13 February 2004

Protecting Children: Child Protection Outcomes Project
5/555 Collins Street
MELBOURNE 3000

Dear Project Team

Re: Protecting Children: Child Protection Outcomes Project

The Mental Health Legal Centre is an organisation committed to the realisation of rights by people with a mental illness through legal advice, advocacy, education, research, policy and law reform. This submission is based on 16 years direct casework, research and anecdotal evidence of interaction with parents with a psychiatric disability encountering the child protection system.

We welcome the opportunity to comment on the issue of child abuse since media campaigns in the past have tended to provoke a process of 'policy development by press release' as opposed to careful consideration and consultation. News coverage can be sensationalist and over simplify the problem by identifying 'deviant perpetrators' of neglect and abuse, while ignoring broader structural factors. Subsequently, statutory solutions have resulted in disproportionate attention being placed on parents with a mental illness due to discriminatory assumptions about their capacity to care for children.

Proposed New Model for Child Protection

Under the current care and protection regime, rigorous examination of parenting skills is made following notifications of abuse or neglect. In this context, it is reassuring to read the Report's strong thrust towards developing proactive policies and partnerships prior to serious protection issues arising.

The current service system is geared towards the protection of children at risk of significant harm, yet debate surrounds consistent interpretation of this term. The subjective application of varying standards by workers across disciplines and according to training and experience, can lead to a wide variety of outcomes. Not only is there no consensus on what constitutes child 'abuse' or 'risk', competing theories alter over time along with advice on relevant treatment programs.

Discrimination Against Parents with a Mental Illness

This Centre has witnessed many examples of prejudicial practices in the assessment of skills and relationships of parents with a mental illness. Frequently, parental ability has been based on discriminatory assumptions derived solely from a psychiatric diagnosis. While the presence of a mental illness alone cannot constitute grounds for intervention, on many

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occasions these parents have been subjected to intense scrutiny and expected to perform to excessive standards.

A fundamental principle to emerge from our work is that mental illness is extremely diverse, and its impact alters from time to time. Caution must be exercised to avoid rigid application of one set of rules to a non-homogenous group. It is necessary to avoid stigmatizing parents with a psychiatric disability in a manner that is patronising or denies individual autonomy.

Professional responses must be respectful, informed, flexible and tailored to individual needs, and workers educated to see beyond the mental illness and focus on ways of enriching familial relationships. Fundamental to this process is training on the impact of mental illness on parenting responsibilities, to ensure that families receive appropriate understanding and dignity.

Since many of the report's recommendations rely on rising rates of self-referral to local centres and community networks, the presence of prejudicial practices must be addressed. Unless workers adjust unfavorable assessment procedures towards parents with a psychiatric disability, the proposed voluntary partnerships with parents are doomed to failure.

Discriminatory responses imposed by protective services, police and Family Court personnel act as a major deterrent to parents with a mental illness initiating any form of contact with support systems. While they may require assistance during intermittent periods of ill-health, the climate of fear created by regulatory procedures prevents them from independently engaging services. The perceived potential for children to be removed causes an unwillingness to request support even when the parent recognizes a compromised coping capacity.

Range of Service Responses

While much is made of the responsibility for service providers to ensure adequate availability and access to support programs, the Report overlooks the source of any additional funding. Since its success relies on a number of intensive and costly operations, the failure to remark on resource issues raises great concern, especially when anticipated to be more expensive in the short term.

The report does not identify a fundamental and gross flaw in the system of child protection in Victoria; that being a blatant conflict between both the provision of support and investigation of reports being made by the same Human Services Department.

One case example which exemplifies this:

> *SD was diagnosed as having a borderline personality disorder. She had a period of not coping with life and was feeling particularly anxious about parenting her son. She stated to her doctor that she was concerned that she might smack him. Mandatory reporting required the doctor to report the incident. The Department assessed the situation and placed him with his grandmother and restricted SD's contact to monthly visits. An Interim Accommodation Order was granted to the grandmother but after 6 months, a Custody to Secretary Order was made in favour of the grandmother.*

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SD self referred to a number of support agencies and established for herself a support network. No assistance had been provided by DHS although this is one of their roles. SD's mental health had also significantly improved. DHS took no account of SD's improvement in mental health and were proceeding on a case plan for permanent care of the child to the grandmother. Child Protection told SD and her mother that overnight contact had to be supervised - this was not in the Order. SD resided in Melbourne while her son was placed with his grandmother at the end of a 3 hour $30 train journey.

Where can a parent go for support without intervention? We know anecdotally that many parents with disabilities are totally isolated, have no family supports, friends or neighbourhood contacts. Support funding is tagged to parents who are identified as needing support through DHS - clearly these parents are then placed in a glass bowl for ongoing assessment, and the stakes are high, and the expectations distorted by often inexperienced child protection workers.

The shifting focus from a predominantly adversarial and reactionary protective system to a self-regulatory and voluntary partnership with parents will require implementation over many years. Budgetary expenditure must therefore reflect the long term commitment of all political parties to the scheme. It requires a shift in culture and attitude and will also require extra resources to be placed outside protective services such as increased availability of maternal health nurses, welfare officers in schools and case managers with specialist skills in parenting Too many innovative ideas have been funded for only pilot or short term projects and ceased after a time limited period, thereby abandoning current program participants.

Interagency Co-operation

Protective Services have failed to work collaboratively with Mental Health Services despite the document's title 'Victoria 's Mental Health Services and Protective Services Working Together.' Our Centre continues to be advised by case workers in mental health services that they are inadequately consulted by child protection workers and their views are not listened to, despite the fact that they are in the best position to know the impact of the persons illness on all aspects of their lives- including parenting. Mental health workers have informed us that they are not told when DHS proposes to issue protection proceedings.

