-disclosure of information, ignoring DoCS requests, missing appointments, non-cooperation with support services recruited by DoCS and non-participation in assessment.
In return, DoCS workers identified the strategies they used to deal with parent behaviours. These included:

- emphasizing their role in family support and preservation
- changing the DoCS caseworker
- involving the police when parents are openly hostile
- asking parents to agree to a list of promises – informal undertakings – which may or may not be used in combination with,
- the threat of child removal and court proceedings. In practice, care proceedings are frequently used as ‘the big stick’ to coerce parents into compliance.

A commonly held view was that parental non-compliance was more often a problem with parents with psychiatric disabilities than parents with intellectual disability. Parents with psychiatric disabilities were seen as often denying their mental health problems while on the other hand parents with intellectual disability frequently welcomed DoCS workers into their homes and enjoyed their visits. Some DoCS workers attributed this openness to social isolation and others—somewhat cynically—to a lack of parental discernment.

DoCS workers identified a range of factors that influenced parental compliance. These included:

- The voluntary nature of mental health services
  Mental health services only intervene with the parent’s consent or if they are threatening to harm themselves or others. If mental health services were prepared to treat parents on an involuntary basis, it was suggested there would be greater compliance and that this would, in many instances, avert the need for child removal.

- The capacity to comply
  For some parents, particularly those with intellectual disability and occasionally psychiatric disability their incapacity to comply, not their unwillingness, was a major issue. Many parents with a disability were thought unable to comprehend what was required to meet their child’s needs. Poor role models and childhood experiences of abuse and neglect could also contribute to not understanding the problem – as DoCS perceived it - and the changes needed.

Example 17: “In relation to mental illness there are far too many kids in care where their parents have mental illness. Where the parents say there is nothing wrong with me, and the system says well we are not going to help you because you don’t think there is anything wrong. The system says they will only help people with mental illness where they’re going to harm to themselves or where they are going to be a harm to someone else, or where they voluntarily agree to treatment. So someone can have a mental illness, not be able to care for the kid and say to us, there is nothing wrong with me. And we say well sorry there is and we are going to take your kid, because the kid is at risk, the court says yes we agree the kid is at risk, we are going to take the kid, and the parent goes off merrily through life…”

Example 18: “… I mean we’ve got cases where I’d suggest the intelligence of the children far exceeds that of the parents. So we’re actually having the parents being parented by the children. And we’re talking about seven, eight, and nine year olds here. And then it becomes a fairly, I guess hard decision to try to figure out what is best in regards to the needs of the child…. But it becomes very hard if it’s a case if you’re trying to resolve an issue when there is an inability for the parents to be able to change. We can put in all sorts of supports, all sorts of educational programs and at the end of that we get a psychological assessment for the child, and under the auspices of that we can certainly I guess assess to a degree the ability of the parent to make those changes that are required. And because of the parent’s disability they are unable to make those changes, and that’s when we resort to court action.”

Example 19: “She had such an horrific childhood herself and just the chaos and it’s like she wants it to happen. She wants things to get fixed but to get it together to do that takes a lot. You know, she can’t, I don’t believe that parents in that situation can meet their own kids needs because they’ve never had their needs met themselves.”

Example 16: “It’s very hard to cooperate to work towards making changes if you don’t see the changes as being necessary. I mean it’s the old adage isn’t it. You gotta want to change. I think particularly if you’re talking about clients with mental health problems, they often have really no insight. They can be quite paranoid, so it’s you know, people are picking on me, you know, it’s just about you, you’re just picking on me, you know. And then all that gets lost, the ability to actually to see, well, okay, maybe this does need to change for the child’s safety or for the child’s wellbeing or health or whatever. So I think it’s often just not even able to see that the change is necessary.”
DoCS Decision to Initiate Care Proceedings

Example 20: “But they can’t understand because they can’t understand their own childhood. They can’t even acknowledge their own losses and the abuse and stuff, they’ll tend to idealize it or minimise it or it hasn’t affected me. So they can’t possibly understand the child’s perspective and the influence that that has.”

Example 21: “I think there are complex issues about why someone won’t (cooperate) and it’s not about I’m not going to do that. It’s more about where they’ve come from. What they are doing is what their mum and dad did to them and their sisters and brothers had done to them.”

- **Staff turnover**

Trust between DoCS workers and parents was thought to be a critical foundation for effective change. Frequent turnover of DoCS workers undermined this trust and contributed to non-compliance. Staff turnover also created a problem for DoCS workers to the extent that when they did not know parents well enough, it was difficult to discern a ‘bad day’ from what was ‘normal’ for that particular family.

Example 22: “I think there’s also another difficulty in that this Department has a huge turnover of staff. And so that clients can sometimes have one worker one week and somebody else the next week and then somebody else. So there’s not that continuity for them to develop trust and for people to get an idea of who these people are …”

- **The ambiguous role of DoCS**

The role of DoCS workers – from all perspectives – is ambiguous. There is conflict in the role of caseworker attempting on the one hand to preserve families and on the other to police and supervise families. From a family perspective it can appear that ‘evidence’ is being covertly gathered by DoCS workers behind a façade of family preservation initiatives. Naturally enough, this inhibits building a trusting relationship and serves to increase parental resistance to DoCS initiatives.

Example 23: “There’s also a definite conflict in the way we present ourselves, the Department. We go in and saying we want to help you, we want to offer you the support you can do this that and the other, here’s all the things you can do, and then the next week we take the child from them. That’s how they can perceive it.

- **The stigma that goes with being a ‘DoCS client’**

The stigma that goes with being a ‘DoCS client’, myths about the Department and the threat represented by ‘the welfare’, as well as parents’ previous experiences of DoCS - often as wards themselves- exacerbated parental non-compliance.

Example 24: “It’s also about just being fearful of the Department. The Department’s image, the myths about it, I mean it’s all that sort of thing as well I think.

*Your history with the Department if you’ve grown up as a ward. Or had the Department knocking on your door

“Yeah. Or you live in a block of flats where every second person in the block of flats is a client of the Department and they’ve been in your ear about how their children were taken.

*Or if you’ve had a baby and somebody said if you don’t look after it DOCS will take it. So from day one it’s a threat. You’ve got that, ‘I can’t let anybody see me fail. I can’t ask for help. I don’t want anybody to see that I’m not coping’. When the reality is, hey maybe with a few supports, we can make this better.”

- **Adequacy of supports and services**

Whether or not supports and services were adequate was another critical factor influencing DoCS hope of effecting change. The presence of informal support, parents’ special learning needs, involvement of mental health services, assessment of parents’ support needs, sustainability of support services and the age of the child were all taken into account.

Example 25: “… there’s nothing, there’s so few resources for people with disabilities and mental illness, they’re just the last on the rung…”

Example 26: “there’s nowhere to send DD mums and dads, … there’s no services that are there that can address the issues of someone with an intellectual disability and their parenting. I tried to find one last year, tried to find something, there was nothing available. … There was no live-in program, there was no program specifically targeted for people with an intellectual disability.”

Parents with a disability and the NSW Children’s Court
Informal supports

Extended family support or a supportive ‘non-disabled’ partner were viewed by many DoCS workers as primary ‘protective’ factors which assist in reducing care concerns. These people were seen as being able to supervise and ‘prop up’ parents and provide the children with ‘normal’ interactions. Where parents had these supports, their cases were often given low priority for services and intervention. In some cases however, family members and partners could be more of a hindrance than help, sabotaging efforts to effect change. In others, parents with a disability were socially isolated and estranged from extended family members.

Example 27: “A case that I had had a whole lot of difficulties that cover all of this because the natural mother had a developmental, some kind of developmental delay and schizophrenia. She had mental illness. And she lived with both of her parents and her mother had probably schizophrenia as well and the grandfather, I don’t know what his diagnosis was, no-one was able to diagnose him, but some kind of mental illness as well. So there was these 3 people caring for this child and initially there was the father. … there was a whole range of issues that affected these people when it finally went to court in terms of supports for this mother. There was nil at home. In fact they were, the parents, the grandparents are more of a hindrance to her than any kind of help. And the fact that she had a developmental delay and a psychiatric illness so that the resources that are set up, there’s mental health teams and there’s disability teams and they very rarely talk to each other and this woman needed help from everywhere. Initially it didn’t go to court. It didn’t go to court until the little boy was 3 because initially there was a father living there who didn’t have any of the problems. The grandfather made himself involved. He became an interested party and took over the whole thing for the mother, prevented her getting any help, prevented anyone, there was no acknowledgment of her problems at all in the family, so she was denied any kind of treatment or assistance in any way….this whole court case, she was more or less left out of it. She was just left to sit in the corner. Nobody was, nobody spoke to her. I tried for the whole year that I had this case to involve her, and the family stopped me at every possible step…. She lost her child and there wasn’t any. She didn’t receive any help. And frequently they would abuse her, the grandparents would abuse her in front of me… They blamed her, if we did anything they didn’t like, she was blamed. She was the scapegoat for the whole family.”

Special learning needs of parents with a disability

Lack of suitable services for parents with a disability was identified as a major constraint. Most services were regarded as not equipped to meet the special learning needs of parents with a disability, particularly those with intellectual disability. For example, skills learned by parents in live-in programs were often not used back in their home setting. Parents with dual diagnoses and/or multiple problems were often excluded by referral criteria. In mainstream programs, parents with a disability were considered marginalised due to their mental state or intellectual impairment, personal hygiene or general presentation. Mainstream services were also often inaccessible due to the difficulty and expense of negotiating public transport with young children.

Example 28: “My concern has always been, I’ve had a lot of, well I’ve been with the Department now for 17 years. So I’ve come across a lot of parents with either intellectual or psychiatric disabilities. My biggest concern has always been that most of those parents love their children and they wanted to be good parents. But the kinds of services that they needed to be able to achieve that, to keep them together were non-existent. We had all sorts of you know services, they can go to parenting skills, they can go to this service or the other service, and they would go. But obviously they didn’t get anything out of it because they were not services that were targeted at that particular group of people.

“And funding, I mean I’m sure that we all could think of wonderful services that could exist for people who have those types of disabilities. But there’s no funding for them. So obviously we have this high percentage of people with disabilities going before the court.”
Parents with a disability and the NSW Children’s Court

Example 29: “I was just thinking of another case where Protection Planning meetings have occurred and the family hasn’t followed up on any of our recommendations that occurred then. But then again because all the kids are about seven and they’re all attending school, we’re running with that. We’re running with the school to monitor because this is a situation where to get the mother involved in support groups and that, she presents at a support group and she presents very poorly because of her own personal poor hygiene as well as DD, and if she goes to a mother’s group or something like that, very soon she’s on the outer and the normal parents are very, the other people there are very cliquish. And because she doesn’t get any support from it then she says oh well I’m not going. And then you say, well what about going to this group? And she’s reluctant because she’s tried all the services, or she considers she’s tried all the services. Add to that not driving and having to deal with bus and train timetables, in meeting appointments, I mean that makes it very difficult for her. She has enough trouble getting the kids to school everyday and that’s when the kids travel on a special school bus that comes to her house and picks them up. But for herself it’s difficult to access services.”

Lack of involvement of mental health services

As noted above, the lack of involvement of mental health services with parents with psychiatric disability was a widespread concern. In many cases, joint case management would be welcomed by DoCS workers and in many cases could assist in resolving care concerns.

Example 30: “I mean that particular case that I’m running with at the moment, with the schizophrenic mum, you can tell those kids at some stage of their life had had very good parenting. Because they’re really top kids. So at some stage in mum’s life when she was medicated she was able to parent extremely well. And my frustration is that no one’s addressing that she’s ill and nobody’s helping her. And I think if the lady had a broken leg, you can see the turmoil she’s living with it, she walks miles and miles every day, and my anger is if she had a broken leg someone would help her. But the mental health team won’t help her unless she’s going to kill herself and she’s not going to.”

Assessment of support needs

Some DoCS workers reported difficulties in ‘tying parents down’ long enough to get comprehensive assessments of the parent’s mental state or disability. Without these, it was thought difficult to plan service interventions and effect change. Several DoCS workers acknowledged the difficulty of inferring support needs from a diagnostically related assessment, yet often this was all they had to go on. We discuss the issue of assessment further in Section 6, 7 and 8 of this report.

Sustainability of support services

Providing services for parents with a disability was frequently thought to be impractical due to lack of funding to provide intensive and ongoing services. However, the views of some DoCS workers on this matter reflect some prejudicial presumptions, such as—parents with a disability need 24 hour supervision, and services should be ‘curative’ in nature to enable parents to ‘stand alone’.

Comment

Clearly, the intensity of support required will vary from family to family and over time. Some parents will require long term support to maintain the family unit, but the support may only need to be occasional. Only a realistic and individualised assessment of parent and family needs should provide the basis for determining whether service provision is sustainable (McConnell, Llewellyn & Bye, 1997).

Example 31: “The nature of most services isn’t ongoing, very long-term. And disabilities as ... said don’t go away. So if you can put a service in, I mean, some of these families it is realistic to say they need an ongoing service and it may well be for twelve years and we can’t do funding for twelve years.

*And neither can agencies that are funded by us provide a service at the level...*

“Disability services internal to the department and external will provide a disability service from birth to death if it is required and wanted et cetera. Well not necessarily required but asked for, and accepted. But they can’t provide it at the level of intensity that families need to keep children safe. Because it needs to be on some occasions twenty four hours a day. Or large chunks of the day.

Example 32: “Some agencies, I can think of the other one where we removed the baby and came into the office that day. And mum has an intellectual disability. Dad hasn’t but he doesn’t operate at a very high level. And he’s more reactive than anything. Again the same thing, another agency was arguing that they should keep the child. In fact the agency offered the sun and the moon, I think they stopped short of the stars at the time, and literally didn’t follow through. Within two weeks they were saying oh we can’t manage them. But what they’d done is offered the parents a live-in service where they would be with them 24 hours a day, it was a religious order. They’d be with them 24 hours a day. The child would never be with either of the parents without somebody from the agency being there. It fell apart in two weeks.”
Age of the child and support required

Staff in schools, pre-schools and day care centres were often pro-actively recruited by DoCS to monitor the health and well being of the child - even though a statutory mandate exists requiring such 'services' to report evidence of child maltreatment. Enrolling children in pre-school or day care also ensured 'normal' interactions thus addressing concerns about the child's overall development. When children and their families were more closely 'supervised' in this way, child removal could often be prevented.

DoCS resource constraints

Many DoCS workers felt they were “chasing [their] tails”. They reported having little time to do the necessary casework to avert out-of-home placement and few out-of-home placement options. They generally perceived that foster care was a risky option that did not guarantee “a better life” for children.

Training

Many participants thought their level of training was inadequate for working with parents with a disability. They were often unsure about the ‘risks’, the prospects of effecting change with parents and the best way to go about it. This uncertainty led many to ‘err on the side of caution’ and initiate court proceedings.

The time available for casework and funding for services

Participants from the more socially disadvantaged areas such as Western and South-Western Sydney emphasised that there was simply no time to do ‘good’ casework. For many, this meant that many ‘otherwise redeemable’ cases resulted in wardship orders. Another strong complaint was that funding was often not available or accessible to support family preservation initiatives. In stark contrast, DoCS workers from the more prosperous areas of Sydney talked enthusiastically about their opportunities to do casework.

Knowledge about disability is very, very minimal. On the whole you’d find that the number of people within the Child and Family area who know a lot about disability and a lot about the effects of disability, whether it’s an intellectual disability or any other form of disability, but particularly if it’s an intellectual disability, the level of experience is pretty well zip. And if you look at how does somebody’s assessment of that level of ability of somebody who has an intellectual disability and how does that impact upon their parenting capacity, gee you know, it’s wide open. The amount of knowledge that people have about that you could put into a thimble and, you know, it’s an area of expertise that we’ve really got to develop especially when it has such a major impact upon children.” (DoCS AM)

Example 34: “... the level of expertise of the various people who are responsible for instituting court proceedings differs. The level of training of the people who are involved in the day to day handling and the case work itself differs... Their experience and their exposure and their
Example 36: “...I’ve noticed talking with people that work in other areas of the State that what makes a difference as well, is ... the workload the different offices have - I mean one of the luxuries that we have at ... is that... we can actually do family work with them ... whereas other offices don’t necessarily have the resources or the time or, I mean I think with some workers and some offices part of it is also a mindset a bit as well but, yeah.”

Summary

Three questions underpin child protection practice:

1. Is the child in immediate danger?
2. Is the situation good enough for the child?
3. Can the child’s situation be improved and made good enough?

These three questions lead to two scenarios resulting in Court proceedings:

- Scenario 1: There is a crisis that requires immediate child removal; the child is deemed to be in immediate danger.
- Scenario 2: The child is not in immediate danger however the situation is bad enough to warrant court proceedings.

The following conditions influence whether a child’s situation is judged to be bad enough to warrant court proceedings:

- The assessment of risk
- The relative seriousness of the case
- The strength of the evidence
- Hope of effecting change.

Whether DoCS think they can effect change is influenced by:

- DoCS presumptions about the parenting capacity of parents with a disability
- Parental history and/or history of involvement with DoCS
- The complexity and cumulative effects of care concerns and life stressors
- Parental compliance
- Adequacy of supports and services
- DoCS resource constraints
DoCS Care and Protection Concerns

Contents

Background ................................................................. 32
s.60 / s.62A removal ............................................................ 32
Grounds of application ..................................................... 32
Notifications ..................................................................... 33
History of child removal ................................................... 33
Present concerns ............................................................. 36
Objective 4

To identify potential differences in DoCS care and protection concerns about families headed by parents with a disability compared to concerns about families headed by non-disabled parents.

Background

A Care Application must specify the grounds on which it is alleged that the child is in need of care, s.57 (2). The various grounds are set out under s.10 (1-3) of the Act. The grounds most often cited are under s.10 (1) of the Act.

(A) adequate provision is not being made, or is likely not to be made, for the child’s care;

(B) the child is being, or is likely to be, abused; or

(C) there is a substantially and presently irretrievable breakdown in the relationship between the child and one or more of the child’s parents.

A DoCS Care Application is usually accompanied by an initiating affidavit which typically lists:

- the DoCS worker’s qualifications and experience
- brief details of any previous notifications in regard to the family
- the basis of present concerns which are listed to justify the Care Application
- any action taken by DoCS to remove a child under s.60 or s.62A of the Act.

The Court relies primarily on this information to determine ‘establishment’, that is, whether a child was ‘in need of care’ at the time of the application.

Information contained in the applications and initiating affidavits of the 285 cases initiated by a DoCS Care Application was analysed and statistical comparisons by parent group made on each of the following variables:

1. The action of DoCS to remove a child under s.60/s.62A of the Act.
2. The grounds of the Care Application
3. Number of past notifications/ confirmed and unconfirmed
4. History – whether previous children have been removed
5. Present concerns – number and type

Table 4 lists the descriptive statistics by variable and parent group. Profiles 1 and 2 provide a brief narrative description of the most common concerns in cases involving parents with intellectual disability and psychiatric disability respectively.

s.60 / s.62A removal - Table 4

In 88.2% of DoCS initiated cases, DoCS had removed the subject child or children under s.60 or s.62A of the Act prior to application. This occurred more frequently in cases involving parents with psychiatric and intellectual disability but whether this association was statistically significant could not be determined due to the high incidence across all groups.

Grounds of application - Table 4

- 87.7% of Care Applications were made by DoCS on grounds A, B or A and B. The analysis of group differences was therefore limited to these cases (n=239).
- Using cross-tabulation with chi-square statistic, a statistically significant association was found between parental disability status as represented in Groups 1-5, and the grounds of the DoCS Care Application ($\chi^2 = 23.63, p<.005$).
- Grounds A&B were disproportionally represented in applications concerning families headed by parents with psychiatric (Groups 3 & 4) or intellectual disability (Group 5).
- A disproportionately large number of applications concerning parents without a disability (Group 1) were made on ground B only.
- A disproportionate number of applications concerning parents with suspected D&A use (Group 2) were made on Ground A only.
Table 4: Care and protection concerns

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<tbody>
<tr>
<td>- A</td>
<td>27 (28.1%)</td>
<td>48 (45.7%)</td>
<td>8 (26.7%)</td>
<td>8 (32%)</td>
<td>4 (23.5%)</td>
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<tr>
<td>- B</td>
<td>22 (22.9%)</td>
<td>5 (4.8%)</td>
<td>5 (16.7%)</td>
<td>5 (20%)</td>
<td>2 (11.8%)</td>
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<tr>
<td>- A&amp;B</td>
<td>26 (27.1%)</td>
<td>42 (40%)</td>
<td>16 (53.3%)</td>
<td>12 (48%)</td>
<td>9 (52.9%)</td>
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Notifications [mean & (SE)]

| - Confirmed           | 2.47 (.24)             | 3.32 (.31)                              | 2.6 (.38)                     | 4.04 (.59)                                      | 3.25 (.73)                     |
| - Unconfirmed         | .42 (.14)              | .75 (.22)                               | .34 (.17)                     | .52 (.27)                                       | .19 (.10)                      |
| - Total               | 2.9 (.27)              | 4.08 (.40)                              | 2.9 (.42)                     | 4.52 (.66)                                      | 4.47 (1.24)                   |

Previous child removed

|                  | 11 (11.5%)             | 20 (19%)                                | 6 (20%)                       | 4 (16%)                                         | 4 (23.5%)                     |

The 5 most common concerns:

- Alleged or history of abuse (32.3%)
- Child not wanted (19.4%)
- Substantiated harm (18.3%)
- Domestic violence (18.3%)
- Child’s expressed wishes/fears (16.1%)
- D&A use (76.9%)
- Domestic Violence (33.7%)
- Resistance to DoCS (32.7%)
- Transience/inappropriate housing (25.8%)
- History of DoCS involvement (24%)
- Mental state (71%)
- Disability/medical condition (48.4%)
- Transience/inappropriate housing (25.8%)
- Resistance to DoCS (25.8%)
- Alleged or history of abuse (25.8%)

s60/62A removal

|                  | 83.2%                  | 89.5%                                   | 93.3%                         | 92%                                             | 94.1%                         |

Notifications - Table 4

The initiating affidavit often includes confirmed and unconfirmed notifications.

- The average number of confirmed notifications was 2.99 (SE = .16)
- The average number of unconfirmed notifications was .55 (SE = .10)
- Total average number of prior notifications was 3.59 (SE = .21)
- Group differences in the mean number of confirmed and unconfirmed notifications were not statistically significant

History of child removal - Table 4

In 45 cases (15.8%), the parents had previously had one or more children removed. A cross-tabulation was computed to examine the distribution of these cases across the five groups. Inspection of the cross-tabulation (see Table 4) showed that approximately twice as many parents with a disability (Groups 3-5) compared to parents without a disability (Group 1) had children previously removed.

See profiles 1 and 2 on the following pages.

---

13 Analysis of between group differences was performed using ANOVA with Bonferroni contrasts.
14 Chi-square could not be computed as greater than 20% of cells had expected counts less than 5.
Profile 1

‘Care Profile’

Parents with intellectual disability

The concerns documented by DoCS workers in their initiating affidavits were wide ranging as shown in Tables 5-13. However, four basic themes were evident. Firstly, incidents of abuse (physical, sexual or emotional) and actual physical harm were relatively rare. The concerns of the Department most often related to inadequate provision – or more specifically, neglect by omission. Several DoCS officers suggested that these were “the saddest cases of all”; “in their own mind, in their world, they dearly love the child and they’re doing the best they can with what they’ve got… and that’s true…but it’s not good enough for that kid”. Concerns were often expressed in general terms as the parent’s [usually mother’s] “inability to properly care for” the child. For example, concerns relating to home safety were common, such as the failure to constantly watch a child in the bath, or keep a child away from a hot stove. In other cases concerns were expressed about a child’s developmental delay and the parent’s capacity to provide adequate stimulation to meet their needs. In some instances the child’s developmental delay was implicitly, if not explicitly attributed to the parent’s failure to adequately ‘stimulate’. The allegation that these parents divested their responsibility for the care of their child/ren to others, such as a grandparent, was also a feature in some cases.

The second theme relates to the parent’s personal competence in managing their own affairs. One of the most common concerns reported was ‘poor housekeeping’, or rather, the unhygienic state of the home environment. DoCS workers report their own observations of ‘foul smelling’ and ‘cluttered’ homes, and dirty nappies left “strewn” on the floor for days. Concerns about the parent’s capacity to manage their own finances were also reported in several cases. Parent requests for monetary assistance to help with purchasing food and clothing were documented as evidence of poor money management. The third aspect of personal competence related to personal relationships, or more specifically the parent’s poor choice of partners. Particular concerns reported included the parent’s “string of defacto partners” and “choice of violent partners”. These concerns were documented as evidence of both risk to the child/ren and of the parent’s inter-personal incompetence.

The third theme relates to insight, cooperation and the capacity to change or adapt to future needs. Parents with an intellectual disability are often portrayed as ‘lacking insight’ into the needs of their child/ren, and into their own problems. As one DoCS worker expressed it, the parent “fails to understand the Department’s concerns”. In several cases these parents were reported to be uncooperative with both DoCS and support services, that is, they cancelled or failed to attend appointments, or, less often, they were openly hostile. The parent’s capacity to learn, make changes and adapt to the child’s developing needs was also often questioned. DoCS workers reported that support services had failed to make positive changes, sometimes attributing this to lack of cooperation and in other instances to the parent’s cognitive limitations.

The fourth theme concerned the parent’s emotional state. Several parents were observed to be suffering emotional problems that compounded their difficulties and resulted in a general inability to cope. These emotional problems were identified as the reason why, in a couple of cases, parents were willing to place their children voluntarily into alternative care.
Profile 2

‘Care profile’

Parents with psychiatric disability

Presumed risk to the child emanating from the parent’s psychiatric disability underpins the majority of the care concerns documented by DoCS workers in their affidavits. Three themes dominate: (1) the parent’s mental state, (2) unstable living conditions, and (3) noncompliance.

In families in which a parent has a psychiatric disability, the concerns of the Department frequently refer broadly to the parent’s (usually mother’s) “mental state” that is observed to be “deteriorating”. Substantiated concerns of harm to the child are uncommon. It is the potential for harm, either physical and/or psychological, that is the issue. The concern is about the possible risk of the parent being “physically violent” towards the child and/or the child’s “exposure to emotional abuse”. It is the “unpredictability” or the “instability” associated with the parent’s mental state that is of concern and underpins the perceived risk to the child. In addition, there is also the perceived risk of the child “being drawn into the parent’s disturbed thinking patterns”. DoCS workers support their concerns by reporting the appearance of “delusions” and/or “threats of self harm” and by documenting when the parent is hospitalised. On a number of occasions other service agencies, particularly mental health services, express concerns about the risk to the child and notify the Department as they schedule the parent.

Stressful living conditions, the second theme, are perceived to exacerbate or are exacerbated by the parent’s mental state. Homelessness, a “transient lifestyle”, “unstable housing” and domestic violence are common corollaries and all potentially contribute to the parent “not coping” and becoming “distressed”. Many Departmental concerns state that the parent simply is not coping. Sometimes, these concerns are reflected in the parent’s request for respite or in the parent’s hospitalisation.

Noncompliance is the third predominant theme. A common concern raised by DoCS officers is the parent’s non-compliance with treatment and medication. Not complying with any treatment that attempts to manage the parent’s deteriorating mental state is perceived to increase the unpredictability and therefore the possible risk of harm to the child. In addition, the parent’s “lack of insight” into their own illness and their “poor insight” into the “impact of [their] mental state on the children’s stability” contribute to their noncompliance. The parent’s willingness or ability to control their mental state is seen as an important method of reducing the potential risk of harm to the child. Thus, their resistance to receiving any treatment or service frequently becomes the primary risk factor.
**Present concerns**

A content analysis of the present concerns listed in the initiating affidavits was conducted using a 50 item coding framework (Appendix 3) developed for this purpose from an initial review of a sample of affidavits. A second researcher independently coded a random sample of 20 initiating affidavits using the framework to permit the analysis of inter-rater reliability. This was found to be high with a consistency rate of 96.5%. The frequency in which each present concern was listed for each group of cases is shown in Tables 5-13. Between group differences on each of the 50 present concerns were examined to determine whether they were statistically significant.

- Overall, the most common concerns in descending order were:
  - suspected D&A use (38.1%)
  - alleged or history of abuse (27.8%)
  - resistance to DoCS intervention (26.3%)
  - domestic violence (25.9%)
  - the parent’s mental state (24.4%).

Table 5: Assessment of parents

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases No disability and suspected D&amp;A use</th>
<th>% cases Psychiatric disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>% cases Intellectual disability</th>
<th>χ²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental State</td>
<td>24.4%</td>
<td>14%</td>
<td>12.5%</td>
<td>71%</td>
<td>60%</td>
<td>17.6%</td>
<td>67.42,</td>
<td>p&lt;.00001</td>
</tr>
<tr>
<td>Drug/Alcohol use</td>
<td>38.1%</td>
<td>0</td>
<td>76.9%</td>
<td>0</td>
<td>52%</td>
<td>11.8%</td>
<td>153.44,</td>
<td>p&lt;.00001</td>
</tr>
<tr>
<td>Disability/medical condition</td>
<td>10.7%</td>
<td>1.1%</td>
<td>1.9%</td>
<td>48.4%</td>
<td>28%</td>
<td>23.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent/s or carers not coping</td>
<td>10.4%</td>
<td>15.1%</td>
<td>5.8%</td>
<td>12.9%</td>
<td>8%</td>
<td>11.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad temper/anger control</td>
<td>2.6%</td>
<td>0</td>
<td>2.9%</td>
<td>6.5%</td>
<td>4%</td>
<td>5.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal history/behaviour</td>
<td>4.1%</td>
<td>2.2%</td>
<td>6.7%</td>
<td>3.2%</td>
<td>4%</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning capacity</td>
<td>0.4%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 lists the 5 most common concerns for each parent group. The results of group comparisons on each of the 50 items using chi-square analyses are reported in Tables 5-13.

**Summary of key findings of group comparisons on present concerns**

- Concerns about a parent’s mental state are significantly associated with parental psychiatric disability (Groups 3 & 4)
- Concerns about transience or inappropriate housing are most strongly associated with parental psychiatric disability and/or suspected D&A use (Groups 2, 3 & 4)
- Concerns about domestic violence are significantly associated with suspected parental D&A use (Groups 2 & 4)
- Resistance to DoCS intervention is significantly associated with suspected D&A use and parental intellectual disability (Groups 2, 4 & 5).

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15 Cross-tabulation and chi-square statistic was computed to examine group differences. Valid results are shown in tables 5-13, that is, where less than 20% of cells had expected counts of less than 5.
### Table 6: Assessment of child

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases Psychiatric disability</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child has special needs</td>
<td>12.2%</td>
<td>8.6%</td>
<td>12.5%</td>
<td>9.7%</td>
<td>8%</td>
</tr>
<tr>
<td>Child orphaned wishes/fears</td>
<td>0.7%</td>
<td>2.2%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Child's expressed</td>
<td>10.7%</td>
<td>16.1%</td>
<td>9.6%</td>
<td>3.2%</td>
<td>8%</td>
</tr>
<tr>
<td>Vulnerable age of child</td>
<td>4.8%</td>
<td>3.2%</td>
<td>4.8%</td>
<td>9.7%</td>
<td>4%</td>
</tr>
<tr>
<td>Child behaviour</td>
<td>6.7%</td>
<td>12.9%</td>
<td>2.9%</td>
<td>3.2%</td>
<td>8%</td>
</tr>
</tbody>
</table>

### Table 7: Aspects of the family's social system

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases Psychiatric disability</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transience / inappropriate housing</td>
<td>18.5%</td>
<td>9.7%</td>
<td>26%</td>
<td>25.8%</td>
<td>16%</td>
</tr>
<tr>
<td>Keeping bad company</td>
<td>1.5%</td>
<td>1.1%</td>
<td>2.9%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Money management / debt</td>
<td>5.2%</td>
<td>5.4%</td>
<td>6.7%</td>
<td>0</td>
<td>8%</td>
</tr>
<tr>
<td>Prostitution or multiple</td>
<td>1.9%</td>
<td>0</td>
<td>2.9%</td>
<td>0</td>
<td>4%</td>
</tr>
<tr>
<td>Lack of support / social isolation</td>
<td>3.7%</td>
<td>2.2%</td>
<td>3.8%</td>
<td>6.5%</td>
<td>4%</td>
</tr>
<tr>
<td>Aggressive &amp; threatening member</td>
<td>8.5%</td>
<td>5.4%</td>
<td>10.6%</td>
<td>9.7%</td>
<td>16%</td>
</tr>
</tbody>
</table>

### Table 8: Aspects of marital/defacto relationship

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases Psychiatric disability</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysfunctional relationships</td>
<td>6.7%</td>
<td>6.5%</td>
<td>6.7%</td>
<td>6.5%</td>
<td>12%</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>25.9%</td>
<td>18.3%</td>
<td>33.7%</td>
<td>16.1%</td>
<td>40%</td>
</tr>
</tbody>
</table>
### Table 9: Parent’s lack of cooperation

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases No disability and suspected D&amp;A use</th>
<th>% cases Psychiatric disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to access support services or excessive access</td>
<td>9.3%</td>
<td>7.5%</td>
<td>9.6%</td>
<td>12.9%</td>
<td>8%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td>Non-compliance with medication/treatment</td>
<td>5.9%</td>
<td>1.1%</td>
<td>2.9%</td>
<td>22.6%</td>
<td>16%</td>
<td>5.9%</td>
<td></td>
</tr>
<tr>
<td>Resistant to DoCS intervention</td>
<td>26.3%</td>
<td>14%</td>
<td>32.7%</td>
<td>25.8%</td>
<td>36%</td>
<td>41.2%</td>
<td>12.6 p &lt; .05</td>
</tr>
<tr>
<td>Missing appointments</td>
<td>4.1%</td>
<td>4.3%</td>
<td>1%</td>
<td>9.7%</td>
<td>12%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Lacks insight / denies problem</td>
<td>17%</td>
<td>14%</td>
<td>14.4%</td>
<td>19.4%</td>
<td>20%</td>
<td>41.2%</td>
<td>8.40 p = .08</td>
</tr>
</tbody>
</table>

### Table 10: Severity of abuse

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases No disability and suspected D&amp;A use</th>
<th>% cases Psychiatric disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alleged or history of abuse</td>
<td>27.8%</td>
<td>32.3%</td>
<td>23.1%</td>
<td>25.8%</td>
<td>40%</td>
<td>17.6%</td>
<td>4.87 p = .30</td>
</tr>
<tr>
<td>Substantiated physical harm</td>
<td>15.9%</td>
<td>18.3%</td>
<td>14.4%</td>
<td>12.9%</td>
<td>12%</td>
<td>23.5%</td>
<td>1.79 p = .77</td>
</tr>
<tr>
<td>Alleged emotional abuse/ neglect</td>
<td>9.6%</td>
<td>7.5%</td>
<td>8.7%</td>
<td>9.7%</td>
<td>16%</td>
<td>17.6%</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse (substantiated or not)</td>
<td>8.9%</td>
<td>14%</td>
<td>4.8%</td>
<td>6.5%</td>
<td>12%</td>
<td>5.9%</td>
<td></td>
</tr>
</tbody>
</table>

### Table 11: History

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases No disability and suspected D&amp;A use</th>
<th>% cases Psychiatric disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>% cases Intellectual disability</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of services to resolve problems</td>
<td>5.6%</td>
<td>5.4%</td>
<td>3.8%</td>
<td>6.5%</td>
<td>8%</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td>History of DoCS involvement</td>
<td>22.2%</td>
<td>16.1%</td>
<td>24%</td>
<td>19.4%</td>
<td>32%</td>
<td>35.3%</td>
<td>5.41 p = .25</td>
</tr>
<tr>
<td>Previous death of a child</td>
<td>1.5%</td>
<td>0</td>
<td>1.9%</td>
<td>3.2%</td>
<td>4%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Concerns expressed by health professionals</td>
<td>7.8%</td>
<td>3.2%</td>
<td>4.8%</td>
<td>19.4%</td>
<td>12%</td>
<td>23.5%</td>
<td></td>
</tr>
</tbody>
</table>
### Table 12: Aspects of parenting

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate provision – nutritional needs</td>
<td>4.1%</td>
<td>5.4%</td>
<td>11.8%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Chaotic lifestyle/ Disorganised family routine</td>
<td>4.8%</td>
<td>4.3%</td>
<td>5.8%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Inadequate provision – Clothing</td>
<td>3%</td>
<td>2.2%</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>Housekeeping/unsafe physical environment</td>
<td>6.3%</td>
<td>4.3%</td>
<td>4.8%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Inadequate provision – personal hygiene</td>
<td>2.6%</td>
<td>3.2%</td>
<td>1.9%</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate Provision – School attendance</td>
<td>3.7%</td>
<td>3.2%</td>
<td>2.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Inadequate provision – Stimulation</td>
<td>1.9%</td>
<td>1.1%</td>
<td>1%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Poor parenting skills/parenting capacity</td>
<td>8.5%</td>
<td>3.2%</td>
<td>4.8%</td>
<td>9.7%</td>
</tr>
<tr>
<td>General neglect</td>
<td>14.1%</td>
<td>11.8%</td>
<td>17.3%</td>
<td>16.1%</td>
</tr>
<tr>
<td>Unable to protect child</td>
<td>4.4%</td>
<td>6.5%</td>
<td>2.9%</td>
<td>0</td>
</tr>
<tr>
<td>Unrealistic expectations of child</td>
<td>2.2%</td>
<td>4.3%</td>
<td>1%</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate provision – Supervision</td>
<td>11.9%</td>
<td>7.5%</td>
<td>16.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Inadequate provision – Seeking medical attention</td>
<td>8.1%</td>
<td>7.5%</td>
<td>9.6%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Reliance on others to care for child</td>
<td>3.7%</td>
<td>3.2%</td>
<td>2.9%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

### Table 13: Parent-child relationship

<table>
<thead>
<tr>
<th>Concern</th>
<th>% of cases</th>
<th>% cases No disability</th>
<th>% cases Psychiatric disability and suspected D&amp;A use</th>
<th>χ², p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment/ bonding</td>
<td>3.3%</td>
<td>4.3%</td>
<td>1.9%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Child is presently not wanted in the home</td>
<td>11.9%</td>
<td>19.4%</td>
<td>7.7%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Child abandoned or failure to maintain contact</td>
<td>9.3%</td>
<td>10.8%</td>
<td>13.5%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>
Categories of concerns

The 50 items were grouped into the seven categories of the Dalgleish model (Dalgleish & Drew, 1989) used by DoCS workers to guide risk assessment. Two additional categories, History and Parent-child relationship, were developed by the researchers. The nine categories and their associated ‘present concerns’ are shown in Tables 5-13.

The sum of present concerns was computed to obtain a category score. Group differences in the mean number of concerns in each category were examined using One-Way Anova with Bonferroni contrasts.

Category 1: Assessment of parents – Table 5
- Group differences in relation to the mean number of present concerns was significant (F=24.32, p<.0001)
- At an alpha level of .05, there were significantly more concerns on average in cases featuring parents with psychiatric disability (Group 3) and cases featuring parents with suspected D&A use (Group 2) in comparison to cases involving parents without a disability (Group 1)
- There were also significantly more concerns on average in cases featuring parents with psychiatric disability (Group 3) compared to cases featuring parents with intellectual disability (Group 5).

Category 2: Assessment of child – Table 6
There were no significant differences between groups.

Category 3: Aspects of the family’s social system – Table 7
- Differences between groups in the mean number of concerns were significant (F=3.08, p<.05)
- There were significantly more concerns in cases featuring parents with suspected D&A use (Group 2) than in cases featuring parents without a disability (Group 1) at an alpha level of p<.05.

Category 4: Aspects of the marital/defacto relationship – Table 8
Variation in the mean number of concerns across groups was found to be significant (F=2.77, p<.05) however no two groups could be distinguished using the Bonferroni procedure.

Category 5: Parent’s lack of cooperation – Table 9
- Group differences were found to be significant (F=4.33, p<.01)
- There were, on average, significantly more concerns relating to ‘lack of cooperation’ in cases involving parents with psychiatric disability (Group 3) in comparison to cases involving parents without a disability (Group 1).

Category 6: Severity of abuse – Table 10
There was no significant difference between groups.

Category 7: History – Table 11
- Differences across groups in the mean number of concerns about history were significant (F=2.98, p<.05). However, no two groups could be distinguished using the Bonferroni procedure.

Category 8: Aspects of parenting – Table 12
- Group differences were found to be significant (F=4.74, p<.01)
- There were, on average, significantly more concerns about aspects of parenting in cases featuring parents with intellectual disability (Group 5) in comparison to all other groups (Groups 1, 2, 3 & 4).

Category 9: The parent-child relationship – Table 13
There were no significant differences between groups.
THE OUTCOMES OF CARE PROCEEDINGS

Contents

Background .............................................................. 42
Outcomes of care matters initiated by a
DoCS Application .................................................. 42
  Grounds of establishment ....................................... 42
  Court orders ........................................................ 43
  Order length ....................................................... 43
  Placement type .................................................... 43
Parental disability and court outcomes ...................... 43
  Parental disability and type of orders ....................... 49
  Parental disability and order length ......................... 49
  Parental disability and placement type ..................... 49
Summary ..................................................................... 50
Objective 5

To obtain data on court outcomes for parents with a disability and their children and to determine whether these differ significantly from court outcomes for families headed by non-disabled parents.

Background

Once a care matter is established and the evidence concerning placement is heard, a magistrate can make one or more orders outlined under s.72 of the Act. Different orders can be made for different children subject to any care matter. More than one order can be made pertaining to any one child. A magistrate can make an order:

- accepting undertakings in writing from the parent/s (or persons responsible for the child) and/or the child, remaining in force for any period specified, s.72 (1) (b).
- placing a child under the supervision of the Director-General, DoCS, s.72 (1) (c) (i). This order is often made in combination with undertakings.
- placing the child in the custody of a person deemed suitable by the court, with or without supervision and/or undertakings, s.72 (1) (c) (ii).
- declaring the child to be a ward under the Act, s.72 (1) (c) (iii). A wardship order can apply until the child attains the age of 18 years, or for any specified period short of that.

In this section, the outcomes of care matters initiated by a DoCS Care Application are presented. The outcomes examined include grounds of establishment, order type, order length and placement type. A statistically significant association was found between parental disability and court outcomes. Notably, a disproportionately large number of children of parents with intellectual disability were made state wards and placed out-of-home in foster or residential care. By contrast, outcomes for children of parents with psychiatric disability were the least extreme—as long as there was no mention of drug and/or alcohol use.