Intermediate Level Responses

The establishment of another tier of bureaucracy with indeterminate powers poses the threat of further disempowering our clients, unless adequate safeguards are built in. We recommend independent legal advice and/or representation for our clients as mandatory before an agreement is finalised. This would ensure that our clients are not placed in a position where they are required to comply with an agreement which is more coercive than a court order. To remove the option of legal representation would cause our clients to be coerced into making deleterious decisions in the absence of any legal advice or right's knowledge. They would be greatly disadvantaged by an inability to consult advocates or obtain independent information.

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It is essential that all alternatives are thoroughly explored and exhausted, commencing with the least restrictive option for support and assistance. Implicit in this requirement is that access to adequate legal advice or representation has been provided.

Out Of Home Care

In our experience practices of protective services encourage lengthy out of home care. In the above case the child was on a Custody to Secretary Order and placed with his maternal grandmother. DHS proposed that the permanent care order should be made in favour of the child's grandmother, despite repeated requests from the child to be returned home to his mother. A Children's Court Clinic report was obtained which recommended the child should be returned. DHS did not act on the report until they had obtained their own report which confirmed the report of the Children's Court. There was a delay of 12 months from the date of the Children's Court Clinic report before the child was fully united with his mother. Delays in reunification are too often the fault of DHS.

It is already the case that routine contact arrangements are regularly disrupted due to insufficient facilities and staff to provide supervision. This occurs despite repeated requests from both parent and child, and effectively denies the maintenance of an ongoing relationship, even when DHS concede this interaction to be positive and in the child's 'best interests.'

Inadequate opportunities for contact are frequently misconstrued as a sign of diminished love on the part of the parent, rather than as a real reflection of inadequate resource funding. Many parents are highly motivated to comply with protective orders and medical treatment, but lack access to appropriate programs and facilities. Strong bonds and ongoing attachment between parent and child during times of separation are demonstrated through families constantly striving towards reunification. Expressed preferences in terms of placement options should be sought from age specific children and provision made for attainment of stated options. Requests for assistance must not be seen as indicative of admission of an inability to parent.

Fast tracking of permanency may unfairly impact on our clients particularly where recovery from mental illness may take time. This could unfairly disadvantage our clients who have very good parenting skills but have been temporarily incapacitated by mental illness

Our experience has been that stalling strategies are regularly exercised by DHS to the detriment of ongoing relationships between parents and children when placed in care. Children may be fostered in geographically distant locations to dissuade continual contact, and delays can occur when vacancies for mandated programs are always full. In turn, accusations of non-compliance with parenting plans are unjustly made by protective workers.

In our case example, our client was allowed monthly contact as stated in the Court order. The DHS however, in a case meeting, directed that this was to be supervised- this was not a condition imposed by the Court. Our client had non supervised visits by arrangement with her mother which she openly disclosed to child protection, they interpreted this as a breach of the Custody to Secretary Order and reported it as such in their report. There was no breach nor was there any grounds to their conclusion that she was untrustworthy and deceitful and therefore could not resume contact until she proved she could comply with new DHS directions (whether or not they were reasonable). Frequently the DHS will punish parents for

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not complying with directions. There is nowhere to challenge these directions, or nowhere to complain. Other difficulties associated with supervised contact arrangements have already been explored.

Any additional extension to DHS powers, coupled with a corresponding decrease in levels of transparency in decision making and accountability, are therefore strongly opposed. It is also critical to the success of any suggested systemic reforms that they encompass analysis of societal inequities such as poverty, unemployment and homelessness. Rather than concentrating purely on personal deficiencies and parental impediments, an examination of child abuse issues must be placed its broad social and economic context.

The case example highlights the intransigence of protection workers towards parents with mental illness. Child Protection workers display an entrenched set of assumptions, not subject to scrutiny that parents with a mental illness cannot parent. We recommend a model that assumes the person is able to parent and supports them to do so, that challenges these assumptions. Intervention by child protection services is the most restrictive alternative and to be pursued after all less restrictive options have been explored.

Recommendations:

- The establishment of separate offices for Family Support and Child Protection. Mandatory reporting cannot be a function of family support agencies, this legal requirement must therefore be reviewed to ensure that there is respect and protection for parents who request support and assistance, as well as where necessary intervention to protect children.

- The European model of Family Support to all parents with appropriate resourcing. In addition extra additional support to be available for parents with a mental illness.

- Protective Services to comply with the 'Victoria's Mental Health Services and Protective Services Working Together'

- More resources to Community Mental Health Services to appoint case managers with specific skills in parenting to work with parents with a mental illness. Such case managers should be located at every Area Mental Health Service and protective services must reach agreement with them before taking coercive action.

- More flexibility and greater parental access when a permanent care order is made by the Court. Decisions on access should not be determined by resources of Protective Services but should be based on 'best interests' and the wishes of the child.

- Access should never be withdrawn to punish parents for not complying with child protection directions.

- Any agreement reached in a Family Court Group Conference or Community Child and Family Support Panel only to be finalized when the parent has received independent legal advice about the agreement or has been legally represented.

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- Fast tracking of permanency should only be made once a Court is satisfied that all reasonable steps have been taken by DHS to provide the services necessary to ensure the safety and well being of the child.

- Fast tracking of disputes around access.

- A complaints/dispute resolution service, to be an adjunct of the Court - to resolve issues and misunderstandings between parents and child protection workers.

If you wish to discuss this matter further, please do not hesitate to contact myself or Rhonda Black on 9629-4422.

Yours sincerely,

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Solicitor/Co-ordinator
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