Outcomes of care matters initiated by a DoCS Care Application

Between group comparisons were made to determine whether the outcomes of care matters initiated by a DoCS Care Application were statistically associated with parental disability. Outcomes were examined by child, as there were cases in which different orders were made for different children subject to the same care proceeding. No other group comparisons could be made due to the low prevalence of parents with a disability in care matters initiated by a variation or recission application or by parties other than DoCS. Cases involving parents with physical, sensory or multiple disabilities were excluded from the analysis of group differences due to their low prevalence.

Grounds of establishment – Table 14

- Data on grounds of establishment were only collected in cases involving parents with a disability. Grounds of establishment (A: inadequate provision; B: abuse; C: irretrievable breakdown) in descending order were:
  - Ground A: 64.4%
  - Grounds A&B: 16.4%
  - Ground B: 13.7%
  - Ground C: 5.5%

Statistical comparisons between parent groups (Groups 3-5) could not be made due to the low prevalence of cases established on any ground other than Ground A. Inspection of Table 14 shows that a higher proportion of cases involving parents with intellectual disability resulted in establishment on Ground A (73.3%) compared to cases involving parents with psychiatric disability (65.4%) and cases involving parents with psychiatric disability and suspected D&A use (59.1%).

Appendix 4 lists outcomes for children involved in all other cases reviewed, including those initiated by a Care Application made by a party other than DoCS or by an application for variation or recission of a court order. A list of outcomes for all 622 children involved in the 407 cases reviewed is also given.
### Table 14: Establishment

<table>
<thead>
<tr>
<th>Grounds of establishment</th>
<th>Group 3 Psychiatric disability</th>
<th>Group 4 Psychiatric disability and suspected D&amp;A use</th>
<th>Group 5 Intellectual disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Inadequate provision</td>
<td>17 (65.4%)</td>
<td>13 (59.1%)</td>
<td>11 (73.3%)</td>
</tr>
<tr>
<td>B: Abuse</td>
<td>6 (23.1%)</td>
<td>3 (13.6%)</td>
<td>1</td>
</tr>
<tr>
<td>C: Irretrievable breakdown</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>A &amp; B</td>
<td>2</td>
<td>6 (27.3%)</td>
<td>2</td>
</tr>
</tbody>
</table>

**Court orders**

Of the 469 children subject to care proceedings initiated by a DoCS Care Application:
- 192 children (40.9%) were subject to wardship orders +/- any other order
- 134 children (28.6%) were subject to supervision orders &/or undertakings
- 120 children (25.6%) were subject to custody orders +/- any lesser order
- 21 children (4.5%) were involved in care matters that were withdrawn
- 2 children were involved in care matters that resulted in the application being dismissed.

**Order length**

Of the 446 children involved in care matters initiated by a DoCS Care Application that did not result in either withdrawal or dismissal:
- 258 children (58%) were subject to short term orders of 2 years duration or less
- 157 children (35%) were subject to long term orders, that is, until the child attains the age of 16/18 years
- 31 children (7%) were subject to medium term orders of greater than 2 years duration but short of the child attaining the age of 16 years.

**Placement type**

Of the 446 children involved in care matters initiated by a DoCS Care Application that did not result in either withdrawal or dismissal:
- 164 children (37%) were placed home with a parent or parents.
- 161 children (36%) were placed out-of-home with extended family
- 110 children (25%) were placed out-of-home with non-family, including:
  - 85 (19%) placed with foster carers
  - 10 (2%) placed in a residential care facility
  - 15 (3%) placed with a parent or parents in a supported accommodation setting or with a family friend.
- The placement of 11 children (2%) was still undetermined when the case was finalised and orders made.

**Parental disability and court outcomes**

Table 15 shows the number and percentage of children in each of the five groups subject to each outcome type. For visual comparison, these findings are also presented in Graphs 1-9 on the following pages.
Graph 1: Wardship orders

Graph 2: Custody orders
Graph 3: Supervision orders and/or Undertakings

Graph 4: Long term orders
Graph 5: Medium term orders

Graph 6: Short term orders
Graph 7: Out-of-home placement - non-family

Graph 8: Out-of-home placement - extended family
Graph 9: Home placement

Table 15: Court outcomes by parental disability – DoCS Care Applications

<table>
<thead>
<tr>
<th>Parental Disability</th>
<th>No disability &amp; suspected D&amp;A use</th>
<th>Psychiatric disability &amp; suspected D&amp;A use</th>
<th>Psychiatric &amp; Intellectual disability</th>
<th>Sensory disability</th>
<th>Physical disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wardship +/- any other order</td>
<td>48 (33.8%)</td>
<td>18 (32.7%)</td>
<td>19 (43.2%)</td>
<td>20 (55.6%)</td>
<td>4 (44.4%)</td>
</tr>
<tr>
<td>Custody +/- any lesser order</td>
<td>35 (24.6%)</td>
<td>8 (14.5%)</td>
<td>15 (34.1%)</td>
<td>4 (11.1%)</td>
<td>4 (44.4%)</td>
</tr>
<tr>
<td>Supervision/ undertakings</td>
<td>48 (33.8%)</td>
<td>25 (45.5%)</td>
<td>10 (22.7%)</td>
<td>12 (33.3%)</td>
<td>0</td>
</tr>
<tr>
<td>Long term</td>
<td>54 (38%)</td>
<td>7 (12.7%)</td>
<td>15 (34.1%)</td>
<td>12 (33.3%)</td>
<td>6 (66.7%)</td>
</tr>
<tr>
<td>Medium term</td>
<td>8 (5.6%)</td>
<td>6 (10.9%)</td>
<td>4 (9.1%)</td>
<td>9 (25%)</td>
<td>0</td>
</tr>
<tr>
<td>Short term</td>
<td>69 (48.6%)</td>
<td>38 (69.1%)</td>
<td>25 (56.8%)</td>
<td>15 (41.7%)</td>
<td>2 (22.2%)</td>
</tr>
<tr>
<td>out-of-home placement non-family</td>
<td>33 (23.2%)</td>
<td>15 (27.3%)</td>
<td>6 (13.6%)</td>
<td>16 (44.4%)</td>
<td>0</td>
</tr>
<tr>
<td>out-of-home placement extended-family</td>
<td>33 (23.2%)</td>
<td>8 (14.5%)</td>
<td>23 (52.3%)</td>
<td>6 (16.7%)</td>
<td>7 (77.8%)</td>
</tr>
<tr>
<td>Home placement</td>
<td>57 (40.1%)</td>
<td>26 (47.3%)</td>
<td>15 (34.1%)</td>
<td>14 (38.9%)</td>
<td>1</td>
</tr>
</tbody>
</table>

Parents with a disability and the NSW Children's Court
**Parental disability and type of orders**

There was a statistically significant association between parental disability and type of court order ($\chi^2=22.6, p<.005$):  

- **Wardship orders** were found to be most strongly associated with *parental intellectual disability* (Group 5), and to a lesser extent, suspected parental D&A use (Group 2). Children of parents with intellectual disability, in particular, were subject to a disproportionately large number of wardship orders.

- **Custody orders** were found to be most strongly associated with parents with suspected D&A use. Children in Group 2 (suspected D&A use) were subject to a disproportionately large number of custody orders, as were children in Group 4 (parental psychiatric disability and suspected D&A use).

- **Supervision orders and/or undertakings** were found to be most strongly associated with the absence of suspected parental D&A use. Children of parents with psychiatric disability (Group 3) were subject to a disproportionately large number of supervision orders and/or undertakings, as were children of parents without a disability (Group 1).

**Parental disability and order length**

There was a highly significant statistical association between parental disability and length of order ($\chi^2=35.8, p<.001$):  

- **Short-term orders** were found to be most strongly associated with *parental psychiatric disability*, and to a lesser extent, suspected D&A use. Children of parents with psychiatric disability (Group 3) were subject to a disproportionately large number of short-term orders, as were children of parents with suspected D&A use (Group 2).

**Parental disability and placement type**

There was a highly significant statistical association between parental disability and type of placement ($\chi^2=33.7, p<.001$):  

- **Out-of-home placement with non-family**, for example, in foster care, was found to be most strongly associated with the absence of parental psychiatric disability. Children of parents with intellectual disability (Group 5), in particular, were subject to a disproportionate number of placements out-of-home with non-family. Children of parents without a disability (Group 1) and children of parents with suspected D&A use (Group 2) were also subject to a disproportionate number of placements out-of-home with non-family, but only marginally so.

- **Out-of-home placement with extended family** was found to be most strongly associated with suspected parental D&A use. Children of parents with suspected D&A use (Group 2) were subject to a disproportionate number of placements with extended family members, as were children of parents with psychiatric disability and suspected D&A use.

- **Placement of children home with parent/s** was found to be most strongly associated with the absence of suspicion about D&A use. Children of parents with psychiatric disability and no mention of D&A use (Group 3) were subject to a disproportionate number of placements home with their parents, as were children of parents without a disability (Group 1).

---

17 A 5 x 3 (group by court order) cross-tabulation with Chi-square statistic was computed  
18 A 5 x 3 (group by order length) cross-tabulation with Chi-square statistic was computed
Summary

The trend apparent in the findings on order type, length and placement type is that court outcomes are strongly associated with perceptions of ‘how redeemable’ the situation is, which in turn, is strongly associated with parental disability status. To summarize the evidence:

- Children of parents with a psychiatric disability are more often subject to less intrusive orders such as supervision orders of short-term duration with children placed back home. This is consistent with the view that care concerns can usually be resolved with appropriate medication.

- Children of parents without a disability and of parents with suspected D&A use were disproportionately subject to long-term orders. This finding is consistent with an absence of readily available ‘quick-fix’ solutions for these families.

- In general the more intrusive outcomes were found to be most strongly associated with suspected D&A use and the absence of psychiatric disability. D&A use, it seems, is perceived to be particularly difficult to remedy. These parents were also found to be more resistant to DoCS intervention (see Section 4) and more often contested both establishment and placement (see Section 6).

- Outcomes for children of parents with suspected D&A use however were quite varied, for example, suspected parental D&A use was also associated with short-term orders. This variability may be attributed to the heterogeneity of this group.

- Children of parents with intellectual disability were more often made wards, subject to a higher frequency of medium term orders and placed out-of-home with non-family. These outcomes more closely resembled those for children of parents with suspected D&A use than those for children of parents with psychiatric disability. This finding along with information presented in Section 7 suggests that the Court is generally pessimistic about the capacity of parents with intellectual disability to overcome the parenting deficiencies perceived by DoCS workers.
THE PROCESS OF CARE PROCEEDINGS

Contents

Background ............................................................... 52
   Court appearances, duration of proceedings and magistrates .......... 52
   Interim orders ........................................................................ 52
   Court environment ....................................................................... 54
   Legal representation .................................................................... 54
   Evidence ...................................................................................... 56
   The two stages of care proceedings .............................................. 58
   The nature of care proceedings as a process of law ....................... 58
   Negotiating and crafting an outcome .......................................... 60
   The legislative framework for determining outcomes ..................... 62

Summary .................................................................................... 63
Objective 6
To describe and analyse the court process.

Background

In this section, the Court process is described and relevant Court statistics presented. The discussion focuses on care proceedings initiated by a DoCS Care Application. The findings are derived from all sources of data including interviews and focus groups with magistrates, legal representatives and DoCS workers, data gleaned from court files and courtroom observations. The following aspects of court proceedings are described:

- Appearances, duration and magistrates
- Interim orders
- Court environment
- Legal representation
- Evidence
- The two stages of care proceedings
- The nature of care proceedings as a process of law
- The process of negotiation
- The legislative framework for determining outcomes

The basic steps in the court process are shown in Figure 3.

Court appearances, duration of proceedings and magistrates

When any application is made to the Court, the matter is listed for mention. Under s.58 (1A), court proceedings must commence within 8 days of a Care Application. At the first mention the magistrate decides how the matter will proceed. Usually all parties will seek an adjournment and this will be granted to enable the legal representatives to take instructions and file evidence.

A care matter may be adjourned several times. The average number of Court appearances in care matters initiated by a DoCS Care Application was 6.46 (SE = 0.2).

Inspection of Table 16 shows that cases involving parents suspected of D&A use (with or without psychiatric disability) had the highest mean number of Court appearances. Using one-way Anova, group differences were examined and found to approach significance (F=2.29, p=. 06).

Care proceedings must not be adjourned for a period or for periods in the aggregate, exceeding 42 days except where it is “impracticable” to finalise the proceedings within that period, s.76 (2b). On average, care matters initiated by a DoCS Care Application were adjourned for an aggregate of 140.6 days (SE = 5.33). Only 10.2% of care matters were finalised within 42 days.

Inspection of Table 16 shows that cases involving parents with psychiatric disability and suspected D&A use were the longest in duration taking, on average, 181 days to be finalised. Group differences were examined using one-way Anova and were found to be statistically significant (F=2.62, p<.05). Using the Bonferroni procedure, cases involving parents with psychiatric disability and suspected D&A use were found to be significantly longer in duration than cases involving parents without a disability. No other significant differences were found.

During the 9-month period of this study, the number of magistrates involved in any one case ranged from 1 to 8, with an average of 3 magistrates per care matter. Magistrate Syme, sitting at Campsie Children’s Court finalised 51% of all the care matters in the total sample. Magistrates Longley and Huber finalised another 26% of the sample of care matters. The remaining care matters in the sample were finalised by other specialist Children’s magistrates (9%) and non-specialist magistrates (14%).

Interim orders

When care proceedings are adjourned, the magistrate can make a range of interim orders for the care of a child under s.77 of the Act. If at the time of mention, a child is not in the care of the Director-General, the Court can refuse to make an order; it can order that written undertakings be accepted from the child and/or the person responsible for the child; or it may make an order placing the child in the care of the Director-General.

If on the other hand, a child has been removed by DoCS under s.60 or s.62A of the Act, the Court may make an order discharging a child from the care of the Director-General unconditionally; or it may do so accepting undertakings as above; or it may make an order that the child continue in the care of the
Figure 3: Overview of children’s court proceedings
(Source: Interagency Guidelines for Child Protection Intervention, 1997)

Applications to the Children’s Court, child in need of care
Affidavit/Statement of Fact

Adjournment for 1-2 weeks for Department of Community Services
to file evidence
Interim Orders made

Consent to Application /Orders?

Yes

Adjournment – Respondent to file
Pre-hearing Conference

Hearing

Case established with findings made
that child in need of care?

Yes

Adjournment for Assessment Report
Section 74

Consent to Recommendations?

Yes

Application Dismissed

No

Adjournment – respondent to file
evidence
Hearing

Order made in relation to child (Section 72)
The Process of Care Proceedings

In addition to these potential interim orders, the magistrate may make an order granting or prohibiting access with the child, either unconditionally or subject to conditions such as supervision. A range of provisions is specified in the Act to guide magistrates’ decision making. These are specified below under the legislative framework for determining outcomes.

**Court environment**

Mentions are brief. On any list day a magistrate may hear dozens of mentions. All parties appearing in the proceedings must wait at the Court until their name is called, as there is no appointment system. Often children are excused after the first mention, and do not appear at Court a second time. Court staff attempt to minimise the discomfort of the Court environment for children by listing matters in which they are appearing for mention as early as possible in the day.

One legal representative referred to the Court environment as “the cauldron” where you can observe the fears and frustrations of parents brewing. Parents with psychiatric or intellectual disability were identified as being particularly disadvantaged by having to wait in crowds of anxious/angry people. The tension created undermines their mental state and subsequently effects their presentation in Court.

**Table 16: Court statistics by parent group**

<table>
<thead>
<tr>
<th>Parent group</th>
<th>Group 1 No disability</th>
<th>Group 2 No disability &amp; suspected D&amp;A use</th>
<th>Group 3 Psychiatric disability</th>
<th>Group 4 Psychiatric disability &amp; suspected D&amp;A use</th>
<th>Group 5 Intellectual disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of court appearances</td>
<td>- Mean 5.86</td>
<td>6.85</td>
<td>5.97</td>
<td>7.8</td>
<td>5.88</td>
</tr>
<tr>
<td>- std error .33</td>
<td>.38</td>
<td>.6</td>
<td>.6</td>
<td>.67</td>
<td></td>
</tr>
<tr>
<td>- median 5</td>
<td>6</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Duration (days)</td>
<td>- Mean 121.66</td>
<td>148.04</td>
<td>129.97</td>
<td>180.68</td>
<td>144.06</td>
</tr>
<tr>
<td>- std error 8.52</td>
<td>9.34</td>
<td>17.33</td>
<td>14.88</td>
<td>21.95</td>
<td></td>
</tr>
<tr>
<td>- median 107</td>
<td>123</td>
<td>104</td>
<td>175</td>
<td>101</td>
<td></td>
</tr>
<tr>
<td>Established by consent</td>
<td>94.4%</td>
<td>94%</td>
<td>89.7%</td>
<td>96%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Finalised by consent</td>
<td>91%</td>
<td>84.2%</td>
<td>96.6%</td>
<td>68%</td>
<td>94.1%</td>
</tr>
<tr>
<td>Finalised by pre hearing conference</td>
<td>10.1%</td>
<td>9.9%</td>
<td>17.2%</td>
<td>8%</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Example 1: “They (the magistrates) see these people at their worst because of the stress of the proceedings. The facilities here are dreadful, and that only aggravates it. Very, very often, um, you may have seen this yourself in the Court, um, you’ve got a person with a mental illness waiting in a crowded waiting room with, with a lot of other people who are very stressed… they’ll have to wait three and four and five hours at a time every four weeks, in circumstances where there’s nothing to do but sit and stew. There’s no mystery to me why there are fights between people, why when people get into Court, they are so pumped up by the atmosphere in the waiting area, that they react in extraordinary ways. They blow their stack, they scream at the magistrate. The listing process aggravates their presentation, and it’s just the dreadful resources that we’re faced with… Let people stew here in the in the cauldron of the waiting room and of course they go in and blow their stack. Dreadful. I mean, it is simply, quite simply a need for further magistrates and a better listing process. Developmentally disabled people, ... people with a mental illness are particularly disadvantaged by that.” (Legal representative)

Legal representation

Under s.65 of the Act, DoCS officers (as delegates of the Director-General) and the child/ children and parents (or persons responsible for the child/ children), have the right to legal representation and to appear in person. Any other person who in the
Parents with a disability and the NSW Children’s Court

The opinion of the Court has a genuine concern for the welfare of the child may be party to proceedings and be legally represented.

DoCS employs several lawyers to act for the Director-General in care matters. When these lawyers are not available, DoCS contracts a private solicitor. Parents are usually represented by ‘duty’ (rostered) lawyers whom they meet on the day of their first Court appearance. At Campsie Children’s Court, parents (or persons responsible for the child) are represented by Legal Aid lawyers and private lawyers funded by Legal Aid represent children. At Cobham Children’s Court, private lawyers represent parents and are remunerated for their services by Legal Aid and a solicitor employed by the Children’s Legal Service (CLS), also funded by Legal Aid represents children. This solicitor is assisted/instructed by a social worker employed by the CLS for this purpose.

Many lawyers feel ill-equipped in terms of both training and time to adequately represent parents with a disability. Parents with a disability require significantly more one-to-one time which is almost impossible to achieve given the limitations of Legal Aid funding and heavy caseloads. There was substantial agreement among the lawyers interviewed that:

- it is very difficult to determine whether parents with psychiatric or intellectual disability understand the nature of care proceedings
- it is very difficult to obtain ‘reliable’ instructions when it is unclear how much the parent understands about the Court process
- ‘evidence’ cannot be thoroughly scrutinised if parents are unable to independently review this material as is often the case for parents with intellectual disability
- it is very difficult to explain legal strategy to parents with psychiatric or intellectual disability in ways they can understand and accept
- it is most unsatisfactory having to rely on reports from designated ‘experts’ contracted by DoCS for information about the significance of the parent’s disability in determining realistic goals
- legal training is not adequate for the task of representing parents with psychiatric or intellectual disability

Many DoCS officers shared these concerns. One of the most common concerns is that parents with a disability rarely understand what is happening in the courtroom and what they are agreeing to. Ironically, it is often left to the DoCS worker who has initiated the Care Application to explain the process and what is in their ‘evidence’. Example 2 provides a typical discussion from one of the focus groups with DoCS workers.

Example 2: “*But also you wonder how much the parent understands ... In that case that I was talking about ... this solicitor, I mean the mother would come up in the Court and say, what did she say? She didn't understand one word. *

*... parents walk out and not even know what the outcome was.

*They don't know anything because they (legal representatives) don't speak to them in the language that the client would understand.

*... even when they come (to Court) we say this is your right. Speak to your solicitor. And we're not really supposed to be doing that but we do. And you sort of like letting them know that well if you want that well then you have to talk to your solicitor about that. So in that way we have a lot of power and people can misuse that you know. And even like after the Court you know with some of my cases I'd say, did you understand what happened? And like you know if I was like I could misuse that so badly it wanted to but you don't. You say, well this is what we're proposing -

“Well I can think of that case ... It dragged out till nine months after myself and one of the other workers removed the baby. Went for nine months. At the end of the nine months literally what happened was the child was made a ward till 18, she (the mother) stood up, everybody else stood up, the magistrate walked out, we turned and walked out the door, her solicitor, she walked out the door and sat on the front steps of the Court. Her solicitor walked straight passed her out down the street, got in the car and drove off. And she sat there on the steps not knowing what had happened. And the solicitor said nothing to her. We walked out had to explain it to her and she got upset. She thought that's what had happened but she got upset. So then we had to talk to her, give her some money and drive her into the city so she could go home.

*I mean I think to be fair that's a real Legal Aid funding issue. And the fact is that those solicitors, they're duty solicitors, they have 15 cases or 10 cases in a day, have no idea what any of them are about until they arrive in the morning -

“They don't have time to really work out, even for supposedly normal parents, to work out what they want and what’s going on or who they see the situation or whatever. And then with a parent with a disability, you know, you need double time.” (DoCS worker)
Evidence

Evidence filed by DoCS

In care proceedings, DoCS voice is dominant. Care matters proceed and decisions are made based on the ‘evidence’ before the Court. Most of the evidence – in some cases all of it, is prepared by DoCS. In the initiating affidavit, the DoCS worker informs the Court of past notifications, present concerns and the grounds on which it is alleged that the child is in need of care. In update reports, the DoCS officer details events or developments that have occurred in the interim. In the s.74 or placement report, the DoCS officer informs the Court of the pros and cons of placement options and makes a recommendation.

Expert opinion

Other reports filed include those from designated experts (such as psychiatrists and psychologists) and affidavits prepared by service providers such as general practitioners and family support workers. Great weight is given to expert evidence, which is more or less routinely sought in care proceedings involving parents with a disability. Predominantly psychiatrists and psychologists are briefed and paid by DoCS either as employees or as contracted professionals. Parents’ legal representatives may seek a grant-in-aid from Legal Aid for an independent expert assessment report, however these are limited to $360. As one legal representative put it – “what you get is $360 worth of report”.

Prevalence of expert reports

Data on expert reports were gathered for cases involving parents with a disability only.

- In 85% of cases featuring parents with a disability at least one psychological and/or psychiatric assessment report was filed.

- One or more psychological reports were filed in 62 cases (62.6%) and one or more psychiatric reports were filed in 53 cases (53.5%).

- ‘Independent’ psychologists paid by DoCS submitted 64 psychological reports. Psychiatrists employed by DoCS submitted a total of 31 reports. Legal representatives acting for parents obtained independent expert reports in just two cases.

- Psychologists’ reports appeared most frequently in cases featuring parents with intellectual disability (in 83.3% of cases).

- Psychiatric reports were obtained most frequently in cases featuring parents with psychiatric disability and suspected D&A use (in 76.6% of cases).

Subjects of psychological assessments – Table 17

- Parents were most frequently subjects of psychological assessment followed by parents and children together.

- Children were the subjects of a higher proportion of assessments conducted by DoCS’ psychologists.

These findings show a tendency of the Court to rely on DoCS psychologists for assessment of children and on ‘independent’ psychologists for assessment of parents.

Reason for request for assessment report – Table 18

The ‘expert’ in their report did not always indicate the reason for referral; when indicated it was coded for analysis.

- Most common reason: assessment of ‘parenting capacity’ and parent ‘cognitive’ assessment

- Psychological assessment of children was also a common reason for referral.

Assessment tools used

- Psychologists used interviews in all assessments.

- Psychometric assessment of the parent’s intelligence (IQ) was most common.
  - DoCS psychologists assessed parent IQ in five cases (21% of their assessments)
  - Independent psychologists contracted by DoCS assessed parent IQ in 20 cases (44% of their assessments)
  - Parent IQ was assessed in one of the two assessments conducted by psychologists contracted by Legal Aid.

The most common assessment tools used were:

- Adult intelligence tests (n=26)
- Child intelligence tests (n=10)
- Achenbach Child Behaviour Checklist (n=10)
- Bene-Anthony Family Relations Test (n=8)
- Vineland Adaptive Behaviour Scales (n=7)
- Parenting Stress Index (n=5)
- Coping Scale for Adults (n=5)
### Table 17: The subjects of expert assessment by psychologists

<table>
<thead>
<tr>
<th>Subject of Assessment</th>
<th>Independent Psychologist - contracted by DoCS</th>
<th>Independent Psychologist - contracted by Legal Aid</th>
<th>DoCS Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/s only</td>
<td>34</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Child/ren only</td>
<td>5</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Parent/s and child/ren</td>
<td>13</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Parent/s + child/ren + other</td>
<td>9</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Child/ren + other</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Parent/s + other</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Table 18: Reason given for referral and assessment

<table>
<thead>
<tr>
<th>Reason for Referral and Assessment</th>
<th>Independent Psychologist - contracted by DoCS</th>
<th>Independent Psychologist - contracted by Legal Aid</th>
<th>DoCS Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>None given</td>
<td>21</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Parenting capacity</td>
<td>7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cognitive assessment</td>
<td>4</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Parenting capacity + cognitive assessment</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Psychological assessment and parenting</td>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Assessment of child and parenting</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Assessment of child</td>
<td>4</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Bonding and parenting capacity</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Bonding and assessment of child</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Placement options</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Progress update</td>
<td>4</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Parents submitted an affidavit in only 48 (48.5%) of the 99 cases featuring parents with a disability. Parents submitting an affidavit by disability were:

- 5 (28%) parents with intellectual disability
- 15 (44%) parents with psychiatric disability
- 17 (56.7%) parents with psychiatric disability and suspected D&A use.

The two stages of care proceedings

Court proceedings initiated by Care Applications are conducted in two stages. Stage 1 is referred to as ‘establishment’. Establishment is the process through which the Court determines whether a child is “in need of care”. The question is not whether a child is currently in need of care, but rather, whether the child was in need of care at the time of application, s.72 (3a). Furthermore, the test is objective in the sense that agency, that is, the person responsible, is irrelevant - there need be no attribution of blame.

In the second stage there is a process of ‘placement’ through which the Court determines what order/s are made and where children are placed. If parents, children or significant others appearing in care proceedings contest establishment or the placement recommendations of DoCS, the care matter will be listed for hearing. Although the Court must establish that a child is in need of care prior to determining placement, a recent decision of Justice Hodgson of the NSW Supreme Court (1998) upheld the practice of ‘hearing’ establishment and placement simultaneously.

The nature of care proceedings as a process of law

The NSW Supreme Court has established that care proceedings are, as a process of law, adversarial in nature (Talbott vs Minister for Community Services, 1993). However, care proceedings have no parallel in criminal or civil jurisdictions and are somewhat ambiguous in nature. There are characteristics of adversarial and ‘inquisitorial’ processes of law present. In practice, care proceedings may be more or less adversarial depending on the personalities involved and the circumstances of the case.

Adversarial aspects of care proceedings

The physical setting of the Children’s Court is the same for both care and criminal proceedings with the magistrate seated at a raised bench facing the Court. The authority invested by the State in the magistrate is signified by the Coat of Arms hanging on the wall above his/her head. The legal representative for DoCS assumes the seat of the DPP public prosecutor in criminal proceedings. The inner circle - those most proximal to the magistrate – are the legal representatives, seated in high back chairs behind tables and close to the microphones where their voices are magnified and recorded. DoCS’ officers usually sit beside their legal representative. In the outer circle parents and children are seated behind their representatives in open (no table/desk) low back chairs. Other persons (including the researcher) with an interest in the proceedings and permission to observe are seated still further towards the back of the Court. The exception to this arrangement is when parents or significant others are representing themselves in the proceedings.

As in other adversarial proceedings, formality governs how and when evidence is filed. Evidence must be submitted in affidavit form. Further, the magistrates have introduced the practice of setting final dates for the servicing of document evidence and notification of witnesses prior to hearing. After this date, submissions may not be accepted and hearings proceed on the basis of the evidence filed. These ‘rules’ are designed to give all parties the opportunity to review submissions prior to hearing and to expedite the Court process. In practice, these ‘rules’ are subject to the discretion of magistrates. Often magistrates will accept late submissions because the welfare of a child is at stake.

The adversarial nature of care proceedings is also reflected in how evidence is documented. Parties select what information they document and the ‘spin’ put on this as they ‘mount their case’. Several DoCS workers acknowledged that information about parent strengths was often excluded from affidavit evidence. This was necessary in order to “play the game” by not giving anything to “the parent’s legal representative to fight you with”.

Example 3: “And I think unconsciously you tend to play down the parent’s strengths because you’re trying to sort of create a case that defends the child’s rights so you tend to play down the strengths of the parents, which you might have really known are there and unconsciously you sort of don’t want to highlight it.” (DoCS worker)
The approaches adopted by the various parties influence how adversarial the proceedings become. The metaphors used by magistrates, lawyers and DoCS workers are illustrative. The court process, particularly placement, was described as a “real fight”, legal representatives as “going into bat for...” their clients, and a strong case as “a lay down mozaire”. Several DoCS workers attributed the “regrettably adversarial” nature of care proceedings to the influence of the lawyers working at the Courts.

Example 4: “But see I actually think that putting a case to the Court that’s very one sided doesn’t do our cause justice at all. I feel that if you’re writing a proper report, if you’ve got a balance at what, I mean, most people have some strengths. And we’ve got risk factors. But you mean you’re looking at that case bringing it, justifying why you’ve come to this recommendation. So I mean to my way of thinking in the Court, if you’re saying there’s nothing, I mean, basically, no in the way you’re presenting it I mean. I mean I think then you’re coming across as not fair in the way you handle the case...
* But it’s like playing a game where you’re playing fair and they’re cheating. You lose.”
(DoCS worker)

Example 5: “It’s not about us saying how bad these people are. It’s like to try and look for the positives and focus on it and try and say, well what can we, how do we manage the situation? But when we go to Court we can’t do that because the adversarial process says that if we start arguing about, well what are the positive strengths of these people? Then the solicitors are gonna pick up on that and, you know, we’re all on the same side. So we have to then start arguing about how unable are these people to do things? And so you start putting up psych reports saying oh you know, they’ve got an IQ of you know whatever. I just had an example recently where a woman who I’d never thought about her capacity to, in terms of the intellect, it was more about the behavioural stuff, you know, what can she do? What does she want? But we ended up having a psych assessment. So the psychologist had to give the report and then start saying you know they’ve got this IQ and start talking about it. And I could the person sitting in the chair going, oh, you know? Like, she knew she was never top of the class, but it didn’t matter in terms of what we were doing with her. But once she’d been through that process, she got a very strong (message) that she was stupid, you know, that she was dull.”
(Assistant Manager, DoCS)

Example 6: “No, the one’s [solicitors] that over the years have dominated [the] Children’s Court, that have represented children or parents over the years, have changed the Children’s Court. I mean it was set up as a Court of inquiry and formal Court, many, many years ago, and it ran a bit more informally then... they just changed the culture of the [Court], more than in the legislation. They turned it into a much more adversarial system over the years.”
(DoCS worker)

Example 7: “…it’s a game, for them (legal reps) it’s a win and lose game and they’ll say and do whatever they can to win their case, regardless of what the issues are... But that’s their job, they’re doing their job. They’re not child protection workers or district officers, they’re lawyers. Fighting for a person’s right to be heard.”
(Assistant Manager, DoCS)

The lawyers argued that the approach they adopted varied depending on the circumstances of the case and the ‘style’ of the magistrate presiding. Some magistrates were more judicial or ‘hands-off’, whilst others were more interventionist, conducting their own inquiry and generally directing the care proceedings. The lawyers also adapt their approach according to DoCS expressed aims. For example, if DoCS preference is to return the child to the parent’s care – albeit under certain conditions – the parent’s solicitor may adopt a more conciliatory approach. If DoCS is seeking long term wardship and the lawyer feels their clients are being ‘hard done by’, their approach will be more adversarial. A barrier here is that DoCS rarely formulates recommendations early in proceedings as they wait to see whether the parent becomes more cooperative and what the ‘expert’ psychiatrists and psychologists conclude.

Often the ‘evidence’ documented in parent affidavits is also constrained by legal imperative, that is, by what parents must do to have their child/ren returned to their care. There is a widespread belief that parents have to demonstrate ‘insight’ and a willingness to cooperate. Consequently, many parent affidavits are limited to a proclamation of love for the child, the parent’s version of critical incidents, an acknowledgement of difficulties and their intent to work willingly with support services – including DoCS. What parents would often like to say about ‘the problem’ and DoCS intervention is deemed at best irrelevant to care proceedings and at worst detrimental to their case.
**Inquisitorial aspects of care proceedings**

As a matter of law, care proceedings may be adversarial but clearly not in the same sense as criminal proceedings, s.70 (2). Several provisions in the Act imply an inquisitorial process. When a Care Application is made, the Act states that “the Children’s Court shall inquire into the matter”, s.72 (1). In conducting this inquiry, the Act implies under s.70 (4) an interventionist role for the magistracy who may examine and cross-examine any witness for the purpose of eliciting relevant information. Our observation is that the extent of inquiry depends on which magistrate is presiding.

S.70 (1) of the Act states that care proceedings will be conducted with as little formality and legal technicality as the circumstances of the case permits. Parties remaining seated when making submissions; absence of gown and wig and lack of strict turn-taking protocols assist in this process.

The dominant role of DoCS implies a presumption of objectivity that is inconsistent with an adversarial process of law. As noted above, DoCS is the primary and often the sole contributor of evidence. Even ‘independent’ expert assessment reports are usually paid for by DoCS. Furthermore, under s.74 of the Act there is a specific designation of responsibility to the Director-General (DoCS) to tender to the Children’s Court an assessment report that provides “such advice as is appropriate to enable the Children’s Court to make an appropriate order in relation to the child”, s.74 (2). In the words of one magistrate “…in many ways the section 74 report, a good one, which is well written, well argued… a good section 74 report is almost a magistrate’s judgement…” DoCS also determine whether there are funds available to support family preservation initiatives in each individual case. As one solicitor put it, “DoCS holds the purse strings”. The Court has no capacity to determine whether DoCS has the resources required for appropriate service intervention or the manner in which resources or services are distributed. In short, DoCS defines both the current situation and the future possibilities for the Court.

In care proceedings there is an absence of natural justice/due process safeguards structured into criminal proceedings. The standard of proof is lesser than the ‘beyond reasonable doubt’ standard applied in criminal proceedings. The Act states that an order cannot be made in respect of a child unless the Children’s Court is satisfied that it “is very highly probable” that the child is in need of care, s.70 (2). Nor is the Children’s Court bound by the rules of evidence, s.70 (3). The magistrate may consider any submissions; in practice it appears that all submissions are accepted with the magistrate deciding what weight to give this evidence. Legal representatives have no legal basis on which to challenge hearsay or prejudicial evidence that may impress upon a magistrate’s decision-making.

**Negotiating and crafting an outcome**

Most care matters are resolved without recourse to a hearing. Through a process of negotiation and compromise mutually acceptable outcomes are crafted. The Children’s Court acts as arbiter by bringing both DoCS and parents to the ‘negotiating table’. When establishment or placement is contested the process is viewed by many to have failed. The frequency of cases established or finalised by consent are shown in Table 16.

- Almost all care matters (93.7%) were established by consent.
- Greater than 90% of cases were established by consent in each group with the exception of cases featuring parents with psychiatric disability.
- The vast majority of cases (86%) were finalised by consent without recourse to a formal hearing.
- ‘Placement’ was most often contested in cases featuring parents with suspected D&A use and those featuring parents with psychiatric disability and suspected D&A use.

What takes place in the Courtroom is just “the tip of the iceberg”. The negotiation process is mostly informal, occurring between the respective lawyers outside the Courtroom. The pre-hearing conferences instigated at Campsie and Cobham Children’s Courts are formal venues for negotiation. In practice, these are often a final attempt to arrive at a mutually acceptable resolution when informal negotiations between the parties have failed.

- Approximately 26% of cases were listed for hearing. Of these, approximately 40% were resolved in pre-hearing conferences. The 40% resolved through pre-hearing conferences constituted 10.3% of all care matters initiated by a DoCS Care Application. Statistical comparisons between groups could not be made due to the small number of cases in which establishment and/or placement was contested.
The Process of Care Proceedings

- Inspection of Table 16 shows that resolution through pre-hearing conferences is most common in cases involving parents with psychiatric disability and least common in cases involving parents with intellectual disability.

DoCS workers often felt excluded from this process of “negotiating and bargaining” in the “clubby culture” of the Children’s Court. Their concern was that children and their best interests got lost in this process.

Example 8: “...even though it’s not the large pretentious Court building or the Court room. It is still very much a formal arrangement with you know that formal layout, formal processes, unknown processes, often unknown to us even when we’re in and out of the Court. Like there’s a clique. That’s the way it functions that clique sits there and they know what’s going on. And even we don’t always know what’s going on and so the clients I would say are almost totally disempowered. Even clients of fully functioning intelligence whatever.

* It’s such a closed thing. ... when they have one magistrate sitting there and then they have the same solicitor representing the children time after time after time and the same duty solicitors representing parents, everyone knows what the game is and no one upsetting it ... everyone knows the routine. Come in, you say this, you say that, out you go, we all know what. There’s a clique. That’s the way it functions that clique sits there and they know what’s going on. And even we don’t always know what’s going on and so the clients I would say are almost totally disempowered. Even clients of fully functioning intelligence whatever.

The process of negotiation may be conducted through mediation, through vigorous advocacy or in combination. The quote below provides an example of how parent lawyers use mediation to achieve a mutually acceptable resolution.

Example 9: “Your clients too they all hate district officers. And they all say they treat them badly, they swear at them, there’s a lot of language and so often I will then intervene and say, well look talk to me and I’ll talk to the district officer and I will then be able to go and relay my client’s concerns in perhaps a little bit different language to the district officer. And you know again I can get the district officer’s feedback and go back and say this and say well look this is the situation, we’ve got this problem, the district officer wants to help, you know we can do this, this and this. And I mean you never know how much good you do. But at the end of the day I think it is good. Because you’re an objective person... I mean everyone I keep saying to them, we’re all working for the child... we’re all working towards the same end. You know you might be having some little conflict here but everyone is trying to do the best for the child. That’s what I try and do.” (Legal representative)

Vigorous advocacy by parent lawyers on the other hand involves different strategies and is aimed at creating tension and putting pressure on DoCS to compromise, for example:

- making a case that DoCS has not done all it can to support the family
- presenting feasible options such as identifying potential formal and/or informal supports for the parents
- identifying errors and/or weaknesses in DoCS evidence, and providing feasible alternative explanations for critical incidents
- intimidating DoCS officers directly
- raising doubt about the experience, qualifications or expert status of those giving evidence.

Many DoCS workers described how they had experienced the process of negotiation when parent lawyers were advocating vigorously for their clients. An example is given below.

Example 10: “Like if you’re going for a wardship till 18 or whatever, through negotiating with their solicitor it can be knocked back to 6 months. I mean hypothetically speaking.

*Because they flabbergast you. Like you stand there and they go, what evidence have you got? Why have you done this? Why haven’t you done that?

*But that’s part of the game. Trying to intimidate you and you thinking oh I haven’t got a good case, maybe I better negotiate to 12 months wardship instead of till age 18.” (DoCS workers)

The magistrates also play a vital role in moving the process of negotiation and bargaining forward. Their authoritative scrutiny of parents and DoCS casework brings both parties to the negotiating table. The prospect of a hearing brings psychological pressure to bear increasing the likelihood of settlement. In many instances magistrates suggest possible solutions as ‘arbiter and catalyst’ – “getting parents and DoCS to bite”.
The legislative framework for determining outcomes

When a care applicant fails to prove their case that the child was in need of care at the time of application to a very highly probable standard, the magistrate makes an order dismissing the application, s.72 (1a). Alternatively, once a matter is established, and the evidence concerning placement is heard, the magistrate can make one or more orders outlined under s.72 of the Act.

A magistrate can make an order accepting undertakings in writing from the parent/s (or persons responsible for the child) and/or the child, remaining in force for the duration specified s.72 (1) (b). An undertaking is a pledge, for example, by a parent to accept referrals and comply with service interventions, or by a young person to accept the direction of DoCS. An order can be made placing a child under the supervision of DoCS, s.72 (1) (c) (i). This order is often made in combination with undertakings. An order can be made placing the child in the custody of a person deemed suitable by the Court, with or without undertakings, s.72 (1) (c) (ii). A magistrate can make an order declaring the child to be a ward under the Act, s.72 (1) (c) (iii). A wardship order can apply until the child attains the age of 18 years or for any specified period short of that.

The Act provides a framework of principles and restrictions to guide the Court in the process of determining which order to make. The overriding principle is that the “welfare and interests of children are to be given paramount consideration”, s.55 (a). The Act states that children are entitled to special protection and to opportunities and facilities to enable them to develop in a “healthy and normal manner and in conditions of freedom and dignity”, s.55 (b). Subject to this first consideration, the Act suggests that family preservation is usually in a child’s best interests; children should grow up in the care and under the responsibility of their parent/s, and should not, except in “exceptional circumstances” be separated from them, s.55 (c) & (g). Care matters usually proceed from this fundamental premise.

The Act also emphasizes the importance of preserving a child’s particular cultural environment, s.72 (2) (d). In making a custody order the magistrate must consider the practicability of placing the child with a person belonging to the same cultural group, s.73 (3). Magistrates are also instructed to have regard to the views of the child, s.72 (2) (b), s.77 (2) (a & b). Another directive is for magistrates to consider the practicability of services and facilities being provided to the child without the need for a Court order, s.72 (2) (e).

There is a range of restrictions on the making of orders specified under s.73 of the Act. The overarching restriction is that magistrates must make the least restrictive/intrusive order possible that will be wholly sufficient to meet the child’s need for care. Magistrates cannot make supervision, custody or wardship orders under s.72 (c) of the Act unless the child is under the age of 16 years, and an order accepting undertakings would be “wholly insufficient to meet the child’s need for care”, s.73 (1). In the same vein, wardship orders can only be made when supervision or custody orders will not suffice, s.73 (2). For details of other restrictions on the making of orders, see s.73 of the Act.
Summary

The general view that emerged from the interviews and focus groups was that the “court process is the same for everybody, it’s just worse for parents with a disability”. In summary, the key findings are:

- Care proceedings take, on average, 140 days to be resolved – significantly longer for parents with psychiatric disability and suspected D&A use. This is an extensive period of uncertainty, confusion and often separation for parents and their children.

- Parents have to make an average of six court appearances. The Court environment is stress magnifying, particularly for parents with psychiatric or intellectual disability. This stressful situation can undermine their mental state and affect their presentation in Court.

- DoCS has an extremely powerful position in care proceedings. DoCS defines both the present situation of the child and the future possibilities for the Court.
  - DoCS prepares most of the evidence filed.
  - DoCS workers often select what information to document as they ‘mount their case’. Evidence of parent strengths is often excluded in order to give parent lawyers little “to fight with”.
  - DoCS briefs and pays the ‘independent expert’ assessors, and
  - DoCS decides whether resources are available to support family preservation initiatives.

- By stark contrast, parents with a disability are rarely ‘heard’ in care proceedings. Less than half of the parents with a disability filed affidavits. Notably, only 28% of parents with intellectual disability filed an affidavit. Moreover, what parents are able to say is constrained by the legal imperative, that is, what they must say to have any hope of their children being returned to their care.

- Lawyers representing parents with a disability generally feel ill-equipped in terms of both training and time to adequately represent them. In particular, they report having great difficulties explaining the court process to parents with intellectual disability and often to parents with psychiatric disability. Consequently it is difficult to obtain sound instruction. Further, when parents are unable to independently review evidence filed by DoCS, the evidence is often left unscrutinised. Lawyers representing parents also noted their ‘weak legal position’ in care proceedings where the rules of evidence do not apply.

- Lawyers and DoCS workers agree that parents with psychiatric or intellectual disabilities often have no understanding of what is taking place in care proceedings and therefore have no opportunity to participate in the process. DoCS workers noted the irony in that often it was left to them to explain the process and the decisions made to the parents - and give them a ride home!

- The nature of care proceedings, as a process of law, is ambiguous with adversarial and inquisitorial characteristics. Court appearances are often used as vehicles to gain leverage in the process of negotiation and bargaining that take place outside the court. This hidden process aims at negotiating a mutually acceptable resolution. This process was characterised by several interview and focus group participants as “the lawyers sorting it out amongst themselves”.

- Most care matters are resolved through informal negotiations thus averting the need for a hearing. In this way, cases are “processed through” and the system is maintained.
Contents

Part 1 - three popular misconceptions ....................... 66
  The presiding magistrate ................................................................. 66
  The nature of care concerns / severity of maltreatment ......................................................... 66
  DoCS recommendation ...................................................................... 66

Part 2 - key influences on outcomes .................... 67
  Was the child in need of care at the time of application .................. 67
  Is the child’s situation redeemable? .............................................. 70
  Is there someone in the extended family or in the community
  who could be a suitable substitute parent and with whom the
  child would be markedly better off? ............................................... 77

Summary ............................................................. 78
Objective 7:
To identify key influences on Court outcomes.

In this section, the key influences on court outcomes are identified and discussed. The analysis draws on data from interviews and focus groups with magistrates, lawyers and DoCS workers and data gleaned from court files and court room observations. The discussion is presented in two parts. In part 1 we test popular beliefs about outcomes and find they are of little or no significance. In part 2 we present the key influences on court outcomes for parents with a disability and their children.

Part 1 – three popular misconceptions

Three factors hypothesised to influence court outcomes were subjected to empirical testing. These three factors are:
- the presiding magistrate
- the nature of care concerns and severity of maltreatment
- DoCS recommendation

The presiding magistrate

This factor was thought to operate by magistrates’ having preferences for wardship orders or for returning children home. To test this hypothesis, the relationship between care outcomes and magistrate presiding was examined statistically.

A 5 x 2 cross-tabulation with Chi-square statistic was computed to determine whether there was a significant association between the magistrate making the order and placement of children home or in alternative care. To ensure adequate cell sizes, the variable – magistrate presiding - was recoded into five categories. These were: Syme, Longley, Huber, other specialist and non-specialist magistrates. The Chi-square analysis found that the association was not statistically significant ($\chi^2=5.3$, $p=.26$). The magistrate presiding did not significantly influence care outcomes.

The nature of care concerns / severity of maltreatment

Cases of severe maltreatment were hypothesised to result in more severe orders than cases of neglect by omission. To test this hypothesis the relationship between Court outcomes and the nature of care concerns, history of involvement with child protection services, and the severity of maltreatment was examined statistically.

A direct logistic regression analysis was performed on placement type (home vs out-of-home placement) as outcome and nine predictors (the number of care concerns in each of the nine categories- see Tables 5-13). After deletion of 21 cases due to missing data, data from 264 cases were available for analysis. The analysis found that these predictors could not reliably distinguish between placement types ($\chi^2=13.14$, df=9, $p=.16$). The variance in placement type accounted for was small, with the Cox & Snell $rho=.05$. The nature of care concerns as documented by DoCS workers in their initiating affidavits did not have a statistically discernable influence on placement outcome.

A direct logistic regression analysis was also performed on placement type (home vs out-of-home placement) as outcome with three predictors: total notifications, children previously removed and care concerns pertaining to the severity of abuse (see Table 11). After deletion of 22 cases due to missing data, data from 263 cases were available for analysis. The analysis found that these predictors could not reliably distinguish between placement types ($\chi^2=1.317$, df=3, $p=.725$). The variance in placement type accounted for was small, with the Cox & Snell $rho=.005$. Child protection history and the severity of maltreatment did not have a statistically discernable influence on placement outcome.

DoCS recommendation - Table 19

This factor was thought to operate by the dominance of DoCS in care proceedings reducing the Court to a “rubber stamp” – legitimating whatever DoCS determines to be the appropriate course of action.

There is a high degree of consistency between DoCS recommendations and the final Court orders. For example, in 92.8% of cases where DoCS recommended wardship orders, this was the result. The final outcome is rarely different to that proposed by DoCS and when there is variance, the outcome is
Table 19: DoCS recommendations and court outcomes

<table>
<thead>
<tr>
<th>DoCS recommendation</th>
<th>Court order</th>
<th>Dismiss/Withdraw</th>
<th>Supervision and/or Undertakings</th>
<th>Custody +/- any lesser order</th>
<th>Wardship +/- any other order</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dismiss/withdraw</td>
<td>77.8%</td>
<td>22.2%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supervision &amp;/or undertakings</td>
<td>1.4%</td>
<td>93%</td>
<td>2.8%</td>
<td>2.8%</td>
<td>93%</td>
</tr>
<tr>
<td>Custody +/- any lesser order</td>
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<td>6.6%</td>
<td>85.5%</td>
<td>7.9%</td>
<td>0</td>
</tr>
<tr>
<td>Wardship +/- any other order</td>
<td>0</td>
<td>0</td>
<td>7.2%</td>
<td>92.8%</td>
<td>0</td>
</tr>
</tbody>
</table>

close to that recommended in terms of severity. However, the ‘rubber stamp’ hypothesis does not hold up under scrutiny. The DoCS recommendation is usually arrived at as a product of the Court process in which all parties engage to achieve a negotiated, mutually acceptable resolution as noted in Section 6.

Part 2 - key influences on outcomes

The primary consideration in determining court outcomes is the welfare and best interests of the child. In determining what is in the child’s best interests, the Court process addresses three fundamental questions (see Figure 4). These are:

- Was the child in need of care at the time of application?
- Is the child’s situation redeemable?
- Is there someone in the extended family or in the community who could be a suitable substitute parent and with whom the child would be markedly better off?

Was the child in need of care at the time of application?

In care proceedings, a finding that the child was in need of care at the time of application, is virtually a fait accompli. Establishment is rarely contested. We found that 93.7% of care matters were established by consent, that is, where all parties were in agreement. Many interview and focus group participants viewed parental consent to establishment as a system and strategic imperative.

The system imperative

Efforts to craft a mutually acceptable outcome are driven by a system imperative for a negotiated resolution. The court system would “grind to a halt” if more than a very small proportion of matters were contested. To maintain the system and “process cases through” there appears to be a complicit agreement between the core group of regular lawyers to work together (to a degree) to achieve mutually acceptable resolutions. Parent lawyers may agree not to “take the Department (DoCS) on” by vigorously contesting all matters. In exchange, DoCS’ Legal Officers work at finding a compromise. Parental consent to establishment opens the process of negotiation and bargaining. “Everyone breathes a sigh of relief when the case is established”.

Example 1: “we are just doing it piecemeal. We are flying by the seat of our pants, out of control, and we are doing things, ... we get most of the people through, It’s only a very small percentage in terms of going to hearing. But that’s only because people have come to this sort of agreement that they won’t take us on all the time. Because if the lawyers took us on when they could, this whole system would come to a grinding halt… If you look at the evidence in all the cases we run before the Court, in 50% of them there is evidence there. In 50% there isn’t. If you look very closely there is not evidence that would get to a very highly probable standard in a Court of law... we don’t have that evidence, that standard of evidence, and if lawyers took us on, we would be going to hearing in at least 50% of these cases. But they don’t because the whole thing would just collapse.” (Legal representative)
Was the child ‘in need of care’ at the time of Application?

No

Dismissed

Yes

Is the child’s situation redeemable?

No

Is there a suitable ‘substitute parent’?

Yes

Home placement

No

Home placement

YES

Out-of-home placement
For the negotiation process to work, parents have to get something in return for their cooperation. This trade-off is usually made through a modification of the grounds on which it is alleged that a child is in need of care. DoCS Legal Officers usually advise DoCS workers to seek leave to modify the grounds and the magistrates generally give DoCS leave to amend their Care Application. The more stigmatising Ground (B) abuse is usually dropped and/or replaced with ground (A) inadequate provision or (C) irretrievable breakdown. Evidence for this is in the significant difference in application and establishment rates on ground A (Table 14) and as follows.

Parents with intellectual disability: application 23.5%, establishment 73.3%

Parents with psychiatric disability: application 26.7%, establishment 65.4%

Psychiatric disability and suspected D&A use: application 32%, establishment 59.1%

**The strategic imperative**

The parents consent to establishment was also widely viewed to be a strategic imperative, that is, something they must do to achieve the best possible outcome. This view is supported by our findings on outcomes.

- Contested matters result in significantly more ‘extreme’ outcomes
- 65.8% of care matters that went to hearing resulted in wardship orders and just 10.5% resulted in supervision orders and/or undertakings
- In comparison, 39.9% of care matters resolved through negotiation resulted in wardship orders, and 30.9% in supervision orders and/or undertakings.

Lawyers generally advise parents to consent to establishment. On the one hand, their consent achieves the following strategic gains:

- the parent’s consent demonstrates their cooperation/compliance (discussed further below)
- the onus is placed back on to DoCS to contribute to the negotiation and bargaining process
- a contested hearing is averted and care proceedings are potentially short circuited
- DoCS are more inclined to facilitate more regular access for parents and their children.

**Example 2:** “Well I don’t know whether you know the real procedure and what happens, but if you don’t consent to an establishment first up, then because of the back log, it is three months before you get a hearing. The department won’t return the kids to you in 99% of cases until it is established. The main reason is that, if you don’t acknowledge that your kid is being abused, how can they be safe in putting the kid back there… And once you go to your hearing three months down the track, then you have got a placement, and the department will say because you fought that, you haven’t acknowledged that the child is being abused, you have got no insight into it, and therefore we are not going to return the kid so the report comes out, the placement report, the 74 report, says hey we are not going to give them to mum and dad, so then you get into another hearing another three months down the track. So there is a six month go to get the kid back. In the mean time, because you haven’t really been acknowledging it, the Department won’t really work towards too much access to you… if they are working towards trying to restore the kids, and mum has acknowledged that she has belted them and all that sort of thing, then they will put that effort into it, but if they are not they won’t put that effort into it, because they have so many other cases going. So that becomes a real problem. So the establishment factor is that we as lawyers try and get our clients to see that the reason of getting it established early so that there is a bigger chance you get the kids back and getting them back much quicker.” (Legal representative)

Contesting establishment is thought, in most cases, to be a futile exercise. Reasons given by magistrates and lawyers include:

- DoCS only has to prove to a very highly probable standard that a child was in need of care *at the time* of application
- DoCS does not have to prove fault thus the question of agency is not relevant to establishment
- as DoCS officers tend to “throw everything into their initiating affidavit” it is difficult to challenge each and every concern especially as the rules of evidence do not apply and DoCS can base their concerns on hearsay
- any doubts usually go in favour of DoCS with magistrates “err[ing] on the side of caution” with a child’s welfare at stake
How Care Outcomes are Determined

- DoCS tend only to bring the ‘lay down mozaire’ cases due to the limited capacity (Court days) of the NSW Children’s Court.

On the other hand, many DoCS workers had a different view on establishment, viewing it as the time when parents should really be ‘fighting’. They suggested that the high rate of parent consent raises the question of whether parents, particularly those with disabilities, understand what establishment means. The following quote is illustrative:

Example 3: “I don’t know a parent yet who understands that the matter has been established. I don’t know anyone yet. There’s enough DO’s that don’t understand that. But a parent, and often they’ll agree to establishment, without a clue that they’ve done that even though that process is explained. But when they also have a disability like it becomes even more difficult – they haven’t got a clue, and basically that is the crucial point. Once they are established it’s like you’re handing it to us in a sense, in term of power. But if they fight establishment, that’s when they need to fight.” (DoCS worker)

Is the child’s situation redeemable?
The Act suggests that family preservation is usually in a child’s best interests, and this is the fundamental premise from which care matters usually proceed. The question of whether a child’s situation, that is, their family unit, is redeemable becomes then the focus of care proceedings. In practice, this question is addressed by way of two sub-questions. These are as follows:

- Has DoCS seriously attempted to resolve the care concerns through the provision of support services and fully explored service options as an alternative to out-of-home placement?
- Can the parent lift their game and placement (of the child) with his/her family be propped up or is it completely hopeless?

DoCS efforts, support services and alternatives to out-of-home placement
The Act requires DoCS workers as delegates of the Director-General to explore all alternative means of ensuring the welfare of the child prior to initiating care proceedings, s.57 (3). Often however, DoCS removes children first, and considers support services and alternatives to out-of-home placement later in the context of care proceedings. This is necessary, for example, when a child is deemed to be in immediate danger. Increasingly however, as noted in Section 3, DoCS is initiating care proceedings in less dire circumstances – “just to err on the side of caution”. In such cases, there may be long adjournments whilst remedial support services are tried and parents are given the chance to demonstrate parenting competence and/or receive treatment such as drug detoxification.

In the majority of cases however, DoCS have usually initiated care proceedings after they have lost hope of effecting change and improving the situation for the child (see Section 3). In such cases, DoCS casework is usually scrutinised. The obligation for the Director-General to explore all alternative means of ensuring the child’s welfare is the only substantive matter of law with which parent lawyers can challenge DoCS. Parent lawyers gain leverage in the process of negotiation and bargaining by demonstrating that DoCS has failed to provide suitable supports or explore alternatives to out-of-home placement. Lawyers representing children and the magistrates themselves are also keenly interested in whether DoCS has ‘really given the parents a go’ and may also question DoCS. Their interest stems not so much from the fact that there is a legislative requirement for DoCS to do so, but rather, because it bears on the question of whether parents can lift their game (discussed below). If DoCS has made serious efforts to no effect, the magistrate is more likely to conclude that the child’s situation is hopeless (irredeemable) and subsequently order out-of-home placement.

Despite this scrutiny, the court has no mandate to intervene in DoCS distribution of resources to support family preservation initiatives. Magistrates expressed a range of concerns, including:

- DoCS’ officers are “thin on the ground”. Out-of-home placement is often sought in preference to the resource intensive task of supporting families, especially families where there is parental disability and particularly for parents with intellectual disability who are too often “put into the too hard basket”.
- DoCS resources are directed into “reactive, crisis oriented” interventions and family ‘policing’ and not into crisis prevention and family support. As one magistrate put it: (See example 5)
Commentary on Magistrates’ Decision-Making

Although in most instances the court determines whether a child’s home situation is redeemable before contemplating out-of-home placement, there was some contradictory evidence. There were several cases where DoCS used evidence of the child thriving in out-of-home care, such as developmental gains, to support their argument for wardship.

Moreover, one magistrate explicitly questioned the presumption that family preservation is usually in the child’s best interests. He argued that virtually all cases appearing before him were ‘exceptional’ when community norms were the criteria for judgement and therefore met the legislated criteria for out-of-home placement, s.55 (c). For this magistrate, the process of determining what is in the child’s best interests therefore involves an examination of the options available. Regardless of whether a child’s situation is redeemable, the child has to be placed where their interests would best be served. The Court outcome would therefore depend on how parents shape up against any potential alternative carers.

Example 4: “[The Act is] one of those comparatively rare pieces of legislation where I can look at it and say I think the legislator has got it fairly right. Quite often courts deal with legislation on a basis of having to tolerate, having to live with it because that’s what Parliament has said. This is one of those statutes which at least in respect of that particular section [s.55], I think the legislators got it fairly right. Probably the only factor in the section that I disagree with is the line that says that children should not other than in exceptional circumstances be separated from their parents. Well, in practical terms, most of the matters the court deals with would be seen as exceptional circumstances. I think if you read the term ‘exceptional circumstances’ in the light of exceptional measured against the whole of the community not just against the parents that come in for care proceedings, then its much easier to understand. Another way of looking at it, just about everything the court deals with is exceptional because there is a problem of sufficient weight to bring it to court.

…the act says that the welfare of the child is paramount. That’s what we are doing and quite often we have to remind parents who come along and say ‘it’s my child, I want my child back.’ And say ‘no, the child’s not your property, we are looking at what is best for the child.’ That could be well illustrated by what was almost the last matter I dealt with today where we’ve got a natural father who is asking for a child to be restored to his care, the Department are freely conceding that they really can’t criticise him, he might have had his problems in the past but he has been very cooperative with the Department, changed his lifestyle, he’s changed where he lives, changed who he lives with . . . there are all of these things and the Department is saying ‘Well we can’t criticise him, but it is still in the child’s best interests in our view to stay where he is . . .

There’s also the other line, and this is where we look not at the rights of the parents . . . you don’t talk about rights of parents, you talk about what is best for the child. Hopefully that coincides with what parents see as their rights anyway, in the better cases. We are talking about the right of the child to live in security and safety, in a caring, non-abusive atmosphere. That’s what it is all about and this child is well established and you don’t uproot a child who is well settled.

I remember putting my foot in it almost by saying to a mother once ‘your life is pretty dreadful, if you get your act together come back and talk about restoration then.’ She took that really as saying, almost a promise by the court, that she could have the child back if she got her act together. She did, she made a remarkable turnaround in her life, but the child in that particular case had serious medical problems that would need ongoing care, the child was placed with fantastic foster family - in fact the mother in the family was a nursing sister herself, so she was particularly able to address the child’s needs and I had to say to mum ‘look I don’t care how good a job you have now done, the child is still better off with this foster family.” (Magistrate)

Whether this magistrate’s practice is idiosyncratic or reflects a new trend emerging in statutory child protection proceedings is unknown. Clearly however, it should be the topic of serious debate and scrutiny. The implications are far reaching.

- How do parents with a disability - whose competency is already shrouded in doubt by virtue of stereotypic perceptions and who are almost always socio-economically disadvantaged - compete with carers selected by DoCS or other contracted agencies?
- Does the criteria for the selection of foster carers become the new standard against which parents are judged? What are the implications if these criteria are applied to all parents or would-be parents?
How Care Outcomes are Determined

Example 5: “Oh yes, it is (reactionary), It’s a fire brigade. It trundles out when the fire is there. ... I get angry from time to time and think... let’s face it making a child a ward... just talking in money terms, forget human terms, making a child a ward commits the state to an enormous amount and I’ll accept that no matter what we do there are going to be a certain number of children we must make wards every year. But I am sure that if we spent the money, rather large buckets of money, on some of these parents, perhaps even before they get to Court, we wouldn’t be making as many kids wards and that ultimately has got to save us money”. (Magistrate)

- DoCS workers are often inexperienced and not aware of available community services to the extent that magistrates felt strongly that it was not the business of the Court to inform DoCS officers of what services are available.
- DoCS will often tie resources to wardship orders. This is clearly expressed in the following quote from one magistrate:

Example 6: “One of the other things we find too with the resources available within the Department of Community Services is that they tend to be tied to wardship orders and that there’s this push to wardship before the finance will be available when we’re saying, well look, there’s a threshold test, we’ve got to be satisfied that nothing else is appropriate. ...And we see that as a perversion of the wardship concept. The Courts are saying, well if there’s money available, the money should or resources or places should be made available whether a child’s a ward or not. If the Department needs to supervise the child, accept that they do, well ok there are other orders that we can make. But this blanket tying money to wardship or tying resources to wardship is something that the Court has constantly complained about and I think most of us, all of us are constantly fighting against it.” (Magistrate)

Advocacy for services on the part of professionals or family can influence the Court in determining whether parents can lift their game by raising doubts about whether alternatives to out-of-home placement have been explored. For example, Aboriginal Legal Aid often advocate for their clients and parents of children with disabilities often advocate for services themselves. Parents with a disability however, rarely have advocates who put pressure on DoCS to attempt to resolve care concerns through provision of services. In some instances, legal representatives take on this advocacy role and attempt to track down potential services however the costs incurred are a significant disincentive. One legal representative described the lengths she went to in acting for a mother with intellectual disability:

Example 7: “I also got the local church which she had been going to involved with her to put in some informal support. So I went to one of their prayer meetings on Wednesday night and said this is what I need Ok, so you know, she loved the kids she had never abused the kids, it is just that she will have them in a bath and walks off. She can’t comprehend. So I said (to the Court) why don’t we give her 2 hours support in the morning and two hours in the evening. The critical time. Put them into preschool during the week, I said it is going to be cheaper, because I also got the costing, what they pay foster parents to have kids and they get more.” (Legal representative)

Service workers may also act as advocates. In one case, a combination of family support agencies put forward a case plan to provide a mother with an extended period of supported accommodation and ongoing family support. This lead to a negotiated compromise with the child returned to the mother’s care with a supervision order and undertakings instead of wardship. In another case, the positive outcome (i.e. supervision order with undertakings) was negotiated when several agencies, including supported employment and family support service workers wrote letters of support for the family. For example, one service worker wrote:

Example 8: “It is my understanding that the Disability Services Act, ... states that people with a disability should be supported as needed. I fail to see how a District Officer from the Department of Community Services could withdraw services after 18 months, given that both parents and the youngest child all have disabilities. In my opinion, having worked in community services for 10 years, this family will always need some type of intervention and support but that with this support, they can maintain a family unit”.

Parents with a disability and the NSW Children’s Court
Can the parent lift their game and placement of the child with his/her family be propped up, or is it completely hopeless?

In determining whether a parent ‘can lift their game’ the court considers:

- Whether DoCS has seriously attempted to resolve the care concerns by way of service provision (discussed above);
- Parent compliance,
- Expert opinion, and
- The adequacy of support services

Parent compliance

In many cases, parent compliance may be all that is required to resolve care concerns and finalise care proceedings. As noted in Section 3, the Court system is often used by DoCS to trigger a crisis and, in essence, coerce parents into ‘compliance’, that is, insight and cooperation. By making a Care Application DoCS successfully re-defines the problem for parents. This can no longer be, for example, parent dissatisfaction with DoCS intervention, rather it becomes “what do I have to do to get my child back?”. Parent compliance often follows. Cases featuring parents with psychiatric disability are the exemplar of this practice where compliance with medication is often what DoCS is seeking.

In addressing the question of whether parents ‘can lift their game’, two aspects of parent compliance are important. Firstly, parent insight and cooperation are necessary pre-requisites for the Court to conclude that a parent can mend their ways. If a parent acknowledges difficulties, is willing to cooperate, engage with support services, and accept supervision and reasonable direction from DoCS, the scrutiny of the Court will turn upon DoCS, and the onus fall and reasonable direction from DoCS, the scrutiny of the Court will turn upon DoCS, and the onus fall.

Secondly, parent compliance with the court process is often treated by magistrates as an indicator of how redeemable a child’s situation is. Parent behaviour is often under scrutiny in the courtroom as magistrates try to “size up” the parent. ‘Misbehaviour’, failure to attend, to take the advice of their legal representative, or to comply with the Courts’ requirements for the submission of affidavit evidence may be viewed as confirmation of parental inadequacy. On the other hand, parent cooperation in the court process may be interpreted as demonstrated change.

Example 9: “This is something that I think people with intellectual disability think is going to happen. If I jump through this hoop (e.g. attend a particular service) then my child is on the other side. I’m sure that’s what they understand they have to do. What they can’t understand is that they have to jump through the hoop and come down the other side a changed person”. (Magistrate)

Example 10: “I can have my lady there (in the Court room) effectively destroying my case... I’m thinking of a case, the mother was sitting there in the front row with a big green apple, taking huge chunks out of it and disrupting the process of the Court, getting on with it in a mischievous fashion … she was making a social comment, about um, that she didn’t want to be there, and very loudly too … the fact that she was displaying a ... arrogant ... ah, disrespectful, … I mean it helped the Court come to a decision” (Legal representative)

Example 11: “You see clients who’ll go in and argue that they don’t have drug and alcohol problems and they’re on the nod at the back of the Court. Well that’s worth more reports than you could ever get presented. Or the same way if you’re saying that they have particular problems and they display outlandish behaviour in the Court. And that’s really unfortunate because we might know them and think, oh yeah we’ll let ‘em blow off steam and then we can start dealing with what’s going on. But everyone’s you know influenced by their carry on in the Court and that’s another thing I hate about the Court. It’s a foreign environment and they are not articulate and they are not able to do all of the things and they don’t conform to norms anyway so they stand up in Court and they want to say, your majesty, you know, I don’t agree with this … particularly psychiatric and intellectual disability, either they’re intimidated or they stand up and behave a bit silly because it’s a foreign environment. If you took them outside and everyone conducted the same process sitting outside it would probably work a lot better for them.” (DoCS worker)
Expert opinion

The Court looks to ‘expert’ psychiatric and/or psychological reports to:

- provide a diagnosis as an explanatory framework for the behaviour of parents and children
- determine whether parents can “lift their game”. For parents with psychiatric disability this means managing the ‘psychiatric disability’; for parents with intellectual disability this means whether the parent can learn and overcome parenting deficiencies
- provide a prognosis that offers a prediction about the future for the child and/or parenting capacity.

Example 12: “*Interviewer: What are you looking for from the psychiatrist or psychologist?* 

“*Magistrate: A diagnosis ... What it does is give you an understanding of the behaviour, a diagnosis would probably include a management plan, take this take that, visit me three times per year, do all the other things, ... and there is no reason why you can’t behave appropriately. ... and if the child is exhibiting signs of living with an unstable person, turns up at school irregularly, behaves in an aggressive manner from time to time, so you see manifestations of the parents behaviour in the child, a diagnosis of the mother would simply serve to explain and understand why the child’s behaviour is so strange. ... It gives you an explanation and it gives you a treatment plan. For example schizophrenia is much more difficult to deal with... far more difficult to control and requires far more supports within the family if a child is still living with a schizophrenia parent, not impossible by any means, it means a lot of monitoring, a lot more props from the department to ensure that things are OK.”

Psychiatric or psychological reports are often used strategically by DoCS “to get a case up”. A pessimistic prognosis also serves to increase DoCS leverage in the negotiation and bargaining process. In a few instances, parent lawyers also used the ‘expert’ report when conditions for parent learning were specified to argue that DoCS had not provided appropriate services.

Example 13: “Sometimes we only use (psychiatric/psychological) reports because they’re perceived to be independent of our own reports. Sometimes, magistrates, being a magistrate, some magistrates put, it’s a bit like doctors are gods, psychologists. We could explain a history of a parent over a period of time with some chronic stuff and they’re going, oh yeah, well that’s the department, the solicitors will just say, well that’s the department. We go and get a psychologist who repeats exactly the same thing as we said probably not as well for $5000, and the magistrate goes, oh must be true! ... I use it as a tactic all the time. It’s an expensive tactic but it’s a tactic. You know, and often district officers will know what the psychologist’s reports going to say. I mean, it probably comes with experience, but there aren’t many psychologist reports I read and go, oh wow!” (DoCS worker)

We empirically tested the relationship between ‘expert’ opinion and court outcomes. Recommendations with regard to placement were coded as follows:

- no explicit recommendation
- recommend home placement
- recommend out-of-home placement.

Where more than one report was filed, the balance of opinion was used to code the recommendation as follows:

- conflicting opinion – even
- balance in favour of home placement
- balance in favour of out-of-home placement.

The recommendations made by each ‘expert’ group, that is, psychiatrists and psychologists (DoCS, independent and contracted by Legal Aid) are shown in Table 20. The expert recommendations for each group of parents with a disability are shown in Table 21.

- Overall, expert opinion more often than not favoured out-of-home placement
- Out-of-home placement was more frequently recommended in cases featuring parents with intellectual disability than in cases featuring parents with psychiatric disability.
### Table 20: Expert opinion

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<tr>
<th></th>
<th>No opinion sought</th>
<th>No recommendation</th>
<th>Home placement</th>
<th>Out-of-home placement</th>
<th>Conflicting opinions</th>
<th>Balance in favour of home placement</th>
<th>Balance in favour of out-of-home placement</th>
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<td><em>Expert opinion</em></td>
<td>14 (14%)</td>
<td>16 (16%)</td>
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<td>36 (36%)</td>
<td>7 (7%)</td>
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<td>Psychiatrists</td>
<td>47 (48%)</td>
<td>21 (21%)</td>
<td>14 (14%)</td>
<td>12 (12%)</td>
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<td><strong>Psychologists</strong></td>
<td>36 (36%)</td>
<td>9 (9%)</td>
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<td>-DCS psychologists</td>
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<td>-Legal Aid Psychologists</td>
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<td>0</td>
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</tbody>
</table>

*Expert opinion refers to the balance of opinion across all expert groups

** Psychologists refers to the balance of opinion across psychologist groups

### Table 21: Expert opinion by disability status

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<th>Disability Status</th>
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<th>No clear recommendation</th>
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<th>Out-of-home placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intellectual disability (mother &amp;/or father) n=18</td>
<td>2 (11.1%)</td>
<td>2 (11.1%)</td>
<td>7 (38.9%)</td>
<td>7 (38.9%)</td>
</tr>
<tr>
<td>Psychiatric disability (mother &amp;/or father) n=34</td>
<td>7 (20.6%)</td>
<td>11 (32.4%)</td>
<td>6 (17.6%)</td>
<td>10 (29.4%)</td>
</tr>
<tr>
<td>Psychiatric disability + D&amp;A (mother &amp;/or father) n=30</td>
<td>3 (10%)</td>
<td>7 (23.3%)</td>
<td>10 (33.3%)</td>
<td>10 (33.3%)</td>
</tr>
</tbody>
</table>

### Table 22: Expert opinion by court outcome (placement)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Recommendation</th>
<th>Not sought</th>
<th>No clear recommendation</th>
<th>Home placement</th>
<th>Out-of-home placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home placement</td>
<td>6 (54.5%)</td>
<td>9 (45%)</td>
<td>13 (61.9%)</td>
<td>3 (10%)</td>
<td></td>
</tr>
<tr>
<td>Out-of-home placement</td>
<td>5 (45.5%)</td>
<td>11 (55%)</td>
<td>8 (38.1%)</td>
<td>27 (90%)</td>
<td></td>
</tr>
</tbody>
</table>
Using cross tabulation with Chi-square statistic we found a highly significant relationship between expert opinion and Court outcome (home vs out-of-home placement) in cases featuring parents with a disability ($\chi^2 = 17.92$, $p < .001$). Table 22 shows that 90% of cases where the balance of expert opinion was in favour of out-of-home placement, the order made was for out-of-home placement. The relationship between the expert recommendation of psychiatrists and psychologists and Court outcomes is shown in Tables 23 and 24 respectively.

**The adequacy of support services**

Whether parents can ‘lift their game’ and the child placed home depends to a great extent on the availability of support services. Magistrates, lawyers and DoCS workers all asserted that adequate support services for parents with a disability do not exist. This limits DoCS capacity to offer and support any family preservation initiatives. Those services that do exist are widely spread and poorly coordinated such that developing a family support plan involves an ad-hoc ‘patching together’ of a range of services. Out-of-home placement could be averted in many cases if appropriate services were available. Court outcomes are ultimately limited by the willingness of government to fund adequate services. (See examples 14 & 15)

The finding that the lack of suitable support services is often a major influence on Court outcomes raises another concern. At best, support needs were only indirectly assessed in care proceedings. As noted above, psychiatric and psychological assessment reports often do not go far enough. Beyond the need for medical or psycho-therapeutic treatment, support needs are rarely assessed, though in some instances they are inferred. The question is how can any judgement be made that adequate services do not exist when the range and intensity of services required are not assessed? In this context, parents with a disability are particularly vulnerable.

When ‘diagnoses’ are used inappropriately the Court may conclude that a parent is unable, by virtue of an intellectual impairment to mend their ways or “lift their game”. A need for 24 hour per day support is frequently presumed and viewed as impractical. One magistrate’s comments illustrate this misconception in example 16.

| Table 23: Psychiatrists’ opinions and court outcomes |
|---------------|-----------------|-----------------|-----------------|-----------------|
| Recommendation | Not sought | No clear (recommendation) | Home placement | Out-of-home placement |
| Home placement | 14 (36.8%) | 9 (42.9%) | 6 (46.2%) | 2 (20%) |
| Out-of-home placement | 24 (63.2%) | 12 (57.1%) | 7 (53.8%) | 8 (80%) |

| Table 24: Psychologists’ opinions and court outcomes |
|---------------|-----------------|-----------------|-----------------|-----------------|
| Recommendation | Not sought | No clear (recommendation) | Home placement | Out-of-home placement |
| Home placement | 13 (44.8%) | 3 (37.5%) | 12 (66.7%) | 3 (11.1%) |
| Out-of-home placement | 16 (55.2%) | 5 (62.5%) | 6 (33.3%) | 24 (88.9%) |
Example 14: “Next question (after establishment) has to be can we prop up the placement with the family. Ah, and that will depend upon, that is the longest part of the case, that’s the psychological assessment part of the case, that is the evidence gathering part of the case, and then often it is part of the case which is also the experiment to see if the attempt to prop the parents up, can do so to the extent that it looks like the child could go home, or if the child is already at home, is it worth looking around. That might result in either a short term wardship order with props being put in to enable the child to go home or a longer term supervision order leaving the child where he is and keeping the props in place. The difficulty I perceive is that the props … part of the department (DoCS) is seriously under resourced, and … the props aren’t there, … and that’s the problem we’ve got.” (Magistrate)

Example 15: “The state has abrogated its responsibility for the provision of support services in favor of community or charitably based organisations… This to me is a core function of government that ought not to be divested because the people who are most in need of this support are people who are often most lacking in a voice to be heard, who are not of – and I have to say this quite harshly – great political significance, and who accordingly cannot attract a level of support that a government ought to make itself in the business of providing” (Magistrate)

Example 16: “If they’ve got that disability, you can’t fix it. If there’s impairment to the brain there’s nothing you can do to fix it. They don’t know how to cook a meal. They don’t know how to wash it in the bath and they’re not going to be able ["other participant: You could provide live-in carers] … but then that’s the thing, a permanent person who’s not going to ever be able to leave because this person is never going to learn how to cook that meal because they can’t.” (Magistrate)

Identified service needs include:

- Mediation services to address the breakdown in the DoCS- parent relationship and help build a trusting, working relationship
- Ongoing drug and alcohol rehabilitation services to address the personal and social conditions that inhibit efforts to overcome dependence
- Mental health services to support families with clear inter-agency guidelines to facilitate a working partnership between these services and DoCS
- Ongoing support services that adapt to family needs and are not limited to ‘quick-fix’ interventions/solutions
- A service continuum to encompass centre-based and supported accommodation programs to home-based parenting education and family support services
- Specialised training programs for generic service providers to develop the necessary skills for effective family support work with parents with psychiatric or intellectual disability
- A comprehensive and up-to-date database of services accessible via the Internet.

Is there someone in the extended family or in the community who could be a suitable substitute parent and with whom the child would be markedly better off?

When the child’s situation is judged irredeemable, the Court turns to the question of an appropriate alternative. Magistrates make orders, in most cases, only when they are assured that the child will be markedly better off being placed with a specific person in a particular place. For just 14 children, court orders were made when the placement was still undetermined. However, the Court is limited by the options presented, and an ideal placement often does not exist. It is often difficult to locate appropriate long-term carers, particularly when there is more than one child involved.

The constraint of limited placement options often underscores DoCS readiness to negotiate a mutually acceptable resolution. If parents are willing to comply, DoCS is often willing to compromise. Many DoCS workers view wardship as the order of last choice because of the limited number and uncertainty of
foster placements. As one DoCS officer put it “it comes down to what options you’ve got as to whether you are going to place that child out of the home” and the options are usually limited. That is why, as another DoCS officer explained “…the second after removal, you know you do the removal and the next day you’re trying to work out how many services you’ll need in place and what sort of supports you can offer so we can get them back”.

Potential ‘substitute parents’ that are not already screened foster carers are usually assessed by DoCS and/or contracted psychologists. When a child’s situation is judged irredeemable and a suitable substitute parent has been identified, a custody or wardship order is usually made and the child placed out-of-home. When a child’s situation is judged irredeemable, but a suitable ‘substitute parent’ has not been identified, the outcome is less certain. In some cases, wardship orders were made and the child placed home with his or her parents. Such an arrangement releases the necessary resources, and ensures DoCS maintains a close eye on the child’s situation. It also permits DoCS to remove a child at any time and place them with alternative carers without any further Court scrutiny.

**Summary**

In determining what is in the child’s best interests, the court process addresses three fundamental questions:

1. Was the child ‘in need of care’ at the time of the Care Application?
2. Is the child’s situation redeemable?
3. Is there someone in the extended family or in the community who could be a suitable substitute parent and with whom the child would be markedly better off?

**Was the child ‘in need of care’?**

- 93.7% of all cases were established by consent.
- The allegation that the child is ‘in need of care’ is rarely contested. In part, this is because the system would grind to a halt if more than a small proportion of cases went to hearing. Consequently, the core group of lawyers often work together (to a degree) to find a mutually acceptable resolution. The parent’s consent to establishment opens the process of negotiation.

In exchange, the grounds on which it is alleged that the child is ‘in need of care’ are usually modified to exclude ‘abuse’.

- Lawyers representing parents generally viewed the parent’s consent to establishment to be a strategic imperative, that is, something they must do to achieve the best possible outcome. Parent consent demonstrates ‘insight’ and a readiness to cooperate, the onus is placed back on to DoCS to contribute to the negotiation process, and DoCS are likely to provide more frequent access for the parent and child.
- Contesting establishment is thought, in most cases, to be a futile exercise. Lawyers representing parents suggested: it is difficult to challenge each and every concern listed by DoCS when the rules of evidence do not apply; DoCS only has to demonstrate that the child was ‘in need of care’ at the time of application; the question of agency is not relevant; and, any doubts usually go in favour of DoCS with magistrates erring on the side of caution.

**Is the child’s situation redeemable?**

In determining whether the child’s situation is redeemable, there are four fundamental considerations. These are:

- The extent to which DoCS has seriously explored other means (other than court action) of ensuring the welfare of the child. If DoCS can demonstrate that serious efforts have been made to support the family and prevent the need for court action, out-of-home placement is more likely. If DoCS has not fully explored service options, then a long adjournment period often follows during which services are trialed.
- Parent insight and compliance are pre-requisites for the court to conclude that the parent can ‘lift their game’. If a parent acknowledges their difficulties, is willing to cooperate with services, accept supervision and demonstrate change, the scrutiny of the court will turn upon DoCS. However, often parent compliance is all that DoCS is seeking. In particular, compliance with medication is often the chief concern in cases featuring parents with a psychiatric disability.
- Expert opinion, in the form of psychiatric or psychological reports is given great weight. In cases featuring parents with a disability, the court frequently turns to ‘expert opinion’ for a prognosis, that is, an indication of the parent’s
capacity to change. A statistically significant association was found between expert recommendation and the court outcome. In 90% of cases where the recommendation made was for out-of-home placement, this was the result.

- The availability of support services, or rather lack thereof, is often a determining factor. DoCS workers, lawyers and magistrates alike asserted that there were insufficient support services for parents with a disability. Many participants commented that out-of-home placement could, in many cases, be averted if adequate services were available. However, support needs were, at best, indirectly assessed in care proceedings. In cases featuring parents with intellectual disability, a need for intense, even 24 hour per day support, was often presumed and ruled out as impractical. In addition, several participants observed that in many cases, it was not a lack of available services, but rather the willingness of DoCS to fund family support initiatives which was the determining factor.

**Is there someone who could be a suitable substitute parent and with whom the child would be markedly better off?**

When the child’s situation is judged to be irredeemable, the court looks for an appropriate alternative.

- The magistrates indicated that they are reluctant to order out-of-home placement unless they know where the child will be placed and are assured that the child will be markedly better off there. However, the court is limited by the options presented and an ideal placement often does not exist. The constraint of limited placement options often underscores DoCS readiness to negotiate a mutually acceptable compromise. When a suitable substitute parent has not been identified the outcome of care proceedings is uncertain.
Conclusions and Recommendations

Contents

Conclusions and Recommendations .......................... 82
Parents with a disability are over-represented in care proceedings .................................................... 82
Outcomes for families headed by parents with a disability .......................................................... 82
Influences on initiating care proceedings and on court outcomes ......................................................... 82
DoCS' and court personnel 'thinking' about parents with a disability ..... 83
The concept of 'risk' ............................................................................ 83
The reliance on expert opinion .............................................................. 84
The lack of suitable support services .................................................. 85
System constraints .............................................................................. 86
The court environment .......................................................................... 86
Summary ......................................................................................... 86
Recommendations ............................................................................ 87
Conclusions and Recommendations

This project set out to identify the prevalence of parents with a disability appearing in care proceedings, outcomes for these parents and the processes involved. The catalyst for the study was concern about whether these parents were disadvantaged or indeed discriminated against in care proceedings. The task in this chapter is to draw together the prevalent themes identified in this project and to make recommendations in relation to areas of concern in the current system.

The findings demonstrate conclusively that parents with a disability are over-represented in care proceedings and are subject to differential outcomes. Without a suitable environment, adequate legal representation and support to comprehend the court process, their voices are not heard resulting in discrimination based on their disabling conditions. The Court’s reliance on expert opinion further disadvantages these parents as they are assessed according to diagnosis rather than by their parenting performance. Finally, the absence of suitable support services results in more invasive actions than would otherwise be the case if services were available to assist parents in the community.

Five major concerns are identified from the findings of this project. These are listed below and elaborated in the sections that follow. These concerns are:

- **Almost one-third of all DoCS Care Applications involve parents with a disability**
- **DOCS decision-making is most strongly driven by perceptions of risk to the child, informed - or more accurately - misinformed by beliefs and attitudes about particular disability groups**
- **The inappropriate nature of expert assessment for assessing parenting performance and the use to which this is put in determining court outcomes**
- **The marginalization of parents with a disability by court processes resulting in discriminatory practices based on disability status**
- **The lack of suitable support services available in the community to assist in meeting parents’ needs.**

Parents with a disability are over-represented in care proceedings

A primary aim of this project was to establish the prevalence of parents with a disability in care proceedings. The results are unequivocal. **Almost one-quarter of all care matters involve parents with a disability. This number rises to nearly one-third when considering DoCS’ care applications alone.** There is a substantial over-representation of parents with psychiatric disability at 18.4% of cases compared to mean general population estimates of 4%. There is also substantial over-representation of parents with intellectual disability at 7.1% of cases compared to mean general population estimates of 0.6%.

Outcomes for families headed by parents with a disability

A secondary aim was to determine whether the outcomes for families headed by parents with a disability differ significantly from the outcomes for non-disabled parents. **On all three outcome measures - type of order, length of order and placement type – there are significant differences for families where there is parental disability.** In brief, the children of parents with intellectual disability are more likely to be subject to wardship orders over the medium term with a disproportionate number of children being placed out-of-home with non-family. The children of parents with psychiatric disability on the other hand, are more likely to be placed back home with a short-term supervision order.

Influences on initiating care proceedings and on court outcomes

Additional aims of the project were to examine influences on the decision to initiate care proceedings and those influences that effect court outcomes. In brief these are:

- **DoCS and court personnel ‘thinking’ about parents with a disability**
- **The concept of ‘risk’**
- **The opinions of experts**
- **The lack of suitable support services**
Parents with a disability and the NSW Children's Court

**System constraints**

**The court environment.**

DoCS' and court personnel ‘thinking’ about parents with a disability

As community workers, care and protection personnel hold stereotypical views about people with a disability. Not surprisingly, court personnel also hold these widespread community attitudes toward people with a disability. Based on these outmoded and pejorative beliefs, pessimism permeates the thinking of all involved about the hope of effecting change with parents with a disability. This results in views being held – and not contested – which militate against observing parent strengths, putting the views being held – and not contested – which militate against observing parent strengths, putting the necessary supports in place and working towards preserving existing family connections.

**Prejudicial beliefs**

The views of many DoCS workers and court personnel can be traced to outmoded, pejorative and stereotypic beliefs about people with intellectual disability. People with intellectual disability may, for example, be perceived to be objects of pity and charity, eternal children, as ineducable and only fit for monotonous and repetitive tasks. These beliefs are antithetical to parenting. As ‘eternal children’ people with intellectual disability are thought never to mature sexually, socially or emotionally. Consequently they are perceived to be dependent and therefore incapable of taking responsibility for their children, or of developing and learning the skills necessary to do so.

The presence of prejudicial beliefs such as these amongst DoCS workers and court personnel leads to four serious concerns:

- Any parent with intellectual disability may be labeled incompetent on the basis of their disability alone and without any evidence of incompetence
- With presumed incompetence, child maltreatment may be anticipated, again without any evidence and based on parental disability alone
- With presumed immutability of their ‘condition’, they may be thought incapable of learning and therefore overcoming parenting deficiencies if these exist
- Parenting deficiencies may be blamed on the parent’s disability rather than on other difficulties in the parent’s life. Their parenting difficulties are mistakenly attributed to disability when in fact their problems most likely stem from social constraints such as poverty, social isolation, poor housing and the inadequacy of support services.

**Risk assessment**

Several explanations have been offered for the increasing emphasis on risk and risk assessment protocols in child protection practice internationally. These include the desire to:

- Predict child maltreatment as a way to provide children with greater protection (Wald & Woolverton, 1990)
- Target limited resources for maximum benefit in a climate of decreasing budgets and increasing needs (Lyons, Douek & Wodarski, 1996)
- Ensure more consistent decision-making particularly in a climate of high staff turnover and an inexperienced Child protection workforce (Wald & Woolverton, 1990)
- Deflect blame away from child protection personnel when the inevitable tragedies occur (Goddard, Saunders, Stanley & Tucci, 1999).

There is significant concern about the use of risk and risk assessment protocols (Caldwell, Bogat & Davidson, 1988; Goddard et al., 1996; Lyons et al., 1996; Wald & Woolverton, 1990). One concern is the lack of consensus on what constitutes abuse and neglect and therefore no agreement on what risk assessments are presumed to predict. An example from our study is illustrative. An agency worker stated in court that she had observed the mother (with a psychiatric disability) physically abuse the child. Under cross-examination it emerged that the ‘abuse’ was smacking the child on the bottom. The magistrate questioned whether this constituted abuse and the worker retorted “all smacking is abuse”. In the absence of agreed definitions of abuse and neglect, judgements are unavoidably subjective.

Practically speaking, risk assessment protocols have failed to live up to their promise. Despite huge investments, risk assessment protocols are not able to provide a reliable means of predicting future abuse or neglect. State of the art measures result in the identification of large numbers of false positives, that is, children identified as ‘at risk’ who will never be abused. Caldwell et al. (1988) demonstrated mathematically that even if...
a risk assessment protocol could be developed that has high specificity and high sensitivity, it would still result in a large number of false positives due primarily to the low incidence/base rate of child abuse. It is generally agreed that risk assessment tools will never be an adequate substitute for experience and good case reasoning (Goddard et al., 1999; Wald & Woolverton, 1990).

The failure of risk assessment protocols is not surprising given the poor understanding of the causes of child abuse and neglect. The items on risk assessment protocols come from descriptive data on families who have been subject to statutory child protection intervention (Lyons et al., 1996; Wald & Woolverton, 1990). At best, these items are only correlated with child abuse and neglect. There is no evidence to suggest these items cause abuse or neglect (Goddard et al., 1999). Suggesting that these items are substantiated ‘risk factors’ is misleading.

In sum, risk assessment is generally promoted as a quasi-objective means of determining the potential of the parental situation to provide for the health, safety and well being of the child. This is of major concern given the lack of a sound theoretical and empirical basis to the concept of, and current measures in risk assessment.

The beliefs and attitudes of workers and their reliance on risk assessment are significant contributors to the ways in which DoCS workers frame their concerns about parents – these concerns become embedded in the affidavits which accompany the care application.

In the case of parents with a disability, concerns of DoCS workers typically relate to the perceived potential for harm. Abuse, either alleged or substantiated was rare. Notably, 65.5% of cases involving parents with psychiatric disability and 73.3% of cases featuring parents with intellectual disability were established on Ground A, inadequate provision. Ground B (abuse) was extremely rare occurring in one case only involving parents with intellectual disability and in 9 cases of parental psychiatric disability (of these 3 also involved suspected drug and alcohol use).

With regard to parents with a psychiatric disability, concerns stemmed from the parents’ deteriorating mental state and the perceived unpredictability of their behaviour. Non-compliance with prescribed medication and non-cooperation with DoCS were frequently the central issues. Homelessness or ‘transient’ lifestyle was also a common concern.

In the case of parents with intellectual disability, concerns were generally about the perceived inadequacy of care. Cases involving these parents were viewed by many as the ‘saddest’ cases of all, with the parent’s love for the child frequently being acknowledged. Concerns related to home safety were also common. In many cases, workers expressed concerns about the children’s special needs or developmental delay, suggesting that these parents were not providing sufficient stimulation. Issues of poor housekeeping and poor money management were also frequently documented.

The reliance on expert opinion

We found a heavy reliance on professional opinion in the form of expert reports provided by the parties and/or sought by the court. This is demonstrated by the highly significant relationship found between expert opinion and Court outcome (home vs out-of-home placement) in cases featuring parents with a disability.

The diagnostic-prognostic rationality used by the court and consequently the reliance on the opinion of psychiatrists and psychologists in determining whether parents with psychiatric or intellectual disability can lift their game raises a number of serious concerns. In the first instance a diagnosis can provide neither an adequate explanation of parenting deficiencies (when these exist) or a valid prediction of parenting potential. The use of these ‘expert’ reports to make such predictions is likely to result in empirically invalid and prejudicial judgements.

Secondly, parents with a disability may be denied individual review and adjudication. The following specific concerns emerged from our content analysis of ‘expert’ reports:

- One of the most common reasons for referral was for cognitive assessment of parents. The concern here is that such requests imply an empirically invalid and prejudicial presumption that parenting potential is related to parental intelligence. Intellectual (dis)ability per se is a poor predictor of parenting competence and there is good evidence that when parenting deficiencies do exist these are to a large extent remediable (for comprehensive reviews see Booth & Booth,
Psychologists did not challenge the presumption implicit in the request for parental cognitive assessment. Rather, psychologists complied with the request employing adult IQ tests more often than any other measure. Appropriately, the psychologists rarely dismissed a parent as incompetent or incapable of learning based on their IQ score. However, this was frequently used to infer a range of parenting deficits, including limited capacity to learn. Parental deficits were emphasised and little said about the learning capacity of people with intellectual disability given appropriate instructional methods. The first concern here is that the inferences made by the psychologists may be sufficient to confirm any prejudicial presumptions held by the Court. The second concern is that Courts may assume that the greater time and effort required to teach skills to these parents relieves the state of the duty to provide any training at all (Gilhool & Gran, 1985).

The diagnostic-prognostic rationality used by the Court will inevitably result in the mistake of false attribution. This occurs when existing parenting deficiencies are attributed to the disability when these stem from social constraints such as poverty, social isolation, poor housing and the inadequacy of support services (Booth & Booth, 1993; Rutter & Quinton, 1984). In cases featuring parents with psychiatric disability, this error may result in support plans that fail to address the circumstances precipitating parenting difficulties. In cases featuring parents with intellectual disability this error may result in no support plan at all as the presumed immutability of their condition militates against any hope of change.

In the case of psychiatric disability, diagnosis and prescription for medical management and in the case of parents with intellectual disability an IQ score and guidelines for appropriate teaching methods do not address parenting difficulties and support needs. Medical care and special education requirements are relevant considerations but are not sufficient to address how parenting difficulties may be overcome and how a particular parent and their family may be supported. The psychiatric and psychological assessment practices evident in this study do not assess parenting performance in everyday family life. Rather, parenting difficulties are inferred from diagnoses or psychological testing.

Psychiatric and psychological assessments conducted during care proceedings are of doubtful validity. Stress and confusion aroused by care proceedings and the threat of permanent separation from their child or children may undermine the mental state of parents and consequently impair/diminish their performance. Of particular concern is the validity of attachment and bonding assessments. In many instances these were conducted in an interview and one-off observation of the child-parent interaction during an access visit or in the psychologist’s office. Moreover, these assessments were often conducted after the child had been separated from their parent/s for months. Under such circumstances the behaviour of parents and children may be atypical and therefore misleading.

The lack of suitable support services

As we have noted in every section of this report, throughout the project our attention was drawn to the extreme difficulty in identifying suitable supports and services for parents with a disability. Despite this concern, a note of caution is needed. The outmoded attitudes and beliefs of many involved in care proceedings led to expectations that parents with a disability could only manage ‘adequately’ if provided with intensive, even 24-hour ongoing support if at all. There is clear evidence in Australia and internationally that parents with intellectual disability do not as a group require such support: some parents will be successful independently, some will need minimal support and others will need more intensive supports possibly on a daily basis but not normally for the entire day. The out-of-date misperceptions about disabilities remain prevalent and continue to lead to falsely based speculation about current needs and more dangerously still, about future demands.

Given this caution, it is still the case that there are few services with appropriately trained personnel to cater for the support needs of parents with a disability. This begs the question as to whether the current over-representation of these parents in care applications represents a failure on the part of the parents per se. A more likely scenario is that the system more broadly in health, disability and welfare services fails to assist parents according to their individual need for support in performing the tasks of parenthood.
System constraints

The entire process is driven by system constraints, which results in differential outcomes for parents with a disability. These constraints are:

♦ Constraints on Department of Community Services workers who have not the time, training or resources to adequately support parents with a disability.
♦ Constraints on legal representatives who have not the time, training or resources to adequately represent parents with a disability.
♦ Constraints on the court system which creates an environment in which the process of establishment can be ‘washed over’ as legal representatives work to negotiate a compromise solution to keep the system ‘moving’.

Despite these formidable constraints there are obvious exceptions. In other words, there are legal representatives who go to incredible lengths to track down appropriate support services to ensure that parents get all available help. In some cases, parents are vigorously represented and legal representatives' work extremely hard to ensure that prejudicial beliefs do not influence the ways in which these parents are regarded. In some cases, the court process works to reconcile the conflicting views of DoCS’ workers and the parents rather than use compromise solutions to expedite matters. In some cases, creative solutions are found which work to serve the best interests of the child and their parents. And, in some cases, court personnel work to ensure that every opportunity is provided so that parents can ‘tell their side of the story’. Similarly in some cases, DoCS workers willingly explore creative alternatives, think laterally and take on board and attempt to implement others' suggestions.

The court environment

In describing and analyzing court processes it became immediately obvious that at the most basic level, the court environment is alienating for parents with a disability. This environment exacerbates what is an already tense and potentially explosive situation. There is little opportunity throughout the court process for the parents’ voices to be heard. A concrete example of this is the fact that only 28% of parents with intellectual disability filed an affidavit. DoCS hold the dominant position in care and protection matters – deciding on resources and supports that can or cannot be supplied and responding or not to notifications to give but two examples. Within the court, DoCS holds the dominant position by their initiation of a care application, their preparation of evidence, their briefing of the ‘independent experts’ and their control over whether resources can be made available to support family preservation or restoration initiatives.

The negotiations conducted during the course of the proceedings between all parties - DoCS, the parent’s legal representative and court personnel - are incomprehensible to parents and particularly so to parents with intellectual disability. Much of what is conducted is ‘hidden’ from the key parties – that is, the parents and their children. The language used, the conventions adhered to and the interactions between articulate and educated personnel all serve to further alienate and disempower parents for whom there is real and justifiable concern that they are left totally ignorant of what has been, or is about to be, agreed. Worse still, lawyers representing parents feel ill-equipped in terms of both training and time to adequately represent parents with a disability. They report having great difficulty explaining the court process to the parents and it is often difficult to obtain sound instruction (to know what the parent really wants them to do). In this setting much of the evidence submitted by DoCS is often not scrutinized. In sum, this adds up to totally inadequate attention to the requirements under the Disability Discrimination Act 1992 (Cth) and the Anti-Discrimination Act, 1997 (NSW) to eliminate discriminatory practices. The marginalization of parents with a disability in court processes constitutes a discriminatory practice.

Summary

Drawing together the above concerns it is clear that:

♦ Parents with a disability are substantially over-represented in care proceedings.
♦ DoCS decision-making is most strongly driven by perceptions of risk to the child informed - or more accurately - misinformed by beliefs and attitudes about particular disability groups.
♦ Undue emphasis is given to clinical decision-making based on a diagnostic-prognostic model which bears little relevance to assessing parenting performance.
Conclusions and Recommendations

- The support and services that parents need are not available in the community.
- Discriminatory practices are evident as parents with a disability are seriously marginalized by their lack of access to information in terms that they can understand, well-informed legal representation, and support which is appropriate to their needs during the court process.

Recommendations

**Recommendation 1**

To address the marginalization of parents with a disability in the court process

It is recommended that the Attorney General’s Department (NSW) as a matter of urgency and in consultation with the Senior Magistrate of the Children’s Court and court personnel review court environment, procedures and processes to ensure appropriate accessibility by people with a disability as required under the Disability Discrimination Act 1992 (Cth) and the Anti-Discrimination Act, 1997 (NSW).

Following this and in collaboration with the Department of Community Services and Legal Aid, urgent attention be given to the marginalizing and disempowering nature of court procedures and processes detailed in this report and strategies put in place to remedy this situation as soon as practicable.

Suggested strategies include:

- The development of a video and accompanying plain English resources which explain the court process step-by-step and the rights of participants to a fair hearing.
- The development of an Internet site listing potential support services to assist the Court in establishing what community supports and services are available and with hotlinks to other sites including those which contain up-to-date information about disability and parenting performance.
- The development of a network of volunteers/advocates under the auspices of an independent body such as the Intellectual Disability Rights Service to provide support persons to assist parents with a disability as defined in s.102 of the Children and Young Person’s (Care and Protection) Act 1998.
- Additional funding to support adequate legal representation of parents with a disability given that these parents require significantly more time both to inform and for their legal representatives to obtain sound instructions.

**Recommendation 2**

To address the outmoded inaccurate beliefs and pejorative attitudes held by departmental and court personnel involved in care proceedings

It is recommended that the Attorney General’s Department (NSW) in collaboration with the Department of Community Services develop a joint training module for departmental and court personnel to inform and educate based on up-to-date empirical research and the broad range of community experiences of parents with a disability. This program needs to pay particular attention to:

- The Children and Young Persons (Care and Protection) Act 1998 and specifically Section 71 (2b) that states that “The Children’s Court cannot conclude that the basic needs of a child or young person are likely not to be meet only because of:
  (a) a parent’s disability, or
  (b) poverty.
- The overall intent, principles and objectives of this Act and the specific sections that address the needs of parents with a disability including s.102 on support persons.

**Recommendation 3**

To address the over-representation of parents with a disability in care proceedings

It is recommended that the Department of Community Services develop a professional development module on disability and parenting and implement a training program for district officers and assistant managers as a matter of urgency. This professional development module needs to pay particular attention to:

- Up to date empirical research on parental disability and the broad range of community experiences of parents with a disability.
Conclusions and Recommendations

- The inappropriate use of risk assessment as a proxy measure of parenting performance.
- Appropriate measures of assessing parenting performance in relation to identified concerns.
- Appropriate measures of identifying parents’ support needs.
- Suitable supports and services to assist parents to overcome identified concerns in the context of ensuring the safety, welfare and well being of the child.

**Recommendation 4**

To address the inappropriate reliance on a clinical diagnostic-prognostic model in determining outcomes in cases involving parents with a disability

It is recommended that the Attorney General’s Department (NSW) develops and implements a professional development module to inform magistrates of the inappropriateness and limitations of using clinically determined diagnoses and prognoses to determine current and/or future parenting performance. This professional development module needs to pay particular attention to:

- The use and misuse of clinical diagnoses with regard to current and future parenting performance.
- The appropriate measures for assessing current and estimating future parenting performance.

It is also recommended that the Children’s Court Clinic as a matter of the utmost urgency and as soon as practicable after establishment develop policies and procedures in relation to the appropriate assessment of parenting performance with particular attention to cases involving parents with a disability.

Following this, it is further recommended that the Children’s Court through the auspices of Attorney General’s work collaboratively with the Department of Community Services to assist in the implementation of appropriate methods of assessment of parenting performance as part of all child protection worker’s professional practice.

**Recommendation 5**

To address the lack of suitable support and services for parents with a disability

It is recommended as a matter of urgency that the Attorney General’s Department take a lead role in addressing the shortfall in suitable services via the Human Services Director General’s Group. In the first instance this will require:

- Advice being sought from the relevant departments, Department of Community Services, Aging and Disability Department, and NSW Health on services available to parents with a disability and the geographical location and support provided.
- Advice being sought via way of literature and national and international expertise as to the appropriate formulation of suitable supports and services for parents with a disability.
- The development and planning and/or modifying of current services as appropriate to ensure the establishment of a network of suitable support services for parents with a disability and widespread dissemination about the availability of these services to legal representatives and court personnel.
REFERENCES
References


Community Services and Income Security Administrators, Department of Human Services and Health, Canberra.


Tymchuk, A. J., & Andron, L. (1990) Mothers with mental retardation who do or do not abuse or neglect their children, Child Abuse and Neglect, 14, pp. 313-323


APPENDICES

Contents

Appendix 1: Population Prevalence ......................... 94
Appendix 2: Care Applications by CSC ..................... 95
Appendix 3: Code book .................................... 96
Appendix 4: Court Outcomes .............................. 100
Appendix 1: Population Prevalence

**Population prevalence of psychiatric disability:**

- 17.7% of adult participants in the National Survey of Mental Health and Wellbeing (ABS, 1997) reported experiencing a mental disorder at some time during the last 12 months. This figure:
  - excludes psychotic disorders (included in current study)
  - includes substance abuse disorders (excluded in current study)
- 44% of people with mental disorders (approximately 8% of all adults) were found to have a mild, moderate or severe disability which restricted their activities of daily living.
  - During any 12 months period, 22-23% of the US adult population have mental disorders, excluding substance abuse or ‘addictive’ disorders
  - An estimated 9% of adults experience mental disorders with a related functional impairment
  - Only 5.4% of adults are estimated to experience serious mental illness (SMI), that is, a mental disorder that interferes with some area of social functioning
  - Only 2.6% of all adults are estimated to have an SMI with severe and persistent mental illness. This category includes schizophrenia, bipolar disorder, & severe forms of depression.
- The final categories - ‘SMI’ or ‘SMI with severe and persistent mental illness’ – best fit parents with diagnosed psychiatric disability in the current study.
- Therefore, prevalence of psychiatric disability in the general population assumed for this study is between 2.6% and 5.4%.

**Population prevalence of intellectual disability:**

- Australian Institute of Health and Welfare (1997) prevalence of intellectual disability estimate is 0.99% of the population.
- The ABS (1996) reported 1.7% of the population identify as ‘slow at learning or understanding’.
- For a number of reasons, prevalence of parents with intellectual disability is likely to be significantly lower. A New Zealand prevalence study found that approximately 0.25% of families are headed by parents with intellectual disability (Mirfin-Veitch, et al. 1999).

**References:**


### Appendix 2: Care Applications by CSC

<table>
<thead>
<tr>
<th>DoCS CSC</th>
<th>No. of cases care cases</th>
<th>No. of cases involving parents with disabilities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of all DoCS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ashfield JIT</td>
<td>7</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Auburn CSC</td>
<td>21</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Bankstown CSC</td>
<td>14</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Blacktown CSC</td>
<td>21</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>East Sydney CSC</td>
<td>40</td>
<td>11</td>
<td>13.1</td>
</tr>
<tr>
<td>Fairfield CSC</td>
<td>18</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Hornsby CSC</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Liverpool JIT/CSC</td>
<td>16</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Manly CSC</td>
<td>11</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Marrickville CSC</td>
<td>12</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Mount Druitt CSC</td>
<td>9</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Newtown CSC</td>
<td>10</td>
<td>4</td>
<td>4.8</td>
</tr>
<tr>
<td>Parramatta JIT/CSC</td>
<td>25</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Penrith JIT/CSC</td>
<td>21</td>
<td>7</td>
<td>8.3</td>
</tr>
<tr>
<td>Richmond CSC</td>
<td>4</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Ryde CSC</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St George JIT/CSC</td>
<td>7</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>St Leonards CSC</td>
<td>3</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>St Marys CSC</td>
<td>16</td>
<td>9</td>
<td>10.7</td>
</tr>
<tr>
<td>Strathfield CSC</td>
<td>6</td>
<td>2</td>
<td>2.4</td>
</tr>
<tr>
<td>Sutherland CSC</td>
<td>15</td>
<td>6</td>
<td>7.1</td>
</tr>
<tr>
<td>Out-of-Sydney CSC</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>285</td>
<td>84</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Parents with a disability and the NSW Children’s Court
### Appendix 3: Code book

**Initiating affidavit: Basis of present concerns**

<table>
<thead>
<tr>
<th>CONCERNS</th>
<th>Definitions &amp; Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental State of parent/carer</td>
<td>A parent’s/carer’s mental state/health, including references to: mental state, suicide attempts/risk, unstable mental condition, (apparent) depression, mental health, stress &amp; emotional state. Excludes: references to diagnosed psychiatric disorders.</td>
</tr>
<tr>
<td>Drug &amp; alcohol</td>
<td>A parent’s/carer’s use of drugs and/or alcohol. Includes a broad spectrum of references such as: “smell of liquor on the breath, and empty bottles in the house”, “alcohol use”, “use of marijuana”, “appearing drug affected”, “allegations of drug use”, “history of drug and/or alcohol use/abuse”, “urine tests… positive for heroine” &amp; “currently on methadone program”.</td>
</tr>
<tr>
<td>Disability/medical condition</td>
<td>A parent’s/carer’s disability and/or medical condition. Includes explicit identification of disability type (psychiatric disorder, intellectual disability/developmental delay, physical or sensory disability) and/or medical condition such as diabetes.</td>
</tr>
<tr>
<td>DV Domestic Violence/abusive relationships</td>
<td>Reference to domestic violence and/or history of abusive relationships. In a few instances the concern is explicitly stated as the child’s exposure to domestic violence. In other cases, domestic violence or abusive relationships are stated as concerns in and of themselves – concern re. child’s exposure to DV may be implied.</td>
</tr>
<tr>
<td>History of DCS involvement and/or frequent notifications</td>
<td>Includes references to “(long) history of Departmental involvement”, or “multiple notifications” &amp;/or previous removal and placement of any child who is or was in the parent’s/carer’s custody.</td>
</tr>
<tr>
<td>Parent/carer resistance to DCS intervention</td>
<td>Including references to: “breach of informal undertakings”, “refusing DCS officers entry to home”, “ignoring officers”, “lack of cooperation and compliance with the Department”, “angry/threatening towards officers”, “refusal to accept direction”, “inability to work with the Department”, “has not maintained contact with the Department”, “reluctance to discuss matters with the DCS officers”, “rejecting support offered by officers”.</td>
</tr>
<tr>
<td>Parent/carer missing appointments</td>
<td>Includes references to parent/carer failing to attend or be home for appointments.</td>
</tr>
<tr>
<td>Parent/carer lacks insight &amp;/or denies problems exist</td>
<td>Includes references such as: “lack of/poor insight”, “not seeing this as a problem”, “apparent lack of understanding”, “unable or unwilling to acknowledge…”, denial of problem (e.g. drug use), “not believing allegations of… (e.g. sexual abuse)”.</td>
</tr>
<tr>
<td>Alleged/reported physical abuse</td>
<td>Includes references to allegations/history/risk of physical abuse, in both general and specific terms, such as: allegations of physical abuse, history of physical abuse, at risk of physical harm/abuse, “recurrent theme of physical abuse”, “major concerns for safety of…”, “alleged malicious injury”, “thoughts of killing children”, parent/carer admitting to striking the child, and allegations of infant being shaken. Note, in many cases the parent/carer is not the alleged perpetrator.</td>
</tr>
</tbody>
</table>

*Excludes: incidents of abuse resulting in substantiated harm to the child*
<table>
<thead>
<tr>
<th>Appendices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical harm to child</td>
<td>Includes recent or prior incidents of abuse/neglect resulting in a spectrum of substantiated harm to the child, whether or not perpetrated by a parent/carer. Examples include: hospital admissions following ingestion of drugs, prescription medications or noxious substances, “black/blue eyes”, “red mark on back”, “lesions on legs”, “bruises and injuries”, skull &amp;/or rib fractures, broken bones, “burnt fingertips”, “burn marks”, “cigarette burn”, “severe burns to 58% of body”, “previous harm has occurred from the mother shaking the baby”.</td>
</tr>
<tr>
<td>Alleged/reported emotional harm/neglect of child</td>
<td>Relating to behaviour of parent/carer. Includes general and specific references to emotional harm &amp;/or neglect of the child, such as: “emotional neglect”, “not being cared for emotionally”, verbal abuse &amp; foul language, “constantly berates the child”, “screaming and yelling at children”, “emotionally abused”.</td>
</tr>
<tr>
<td>Alleged/substantiated sexual abuse</td>
<td>Referring to a spectrum of alleged or substantiated sexual abuse, whether or not perpetrated by a parent/carer. Examples include: “alleged sexual abuse/assault of children”, “history of sexual abuse in the family”, “… disclosed sexual abuse”, “touches children’s genitals”, “Mother has shown her son her tattoo on her pubic region”, and “… masturbates in front of child”</td>
</tr>
<tr>
<td>Excludes</td>
<td>references to sexualised behaviour of child with no explicit reference to possible sexual abuse. Such behaviours are coded under ‘child behaviour/conduct’.</td>
</tr>
<tr>
<td>Inadequate provision for child’s nutritional needs</td>
<td>Includes references to a parent’s/carer’s failure to: “provide food”, “prepare bottles appropriately”, and “prepare food for school lunches”.</td>
</tr>
<tr>
<td>Child has special needs</td>
<td>Relating to the condition of the child. Includes references to a child’s “special needs” due to disability (e.g. developmental delay), a medical condition such as asthma, illness, or emotional state. Other examples include references to a child’s high physical and emotional needs, “bedwetting &amp; nightmares”, “low weight for age”, “failure to thrive”, “depression, moderate risk of suicide”.</td>
</tr>
<tr>
<td>Disorganised routine/chaotic lifestyle</td>
<td>Includes references such as “disorganised family routine” or “chaotic lifestyle” of parent/carer.</td>
</tr>
<tr>
<td>Inadequate clothing</td>
<td>Includes references such as “inappropriately dressed for weather conditions”, “dirty clothes”, and “observed to be “wearing no shoes”.</td>
</tr>
<tr>
<td>Housekeeping/unsafe physical environment</td>
<td>Includes (usually strong) references relating to poor housekeeping and the safety of the home environment for the child. Examples include: “dirty nappies scattered, food scattered, smelly house”, “unhygienic environment”, “home environment is filthy”, potentially harmful items, such as ashtrays, sharp objects and noxious substances within reach of child, “rubbish and debris inside and outside the house”, “untidy and dirty home”, “general presentation of the house”.</td>
</tr>
<tr>
<td>Money issues/debt</td>
<td>Includes references to debt, poor money management, and requests for financial assistance</td>
</tr>
<tr>
<td>Dirty child/personal hygiene</td>
<td>Includes references to the child being dirty, having dirt under finger/toe nails, “smelling”, and poor personal hygiene.</td>
</tr>
<tr>
<td>School/preschool attendance</td>
<td>Including references to “below average school attendance”, “poor school attendance”, or being “consistently late to school”, or failure to attend pre-school.</td>
</tr>
<tr>
<td>Lack of stimulation/neglect of developmental &amp; educational needs</td>
<td>Includes references to parents/carers neglecting a child’s developmental and educational needs or providing inadequate stimulation. Examples include: “shows little interest in children’s developmental and educational needs”, “does not allow … to interact with other children”, “failure to engage … in appropriate play or interact with the child”, “lack of toys and activities for the children”</td>
</tr>
</tbody>
</table>
### Transient lifestyle/inappropriate housing
Includes references to the parent/carer being “homeless”, or having a “transient lifestyle, with no fixed address”.
Other examples include parents/carers living in unsuitable accommodation such as a tent or “small mobile home”, their “inability to maintain stable accommodation”, or living in “crowded conditions”.

### Keeping bad Company
Includes such references as the parent/carer having “drug users in the home”, or the family home being a “refuge for violent relatives”, or children being “exposed to a range of people with a known history of sex offences”.

### Inadequate supervision
Includes references to the child being left without (adequate) supervision, or under the supervision of inappropriate others such as a sibling, or “drug users”.

### Problematic child behaviour/conduct
Includes references to a broad spectrum of concerning behaviours such as criminal activity, sexualised behaviours, acts of aggression and violence, truanting, and risky behaviours such as staying out overnight.

### Failure or delay in seeking medical/psychological attention for child
Includes references to a parent/carer’s failure or delay in seeking medical attention for a child, or failure to access assessment, counselling or other support services for a child when the need is “apparent”.

### Question attachment and bonding
Includes questions/concerns re. the attachment and bonding (or lack thereof) between mother and child, and/or observations of attachment and bonding between child and other carer/s.

### Child’s expressed wishes/fears
Includes references to the child expressing fears of a parent/carer, and/or not wishing to return home.

### Prnt/carer does not want child in the home
Includes references to a parent/carer not wanting the child in the home, temporarily or more permanently, for whatever reason.

### Failure of supports to resolve probs/concerns
Including references to the failure of support services to bring about change, such as: “supports do not appear to have improved … coping skills”, “little improvement despite intensive services”, “serious notifications despite intensive services”, “family counselling ineffective”, “… has not been able to put into practice the strategies learnt”, “attempts to resolve the situation were unsuccessful”.

### Prnts/carers not coping
Includes general and specific references to a parent/carer not coping, such as: “question ability to cope”, “cannot cope”, “unable to cope with … behaviour”.

### Failure to access support services/or excessive access
Relates to support services in general. Includes references to parent’s/carer’s “reluctance to pursue referrals” and “not accessing relevant support services”

### Non-compliance with medication/treatment/counselling – failure to care for self
Relates to compliance with medication and supports for parent/carer as individual.
Includes references such as: “non-compliance with medication”, “not accepting/attending counselling”, “lack of commitment to drug rehabilitation programs”, “not caring for herself”, “refusing psychiatric assessment and intervention”.

### Child abandoned/whereabouts
Includes references to a child being (apparently) abandoned by a parent/carer, or when the whereabouts of a parent/carer is unknown, or when a parent/carer has failed to attend access visits or maintain contact with a child placed out-of-home.

### Inadequate/poor parenting skills – Qn. parenting capacity
Concerns relating to parenting skills/capacity and the ability to provide/meet a child’s needs. Includes references such as “question adequate parenting skills”, “parenting skills remain at a concerning level”, “parents require input in terms of parenting skills”
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temper/anger control</td>
<td>Includes references to a parent’s/carer’s temper/anger control.</td>
</tr>
<tr>
<td>Multiple partners/prostitution</td>
<td>Includes references to a parent/carer having multiple partners/short term de facto relationships, or prostitution.</td>
</tr>
<tr>
<td>Dysfunctional relationship between prnts/carers</td>
<td>Concerns regarding a parent’s/carer’s relationship, usually between mother and father, but also between parent/carer and other carer in the home such as a grandmother. Examples include: “conflict in their relationship”, “volatile relationship”, “instability of relationship”, “differences in the relationship leading to arguments”.</td>
</tr>
<tr>
<td></td>
<td><em>Exclude</em>: references to domestic violence only</td>
</tr>
<tr>
<td>Prnt/carer or sibling violent &amp; aggressive</td>
<td>Includes references to a parent/carer or sibling being aggressive or violent. Examples include: “observed to aggressive and threatening”, “violent and dangerous behaviours”, “aggressive and belligerent”.</td>
</tr>
<tr>
<td></td>
<td><em>Exclude</em>: references to domestic violence, or physical abuse only.</td>
</tr>
<tr>
<td>General Neglect / failure to put child’s needs first</td>
<td>Concerns of a general nature pertaining to neglect. References include: “Long history of neglect”, “inadequate provision is being made”, “notifications alleging neglect”, “not placing the child’s needs before their own”.</td>
</tr>
<tr>
<td>Mother/carer unable to protect child from harm</td>
<td>Includes explicit references to a parent’s/carer’s (usually mother’s) inability to protect the child from harm perpetrated by others.</td>
</tr>
<tr>
<td>Criminal history/behaviour of parent/carer</td>
<td>Includes references to a parent’s/carer’s criminal history or involvement in illegal activities such as shoplifting, assault, and drug dealing.</td>
</tr>
<tr>
<td>Prnt/carer has inappropriate expectations</td>
<td>Includes references to a parent/carer as having inappropriate or unrealistic expectations of a child for their age.</td>
</tr>
<tr>
<td>Age of child – vulnerability</td>
<td>Includes explicit reference to the young/tender age of a child as a risk factor.</td>
</tr>
<tr>
<td>Concern/opinion of psychiatrist/psychologist/doctor</td>
<td>Includes specific references to concerns raised by ‘experts’ such as doctors, psychologists or psychiatrists.</td>
</tr>
<tr>
<td>Lack of support/isolation</td>
<td>Concern relating to a parent’s/carer’s social isolation, lack of family or other informal supports.</td>
</tr>
<tr>
<td>Child orphaned</td>
<td>Includes references to the death of a child’s parents/carers</td>
</tr>
<tr>
<td>Reliance on others to parent/care for child</td>
<td>Concern relating to the parents reliance on others to provide care. Examples include references to a reliance on a child’s sibling to provide care and supervision, or a parent/carer frequently leaving a child in the care of friends or family members.</td>
</tr>
<tr>
<td>Previous death of child in care of prnt/carer</td>
<td>Includes any reference to a death of a child, whether accidental, by natural causes or otherwise, whilst that child was in the parent’s/carer’s custody.</td>
</tr>
<tr>
<td>The capacity of parent/carer to learn</td>
<td>Concerns relating to a parent’s/carer’s “capacity to learn” and/or “make changes”, usually with reference to parental disability.</td>
</tr>
</tbody>
</table>
Appendix 4: Court Outcomes

General outcomes – all care matters

Court orders

Of the 622 children involved in the 407 care matters finalised in the 9 month period of the file review:

- 238 children (38.3%) were subject to wardship orders +/- any other orders
- 160 children (25.7%) were subject to custody orders +/- any lesser order
- 156 children (25.1%) were subject to supervision orders &/or undertakings
- 46 children (7.4%) were involved in care matters that were subsequently withdrawn
- 19 children (3.1%) were involved in care matters that were dismissed
- 3 children (0.5%) were subject to recission orders.

Order length

Of the 557 children involved in care proceedings that did not result in withdrawal or dismissal of the application, or recission of a court order:

- 293 children (53%) were subject to short term orders of 2 years or less.
- 225 children (40%) were subject to long-term orders, that is, until the child attained the age of 16/18 years.
- 36 children (7%) were subject to medium term orders, that is, longer than 2 years but short of the child attaining the age of 16 years.

Placement type

Of the 557 children involved in care proceedings that did not result in withdrawal or dismissal of the application, or recission of a court order:

- 194 children (35%) were placed home with a parent or parents
- 194 children (35%) were placed out-of-home with extended family members, including several instances where both mother and child moved in with a child’s grandparents.
- 152 children (27%) were placed out-of-home with non-family, including:
  - 112 children (20%) placed in foster care
  - 22 children (4%) placed in a residential care facility, such as a youth refuge.
  - 18 children (3%) placed either with a parent or parents in a supported accommodation setting, or with a family friend.
- For 14 children (3%) placement was still undetermined when care proceedings were finalised and orders made.

Care matters initiated by a Care Application made by a party other than DoCS on Ground C

Court orders

Of the 42 children involved in care matters initiated by a Care Application made by a party other than DoCS in descending order:

- 13 children (31%) were subject to supervision orders and/or undertakings
- 10 children (24%) were subject to care applications that were withdrawn
- 9 children (21%) were subject to wardship orders +/- any other order
- 5 children (12%) were subject to custody orders +/- any lesser order.
- 5 children (12%) were subject to care applications that were dismissed.

Order length

Of the 27 children involved in care matters initiated by a Care Application made by a party other than DoCS and that were not dismissed or withdrawn:

- 14 children (52%) were subject to short term orders
- 12 children (44%) were subject to long term orders
- 1 child was subject to a medium term order
Placement type
Of the 27 children involved in care matters initiated by a Care Application made by a party other than DoCS that were not withdrawn or dismissed:

- 13 children (48%) were placed home with parents
- 11 children (41%) were placed out-of-home with non-family, including:
  - 3 children placed in foster care
  - 6 children placed in residential care
  - 2 children placed with family friends
- 3 children (11%) were placed with extended family members.

Placement type
Of the 63 children involved in care matters initiated by a Variation Application that were not dismissed or withdrawn:

- 26 children (41%) were placed out-of-home with extended family
- 25 children (40%) were placed out-of-home with non-family, including:
  - 20 children placed in foster care
  - 5 children placed in residential care
- 10 children (19%) were placed home with parents

Care matters initiated by Variation Applications
Court orders
Of the 71 children involved in care matters initiated by an application for variation of a court order in descending order:

- 30 children (42%) were subject to wardship orders +/- any other order
- 23 children (32%) were subject to custody orders +/- any lesser order
- 10 children (14%) were subject to supervision orders and/or undertakings
- 6 children (9%) were subject to care applications that were dismissed
- 2 children were subject to care applications that were withdrawn by the applicant.

Order length
Of the 63 children involved in care matters initiated by a Variation Application that were not dismissed or withdrawn:

- 44 children (70%) were subject to long term orders
- 16 children (25%) were subject to short term orders
- 3 children (5%) were subject to medium term orders

Variation Applications and parents with a disability
As noted in Section 1 – Prevalence, no parents with a disability made an application for variation of a court order. However, of DoCS initiated applications for variation of an order, nine involved parents with a disability.

- One case involved parents with intellectual disability. This resulted in a short-term wardship order, with the child placed out-of-home with non-kin.
- Two cases involved parents with psychiatric disability only. One case resulted in long term wardship order with the child placed out-of-home with non-kin. The other resulted in a long-term custody order with the child placed with extended family members.
- Three cases involved parents with psychiatric disability and suspected D&A use. One resulted in a short-term custody order with the child placed with extended family. Two cases resulted in long term wardship orders with children placed with non-kin.
- Two cases involved parents with intellectual and psychiatric disability. One case resulted in a long-term wardship order with the child placed out-of-home with non-kin. The other resulted in a short-term wardship order with the child placed out-of-home with extended family.
- One case involved a parent with physical disabilities. This case resulted in a medium term custody order with the child placed with extended family.
**Care matters initiated by Recission Applications**

**Court orders**

Of the 40 children involved in care matters initiated by an application for recission of a court order in descending order:

- 13 children (32.5%) were subject to applications that were withdrawn
- 8 children (20%) were subject to custody orders +/- any lesser order
- 7 children (17.5%) were subject to wardship orders +/- any other order
- 6 children (15%) were subject to applications that were dismissed
- 3 children (15%) were subject to supervision orders and/or undertakings.
- 3 children (7.5%) were subjects of successful applications, where the standing order was rescinded.

**Order length**

Of the 18 children involved in care matters initiated by an application for recission that were not either withdrawn, dismissed or rescinded:

- 12 children (67%) were subject to long term orders
- 5 children (28%) were subject to short term orders
- 1 child was subject to a medium term order

**Placement type**

Of the 18 children involved in care matters initiated by an application for recission that were not either withdrawn, dismissed or rescinded:

- 7 children (39%) were placed home with parents
- 6 children (33%) were placed out-of-home with non-family, including:
  - 4 children placed in foster care
  - 1 child placed in residential care
  - 1 child placed with family friends
- 4 children (22%) were placed out-of-home with extended family members
- For one child placement was undetermined

**Recission applications and parents with a disability**

- One care matter involving a parent with disability was initiated by a DoCS application for recission of a court order. This case involved a parent with intellectual and psychiatric disability. The application was revised by DoCS to be an application for variation. The result was a long-term wardship order with the child placed out-of-home with non-kin.
- Five parents with a disability initiated care proceedings with an application for recission of a court order.
  - Two cases involved parents with psychiatric disability only. In both cases the parents withdrew their application.
  - Three cases involved parents with psychiatric disability with suspected D&A use. One case was dismissed, another withdrawn and the third case resulted in a supervision order with undertakings.